NEW ISSUE – BOOK-ENTRY ONLY

Ratings: S&P: A
Moody's: A3
Fitch: A

In the opinion of Stevens & Lee, P.C. ("Bond Counsel"), assuming continuing compliance by the Authority and the Obligated Group with certain covenants to comply with provisions of the Internal Revenue Code of 1986, as amended (the "Code"), and all regulations applicable thereunder, interest on the 2017 Bonds is not includable in gross income under Section 103(a) of the Code and interest on the 2017 Bonds is not an item of tax preference for purposes of the federal, individual or corporate alternative minimum taxes; although Bond Counsel observes that such interest is included in adjusted current earnings when calculating the corporate alternative minimum taxable income; also see "TAX EXEMPTION AND OTHER TAX MATTERS" herein for a brief description of some of the other provisions of the Code affecting the purchasers and holders of the 2017 Bonds. In the opinion of Bond Counsel, under the laws of the Commonwealth of Pennsylvania (the "Commonwealth"), the 2017 Bonds and interest on the 2017 Bonds shall be free from taxation for state and local purposes within the Commonwealth, but this exemption does not extend to gift, estate, succession or inheritance taxes or any other taxes not levied directly on the 2017 Bonds or the income therefrom. Under the laws of the Commonwealth, profits, gains or income derived from the sale, exchange or other disposition of the 2017 Bonds, are subject to state and local taxation within the Commonwealth.

$590,500,000
BERKS COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY
Health System Revenue Bonds
(Tower Health Project)
Series of 2017

Dated: Date of Delivery **Due: November 1, as shown on the inside cover**

Berks County Industrial Development Authority (the "*Authority*") is issuing $590,500,000 of its Health System Revenue Bonds (Tower Health Project), Series of 2017 (the "*2017 Bonds*") for the benefit of Tower Health, formerly known as Reading Health System (the "*System*" or "*Tower Health*"), and certain of its affiliates that constitute the Obligated Group (defined herein) to refinance certain outstanding indebtedness, to finance certain capital expenditures of the Obligated Group and to pay certain costs of refinancing and costs of issuance of the Series 2017 Bonds, as described herein. See "PLAN OF FINANCE" and "ESTIMATED SOURCES AND USES OF FUNDS" herein. The 2017 Bonds will be issued as described herein.

The 2017 Bonds will bear interest at the rates and mature on the dates set forth on the inside cover. The principal or redemption price of the 2017 Bonds will be payable upon presentation and surrender thereof at the office of the Manufacturers and Traders Trust Company (the "*Bond Trustee*"). Interest on the 2017 Bonds will be payable semiannually on May 1 and November 1 of each year, commencing May 1, 2018. So long as The Depository Trust Company, New York, New York ("*DTC*") or its nominee, Cede & Co., is the registered owner of the 2017 Bonds, payments of the principal or redemption price of, and interest on, the 2017 Bonds will be made to DTC. Additional information concerning the terms of the 2017 Bonds is contained under the caption "DESCRIPTION OF THE 2017 BONDS" herein.

The 2017 Bonds will be issued as fully registered bonds without coupons, and, when initially issued, will be registered in the name of Cede & Co., as registered owner and nominee for DTC. DTC will act as securities depository of the 2017 Bonds. Individual purchases will be made only in book-entry form, initially in denominations of $5,000 and in any integral multiple thereof. So long as Cede & Co., as nominee for DTC, is the registered owner of the 2017 Bonds, references herein to the Bondholders or registered owners (other than under the caption "CONTINUING DISCLOSURE" herein) shall mean Cede & Co., as aforesaid, and shall not mean the Beneficial Owners of the 2017 Bonds.

The 2017 Bonds are issued and secured under the provisions of the Trust Indenture, dated as of October 1, 2017 (the "*Bond Indenture*"), by and between the Authority and the Bond Trustee. The 2017 Bonds are payable, in addition to the sources described herein, from loan repayments made by the System pursuant to the Loan Agreement (defined herein), between the Authority and the System and the System's obligations under the Loan Agreement are evidenced and secured by the 2017 Master Note (defined herein), to be delivered under the terms of the Master Indenture (defined herein), by the Obligated Group. See Appendix C – "SUMMARY OF THE BOND INDENTURE AND THE LOAN AGREEMENT" and Appendix D – "SUMMARY OF THE MASTER INDENTURE" hereto.

The 2017 Bonds are subject to optional, mandatory and extraordinary redemption prior to maturity as described herein. See "DESCRIPTION OF THE 2017 BONDS – Redemption Provisions" herein.

THE 2017 BONDS ARE SPECIAL LIMITED OBLIGATIONS OF THE AUTHORITY AND DO NOT CONSTITUTE A DEBT OR LIABILITY OF THE COUNTY OF BERKS, THE COMMONWEALTH, OR ANY POLITICAL SUBDIVISION, AGENCY OR INSTRUMENTALITY THEREOF OTHER THAN THE AUTHORITY. NEITHER THE CREDIT NOR THE TAXING POWER OF ANY STATE OR ANY POLITICAL SUBDIVISION, AGENCY OR PUBLIC INSTRUMENTALITY THEREOF IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE 2017 BONDS. THE AUTHORITY HAS NO TAXING POWER AND IS NOT LIABLE FOR THE PAYMENT OF THE 2017 BONDS EXCEPT FROM THE SOURCES HEREIN DESCRIBED.

This cover page contains information for quick reference only. It is not a summary of this issue. Investors must read the entire Official Statement to obtain information essential to the making of an informed investment decision. **There are risks associated with an investment in the 2017 Bonds, some of which are outlined under the caption "BONDHOLDERS' RISKS" herein.**

The 2017 Bonds are offered when, as and if issued by the Authority and received by the Underwriters, subject to prior sale and to approval of legality by Stevens & Lee, P.C., Reading, Pennsylvania, Bond Counsel; and to the approval of certain matters for the Authority by its counsel, Georgeadis Setley LLC, Wyomissing, Pennsylvania; for Tower Health and the Obligated Group by their counsel, Stevens & Lee, P.C., Reading, Pennsylvania; and for the Underwriters by their counsel, Kutak Rock LLP, Washington, D.C. H2C Securities Inc. served as financial advisor to the System and the Obligated Group in connection with the 2017 Bonds. It is expected that the 2017 Bonds in definitive form will be available for delivery to DTC in New York, New York on or about October 31, 2017.

Citigroup **Barclays**

The date of this Official Statement is October 17, 2017.

$590,500,000
Berks County Industrial Development Authority
Health System Revenue Bonds
(Tower Health Project)
Series of 2017

Serial Bonds

Maturity (Nov. 1)	Principal Amount	Interest Rate	Yield	Price	CUSIP†
2021	$1,770,000	5.000%	1.600%	113.123	08451PAA9
2022	3,040,000	5.000%	1.800%	115.235	08451PAB7
2023	5,945,000	5.000%	1.970%	117.067	08451PAC5
2024	6,490,000	5.000%	2.150%	118.429	08451PAD3
2025	7,035,000	5.000%	2.340%	119.304	08451PAE1
2026	7,610,000	5.000%	2.520%	119.858	08451PAF8
2027	8,215,000	5.000%	2.620%	120.818	08451PAG6
2028	8,885,000	5.000%	2.760%*	119.458	08451PAH4
2029	9,580,000	5.000%	2.880%*	118.306	08451PAJ0
2030	10,305,000	5.000%	2.940%*	117.736	08451PAK7
2031	11,005,000	4.000%	3.220%*	106.623	08451PAL5
2032	6,855,000	4.000%	3.340%*	105.571	08451PAM3
2033	7,570,000	4.000%	3.450%*	104.618	08451PAN1
2034	8,375,000	5.000%	3.200%*	115.300	08451PAP6
2035	9,675,000	5.000%	3.250%*	114.839	08451PAQ4
2036	10,735,000	5.000%	3.290%*	114.471	08451PAR2
2037	11,795,000	5.000%	3.320%*	114.196	08451PAS0
2038	12,800,000	4.000%	3.700%*	102.488	08451PAT8
2039	13,715,000	4.000%	3.730%*	102.236	08451PAU5

† Registered trademark of American Bankers Association. CUSIP data herein is provided by Standard and Poor's CUSIP Service Bureau, a division of the McGraw Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP service. CUSIP numbers are provided for reference only. Neither the Authority, the Bond Trustee nor the Underwriters take any responsibility for the accuracy of such numbers.

* Yield to first optional redemption date of November 1, 2027.

$43,185,000; 3.750%; Term Bond Due Nov. 1, 2042; Yield 3.920%; Price 97.306; CUSIP† 08451PAV3

$75,000,000; 4.000%; Term Bond Due Nov. 1, 2047; Yield 3.840%*; Price 101.318; CUSIP† 08451PAW1

$121,320,000; 5.000%; Term Bond Due Nov. 1, 2047; Yield 3.490%*; Price 112.654; CUSIP† 08451PAX9

$25,000,000; 4.000%; Term Bond Due Nov. 1, 2050; Yield 3.900%*; Price 100.821; CUSIP† 08451PAZ4

$164,595,000; 5.000%; Term Bond Due Nov. 1, 2050; Yield 3.550%*; Price 112.116; CUSIP† 08451PAY7

† Registered trademark of American Bankers Association. CUSIP data herein is provided by Standard and Poor's CUSIP Service Bureau, a division of the McGraw Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP service. CUSIP numbers are provided for reference only. Neither the Authority, the Bond Trustee nor the Underwriters take any responsibility for the accuracy of such numbers.

* Yield to first optional redemption date of November 1, 2027.

IN CONNECTION WITH THIS OFFERING, THE UNDERWRITERS MAY OVERALLOT OR EFFECT TRANSACTIONS WHICH STABILIZE OR MAINTAIN THE MARKET PRICE OF THE 2017 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME WITHOUT PRIOR NOTICE. THE UNDERWRITERS MAY OFFER AND SELL THE 2017 BONDS TO CERTAIN DEALERS AT PRICES LOWER THAN THE OFFERING PRICES STATED ON THE INSIDE COVER HEREOF AND SAID OFFERING PRICES MAY BE CHANGED FROM TIME TO TIME BY THE UNDERWRITERS WITHOUT NOTICE.

No dealer, broker, salesperson or other person has been authorized by the Authority, the System, the Obligated Group or the Underwriters to give any information or to make any representations, other than those in this Official Statement, and if given or made, such other information or representations must not be relied upon as having been authorized by any of the foregoing. This Official Statement does not constitute an offer to sell or the solicitation of an offer to buy, and there shall not be any sale of the 2017 Bonds in any state in which it is unlawful to make such offer, solicitation or sale. The information set forth herein has been obtained from the Authority, the System, the Obligated Group and other sources that are believed to be reliable, but the accuracy or completeness of the information is not guaranteed and the information is not to be construed as a representation by the Underwriters. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the Authority, the System or the Obligated Group since the date hereof. This Official Statement is submitted in connection with the issuance of securities referred to herein and may not be used, in whole or in part, for any other purpose.

The Underwriters have reviewed the information in this Official Statement pursuant to their responsibilities to investors under the federal securities laws, but the Underwriters do not guarantee the accuracy or completeness of such information.

The order and placement of materials in this Official Statement, including the Appendices, are not to be deemed a determination of relevance, materiality or importance, and this Official Statement, including the Appendices, must be considered in its entirety.

THE 2017 BONDS HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933 NOR HAS THE BOND INDENTURE NOR THE MASTER INDENTURE BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE REGISTRATION OR QUALIFICATION OF THE 2017 BONDS IN ACCORDANCE WITH APPLICABLE PROVISIONS OF SECURITIES LAWS OF THE STATES IN WHICH THE 2017 BONDS HAVE BEEN REGISTERED OR QUALIFIED AND THE EXEMPTION FROM REGISTRATION OR QUALIFICATION IN THE OTHER STATES CANNOT BE REGARDED AS A RECOMMENDATION THEREOF. NEITHER THESE STATES NOR ANY OF THEIR AGENCIES HAVE PASSED UPON THE MERITS OF THE 2017 BONDS OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT.

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFICIAL STATEMENT

Certain statements included or incorporated by reference in this Official Statement constitute "forward-looking statements." Such statements generally are identifiable by the terminology used, such as "plan," "expect," "estimate," "budget" or other similar words. Such forward-looking statements include, but are not limited to, certain statements under the caption "BONDHOLDERS' RISKS" in the forepart of this Official Statement and in Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP" attached hereto.

The achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Neither the System nor the Obligated Group plans to issue any updates or revisions to those forward-looking statements if or when their expectations of events, conditions or circumstances on which such statements are based occur.

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OFFICIAL STATEMENT

$590,500,000
Berks County Industrial Development Authority
Health System Revenue Bonds
(Tower Health Project)
Series of 2017

INTRODUCTORY STATEMENT

This Official Statement, including the cover page and Appendices attached hereto, is furnished in connection with the offering of $590,500,000 aggregate principal amount of Health System Revenue Bonds (Tower Health Project), Series of 2017 (the "*2017 Bonds*"). The 2017 Bonds are being issued and sold by the Authority pursuant to (i) the Economic Development Financing Law, Act of August 23, 1967, P.L. 251, as amended (the "*Act*"), (ii) resolutions adopted by the Board of the Authority on August 8, 2017 and September 7, 2017, and (iii) a Trust Indenture, dated as of October 1, 2017 (the "*Bond Indenture*"), by and between the Authority and Manufacturers and Traders Trust Company, a New York state chartered bank with trust powers organized and existing under and by virtue of the laws of the State of New York and having a corporate trust office in the City of Harrisburg, Pennsylvania, as trustee (the "*Bond Trustee*").

The 2017 Bonds are being issued to make a loan to Tower Health, a Pennsylvania nonprofit membership corporation (the "*System*" or *"Tower Health"*), in a principal amount equal to the aggregate principal amount of the 2017 Bonds (the proceeds of which loan will be equal to the proceeds received from the sale of the 2017 Bonds), pursuant to a Loan Agreement, dated as of October 1, 2017 (the "*Loan Agreement*"), between the Authority and the System. The System, formerly known as Reading Health System, serves as the parent organization of Reading Hospital and five recently acquired acute care hospitals and related facilities, constituting a part of the Project described below, that will form an integrated healthcare system located in the Counties of Berks, Chester and Montgomery, Pennsylvania and the City of Philadelphia, Pennsylvania. Tower Health and the entities that own and operate the six acute care hospitals currently constitute the Obligated Group. See "THE OBLIGATED GROUP" and Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP".

Pursuant to the Loan Agreement, the Authority will lend the proceeds of the 2017 Bonds to the System for the purpose of financing the costs of a project (the "*Project*"), including among other things, (a) the advance refunding of a portion of The Berks County Municipal Authority's Fixed Rate Revenue Bonds (The Reading Hospital and Medical Center Project) Series 2009A-3 (the *"Refunded 2009A-3 Bonds"*); (b) the design, construction, installation and furnishing of the Reading HealthPlex for Advanced Surgical & Patient Care; (c) the refinancing of a bridge loan from Citibank, N.A., a portion of which was used to finance the acquisition of (i) Brandywine Hospital, a 234-bed acute care hospital located in Coatesville, Pennsylvania, including related office buildings, parking facilities and related facilities, (ii) Chestnut Hill Hospital, a 135-bed acute care hospital located in Philadelphia, Pennsylvania, including related medical office buildings, surgery centers and parking facilities, (iii) Jennersville Regional Hospital, a 63-bed acute care hospital located in West Grove, Pennsylvania, including related medical office buildings and related facilities, (iv) Phoenixville Hospital, a 151-bed acute care hospital located in Phoenixville, Pennsylvania, including related medical office buildings and related facilities, and (v) Pottstown Memorial Medical Center, a 232-bed acute care hospital located in Pottstown, Pennsylvania, including related medical office buildings and surgery centers ((i) through (v) collectively, the "Acquired Hospitals"); and (d) the payment of costs and expenses associated with the refunding of the Refunded 2009A-3 Bonds and the issuance of the 2017 Bonds. See "PLAN OF FINANCING" and "ESTIMATED

SOURCES AND USES OF FUNDS," "THE OBLIGATED GROUP" and Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP."

The 2017 Bonds will be issued in the aggregate principal amount, bear interest at the rates and mature on the dates and in the principal amounts set forth on the inside cover page of this Official Statement. Interest on the 2017 Bonds is payable semiannually on May 1 and November 1 of each year, commencing May 1, 2018. The 2017 Bonds will be authorized in denominations of $5,000 and any integral multiple thereof. Additional information concerning the terms of the 2017 Bonds is contained under the caption "DESCRIPTION OF THE 2017 BONDS" herein.

Security

Pursuant to the Loan Agreement, the System has agreed to make payments at such times and in such amounts as to provide for payment of the principal of, and premium, if any, and interest on, the 2017 Bonds as well as certain fees and expenses of the Authority.

To evidence and secure the System's obligations under the Loan Agreement, the System, as maker, will issue to the Authority, as payee, its Series B of 2017 Master Note (Berks County Industrial Development Authority) dated the date of issuance of the 2017 Bonds (the "*2017 Master Note*"). The Authority's right, title and interest in the 2017 Master Note will be assigned to the Bond Trustee. The 2017 Master Note will be issued under and secured pursuant to a Master Trust Indenture dated as of June 1, 1993 (the "*Master Indenture*") among the Obligated Group (as defined below), the System and The Bank of New York Mellon Trust Company, N.A., as master trustee (in such capacity, the "*Master Trustee*"), as amended, modified or supplemented from time to time, including by a Thirty-Third Supplemental Master Trust Indenture dated as of October 1, 2017 ("*Supplement No. 33*").

The 2017 Master Note and any additional notes issued under the Master Indenture are to be secured, on a parity basis with the other Master Indenture Obligations that heretofore have been issued under the Master Indenture by a lien on and a security interest in the Gross Revenues of the Obligated Group or certain corporate entities that may become members of the Obligated Group for the equal and ratable benefit of the holders of all Master Indenture Obligations. See "SECURITY FOR THE 2017 BONDS" herein and Appendix D - "SUMMARY OF THE MASTER INDENTURE" for a further description of the Master Indenture.

Proposed Amendments to the Master Indenture

In connection with the issuance of the 2017 Bonds, the Obligated Group proposes to make certain amendments to the Master Indenture relating to certain definitional changes, compliance with financial covenants of the Master Indenture upon changes to generally accepted accounting principles, the method of calculating the Long-Term Debt Service Requirements for Commercial Paper Indebtedness, Interim Indebtedness and Balloon Long-Term Indebtedness, the revision of financial compliance tests for certain fundamental transactions and provisions relating to the substitution of Master Indenture Obligations upon the delivery of a substitute master indenture (collectively, the "*Proposed Amendments*"). Pursuant to the terms of the Master Indenture, the Proposed Amendments will only become effective upon the consent of (i) the Holders of not less than a majority in aggregate principal amount of the Master Indenture Obligations then outstanding under the Master Indenture and (ii) the Holders of the Series B of 2016 Master Note (if the rating of the long term unenhanced Indebtedness of the Obligated Group is at or below "BBB+" by S&P, at or below "Baa1" by Moody's or at or below "BBB+" by Fitch Ratings) and the Series D of 2016 Master Note then outstanding under the Master Indenture.

The initial purchasers of the 2017 Bonds by their purchase and acceptance of the 2017 Bonds shall be deemed to have approved and consented to the Proposed Amendments, which consent shall be binding upon all present and future holders of the 2017 Bonds. Upon the issuance and delivery of the 2017 Bonds, the consents required for the Proposed Amendments to become effective will not have been obtained. See Appendix D - "SUMMARY OF THE MASTER INDENTURE" for a description of the Proposed Amendments to the Master Indenture.

Indenture-held Funds

The 2017 Bonds will be further secured by the moneys and securities in certain accounts held by the Bond Trustee under the Bond Indenture. The moneys and securities held in such accounts secure the 2017 Bonds issued under the Bond Indenture.

The 2017 Bonds are special, limited obligations of the Authority issued and separately secured under the Bond Indenture. Except to the extent payable from the proceeds of the 2017 Bonds, the 2017 Bonds will be payable solely from loan repayments made by the System under the Loan Agreement and by the Obligated Group under the 2017 Master Note.

See "SECURITY FOR THE 2017 BONDS" and Appendix D – "SUMMARY OF THE MASTER INDENTURE" hereto for a summary of the terms of the Master Indenture.

Financial Information

Appendix A to this Official Statement includes financial data for the fiscal years ended June 30, 2017 and 2016, which have been derived from the audited consolidated financial financial statements of the System and its controlled entities and from proforma financial data for the Acquired Hospitals, which data in the opinion of management, include all adjustments, consisting of normal, recurring adjustments, necessary for a fair presentation of the financial data solely for such periods.

Appendix B to this Official Statement contains the audited consolidated financial statements of the System and its subsidiaries for the fiscal years ended June 30, 2017 and 2016 (prior to the acquisition of the Acquired Hospitals).

Bondholders' Risks

An investment in the 2017 Bonds involves the assumption of certain risks that relate primarily to the ability of the System and the other members of the Obligated Group to generate revenues from operations that will be sufficient to pay debt service on the 2017 Bonds and other indebtedness of the Obligated Group. The disclosure of risks contained herein under the caption, "BONDHOLDERS' RISKS," is based upon the assessment of the System's management of the impact that such risks might have on the System and the other members of the Obligated Group, taken as a whole. In the event that the identity or composition of the Obligated Group changes, the impact of such risks might differ from the present assessment of the System's management of the impact of such risks.

Defined Terms

All capitalized terms used in this Official Statement, unless otherwise defined or the context otherwise indicates, have the same meaning included in "Definitions of Certain Terms and Summaries of Principal Legal Documents" in Appendix C – "SUMMARY OF THE BOND INDENTURE AND THE LOAN AGREEMENT," and "Definitions of Certain Terms" in Appendix D – "SUMMARY OF THE MASTER INDENTURE" hereto.

Underlying Documents

The descriptions and summaries of various documents hereinafter set forth do not purport to be comprehensive or definitive, and reference is made to each document for the complete details of all terms and conditions. All statements herein are qualified in their entirety by reference to each such document. Copies of the Master Indenture, Supplement No. 33, the Loan Agreement and the Bond Indenture will be available on and after the date of delivery of the 2017 Bonds in reasonable quantities upon written request to the Bond Trustee.

THE AUTHORITY

The Authority is a public instrumentality of the Commonwealth of Pennsylvania (the "*Commonwealth*") and a public body corporate and politic organized and existing under the Act, for the purposes of alleviating unemployment, maintaining employment at a high level and creating and developing business opportunities in the County of Berks, Pennsylvania (the "*County*"). The Authority has the power to exercise any and all powers granted under the Act, which include the power to undertake health care projects for nonprofit institutions located within the Commonwealth and to issue its bonds for such health care projects.

The governing body of the Authority consists of a board of five members (the "*Board of the Authority*"), appointed by the Board of Commissioners of the County of Berks, Pennsylvania. Members of the Authority's board are appointed for five-year terms and may be reappointed. Present members of the Board of the Authority are shown below:

Name	Office	Term Expires
Ken W. Seidel	Chairman	12/31/18
James A. Adams	Vice Chairman, Secretary & Assistant Treasurer	12/31/17
Joseph M. Eways, II	Vice Chairman, Treasurer & Assistant Secretary	12/31/20
Eric W. Jenkins	Vice Chairman, Assistant Secretary & Assistant Treasurer	12/31/21
Rebecca M. Wingenroth	Vice Chairman, Assistant Secretary & Assistant Treasurer	12/31/19

THE 2017 BONDS ARE SPECIAL LIMITED OBLIGATIONS OF THE AUTHORITY, AND THE MEMBERS, OFFICERS AND EMPLOYEES OF THE AUTHORITY ARE NOT PERSONALLY LIABLE ON THE 2017 BONDS. THE AUTHORITY HAS NO TAXING POWER. NEITHER THE CREDIT NOR THE TAXING POWER OF THE COUNTY, THE COMMONWEALTH OR ANY OF THEIR POLITICAL SUBDIVISIONS IS PLEDGED FOR PAYMENT OF THE 2017 BONDS, AND THE 2017 BONDS SHALL NOT BE OR BE DEEMED AN OBLIGATION OF THE COUNTY, THE COMMONWEALTH OR ANY OF THEIR POLITICAL SUBDIVISIONS, AGENCIES OR INSTRUMENTALITIES, OTHER THAN (TO A LIMITED EXTENT) THE AUTHORITY.

The Authority has not prepared or assisted in the preparation of this Official Statement and is not responsible for the statements made herein except with respect to the information specifically related to the Authority under this section entitled "THE AUTHORITY." Except for the execution and delivery of documents required to effect the issuance of the 2017 Bonds, the Authority has not otherwise assisted in the public offer, sale or distribution of the 2017 Bonds. Accordingly, except as aforesaid, the Authority disclaims responsibility for the disclosures set forth in this Official Statement or otherwise made in connection with the offer, sale and distribution of the 2017 Bonds.

The Authority has in the past and may in the future issue other revenue bonds and notes. None of the revenues of the Authority with respect to its other revenue bonds or notes are or will be pledged as security for the 2017 Bonds. Further, the Authority's other revenue bonds and notes are not and will not be payable from or secured by the revenues of the Authority and other moneys securing the 2017 Bonds. All such other revenue bonds and notes which were or may be issued for the benefit of any institution or municipality are and will be secured separately and distinctly from the issues on behalf of every other such institution or municipality and each will be payable solely from revenues and receipts derived from the institution or municipality on whose behalf such bonds or notes were issued.

THE OBLIGATED GROUP

In alignment with its strategic plan, on May 30, 2017, the System entered into an Asset Purchase Agreement with Community Health Systems and its affiliates (collectively, "*CHS*") for the System to acquire the Acquired Hospitals from CHS. The System completed the acquisition of the Acquired Hospitals effective on October 1, 2017, and the post-acquisition integrated healthcare system was rebranded as "Tower Health." See Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP."

Pursuant to a Joinder Agreement dated as of September 29, 2017, Brandywine Hospital, LLC, Chestnut Hill Hospital, LLC, Jennersville Hospital, LLC, Phoenixville Hospital, LLC, and Pottstown Hospital, LLC (collectively, the "New Hospital Entities"), each a Pennsylvania limited liability company, became Master Indenture Obligors and Obligated Group members, as each such term is defined in the Master Indenture. Upon the acquisition of the Acquired Hospitals, the New Hospital Entities became the respective owners and operators of the Acquired Hospitals. The System, Reading Hospital and the New Hospital Entities are the current members of the Obligated Group and are collectively referred to as the "*Obligated Group*". No new members of the Obligated Group are anticipated prior to issuance of the 2017 Bonds. See Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP" for a description of the members of the Obligated Group, the controlled entities and subsidiaries of the System which are not members of the Obligated Group and their respective services, operations, service area and financial results.

PLAN OF FINANCE

The proceeds of the 2017 Bonds will be used to finance the costs of the Project consisting of the (a) advance refunding of the Refunded 2009A-3 Bonds; (b) the design, construction, installation and furnishing of the Reading HealthPlex for Advanced Surgical & Patient Care; (c) the refinancing of a bridge loan from Citibank, N.A., a portion of which was used to finance the acquisition of the Acquired Hospitals; and (d) the payment of costs and expenses associated with the refunding of the Refunded 2009A-3 Bonds and the issuance of the 2017 Bonds. See Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP."

The portion of the proceeds of the 2017 Bonds used to advance refund the Refunded 2009A-3 Bonds will be irrevocably deposited with Manufacturers and Traders Trust Company (the "*Escrow Agent*") for deposit in an escrow fund (the "*Escrow Fund*") to be held under the terms of an Escrow Agreement dated as of October 1, 2017 (the "*Escrow Agreement*") among the Escrow Agent, the System and The Berks County Municipal Authority. The proceeds of the 2017 Bonds deposited in the Escrow Fund are expected to be sufficient to pay interest on the Refunded 2009A-3 Bonds when due and the redemption price of the Refunded 2009A-3 Bonds, equal to principal amount of $44,675,000 plus accrued interest, on November 1, 2019 (the "*Redemption Date*"). The accuracy of arithmetic computations supporting the conclusion that the 2017 Bond proceeds to be deposited in the Escrow Fund will be sufficient to pay interest on the Refunded 2009A-3 Bonds when due and the redemption price of the

Refunded 2009A-3 Bonds on the Redemption Date will be independently verified by Causey Demgen & Moore P.C., certified public accountants. See "VERIFICATION OF MATHEMATICAL CALCULATIONS" herein.

ESTIMATED SOURCES AND USES OF FUNDS

The estimated proceeds of the sale of the 2017 Bonds and the estimated uses of such funds are shown below:

Sources of Funds

Par Amount of the 2017 Bonds	$590,500,000.00
Net Original Issue Premium of 2017 Bonds	56,150,682.75
TOTAL SOURCES OF FUNDS	$646,650,682.75

Uses of Funds:

Refunding of Refunded 2009A-3 Bonds	$49,313,836.11
Deposit to Project Fund	592,992,867.70
Costs of Issuance[(1)]	4,343,978.94
TOTAL USES OF FUNDS	$646,650,682.75

(1) Includes estimated costs of issuance of the 2017 Bonds, including fees and expenses of Bond Counsel, counsel to the System and the Obligated Group, and counsel to the Underwriters, underwriting discount, accountant's fees, fees of the Rating Agencies, printing costs and other miscellaneous expenses.

SECURITY FOR THE 2017 BONDS

General

As security for the payment of the principal, redemption price of and interest on the 2017 Bonds, the Authority will pledge and assign to the Bond Trustee, in accordance with the Bond Indenture, all its right, title and interest in the Loan Agreement (except its right to certain fees and expenses, to indemnification and to amounts required for rebate) and the 2017 Master Note. The 2017 Bonds will also be secured by the money and securities in the funds and accounts held by the Bond Trustee under the Bond Indenture. Pursuant to the Master Indenture, the 2017 Master Note will be secured on a parity basis with any other outstanding Notes by a lien on and security interest in the Gross Revenues of the Obligated Group.

The Loan Agreement

The Loan Agreement is an absolute and unconditional obligation of the System. The Loan Agreement provides, among other things, that (i) the Authority will make a loan to the System in an amount equal to the aggregate proceeds of the sale of the 2017 Bonds; (ii) the aggregate proceeds of the 2017 Bonds will be applied to finance the costs of the Project; (iii) the obligations of the System under the Loan Agreement will be evidenced and secured by the 2017 Master Note to be executed by the System, made payable to the Authority and endorsed and assigned by the Authority, without recourse, to the Bond Trustee; and (iv) the System will pay the principal of, premium, if any, and interest on the 2017 Master Note directly to the Bond Trustee, for the account of the Authority, at the times and in amounts sufficient to make full and prompt payment of the principal of, premium, if any, and interest on the 2017 Bonds as the same will become due and payable. All of the right, title and interest of the Authority in and to the

Loan Agreement, except the Authority's rights with respect to indemnification and payment of expenses and amounts required to be rebated to the federal government, are assigned to the Bond Trustee.

The Master Indenture

Pursuant to the Master Indenture, as supplemented by Supplement No. 33, the Obligated Group will issue the 2017 Master Note to evidence and secure the obligations of the System under the Loan Agreement to make payments that are fixed as to time and amount to enable the Authority to make timely payment of the principal of, premium, if any, and interest on the 2017 Bonds. The 2017 Master Note will be the joint and several obligation of the members of the Obligated Group (each a "*Member*") pursuant to the Master Indenture.

The Master Indenture provides for a pledge of Gross Revenues to secure the payment of Master Indenture Obligations. **Purchasers of the 2017 Bonds should note that the pledge of Gross Revenues is for the equal and ratable benefit of the holders of all outstanding Master Indenture Obligations issued under the Master Indenture.**

The Master Indenture permits other entities, under certain conditions, to become obligated under the Master Indenture and to have Notes or other Master Indenture Obligations issued thereunder on their behalf with the approval of the Obligated Group. Each Member will, subject to the right of such Member to withdraw from the Obligated Group under certain circumstances, jointly and severally covenant promptly to make any and all payments on all Notes and other Master Indenture Obligations theretofore or thereafter issued under the Master Indenture, including the 2017 Master Note, according to the terms thereof.

Pursuant to the Master Indenture, the Obligated Group has agreed with the Master Trustee to subject itself to certain operational and financial restrictions contained therein. Each entity that becomes a Master Indenture Obligor pursuant to the Master Indenture (and therefore a Member) will be required to comply with such restrictions as well. The operational and financial restrictions contained in the Master Indenture relate primarily to limitations on the creation of liens, the incurrence of additional indebtedness, debt service coverage requirements, the ability to transfer assets, including both physical and liquid assets, and the ability to effect mergers and consolidations.

See Appendix D – "SUMMARY OF THE MASTER INDENTURE" for a description of the Master Indenture and a description of the Proposed Amendments to the Master Indenture.

Rate Covenant

Pursuant to the Master Indenture, each Member of the Obligated Group covenants to set rates and charges for its facilities such that the Long-Term Debt Service Coverage Ratio, calculated at the end of each fiscal year of the Obligated Group, will not be less than 1.10. If the Long-Term Debt Service Coverage Ratio, as calculated at the end of any fiscal year, is below 1.10, the Obligated Group covenants to retain a Consultant to make recommendations to increase such Long-Term Debt Service Coverage Ratio for subsequent fiscal years to the level required or, if in the opinion of the Consultant the attainment of such level is impracticable, to the most practicable level. Each member of the Obligated Group agrees that it will, to the extent permitted by law, follow the recommendations of the Consultant. In the event the recommendations of the Consultant are implemented by each member of the Obligated Group affected thereby and the Long-Term Debt Service Coverage Ratio does not meet the requirements of the foregoing rate covenant, there shall be no Event of Default under the Master Indenture, so long as the Long-Term Debt Service Coverage Ratio is not less than 1.00, but the Obligated Group will be under a continuing obligation to engage a Consultant for the purposes described above. If a report of a Consultant is

delivered to the Master Trustee stating that Governmental Restrictions have been imposed which make it impossible for the foregoing ratio requirement to be met, then such ratio requirement will be reduced to the maximum coverage permitted by such Governmental Restrictions, but in no event less than 1.00. See "Debt Service Coverage Ratio" in Appendix D – "SUMMARY OF THE MASTER INDENTURE."

Permitted Indebtedness

The Master Indenture authorizes the Obligated Group and any other Master Indenture Obligor to issue additional Master Indenture Obligations under the Master Indenture upon compliance with the requirements set forth therein. See "Limitations on Incurrence of Additional Indebtedness" in Appendix D – "SUMMARY OF THE MASTER INDENTURE."

Limited Obligations

The 2017 Bonds and the interest thereon, are special, limited obligations of the Authority secured under the provisions of the Bond Indenture and the Master Indenture and will be payable solely from the payments and other moneys received by the Authority under the Loan Agreement, from moneys otherwise received pursuant to the Bond Indenture, and from payments by the Obligated Group under the 2017 Master Note, which is secured by a pledge of Gross Revenues of the Obligated Group. See "SECURITY FOR THE 2017 BONDS – The Master Indenture." The 2017 Bonds shall not be deemed to constitute a debt or liability of the County, the Commonwealth or of any political subdivision thereof within the meaning of any constitutional provision or statutory limitation of the Commonwealth and shall not constitute a pledge of the full faith and credit of the County, the Commonwealth or of any political subdivision thereof. The issuance of the 2017 Bonds shall not, directly, indirectly or contingently, obligate the County, the Commonwealth or any political subdivision thereof to levy any form of taxation therefor or to make any appropriation for their payment. Neither the County nor the Commonwealth shall in any event be liable for the payment of the principal of, premium, if any, or interest on the 2017 Bonds or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the Authority. No breach by the Authority of any such pledge, mortgage, obligation or agreement may impose any liability, pecuniary or otherwise, upon the County or the Commonwealth or any charge upon their general credit or taxing power. Neither the general credit of the Authority nor the general credit or taxing power of the County, the Commonwealth or any political subdivision thereof is pledged to the payment of the 2017 Bonds. The Authority has no taxing power.

Other Parity Indebtedness

The Obligated Group has previously issued and there are currently outstanding the following Master Indenture Obligations under the Master Indenture:

(i) the Series E of 2009 Master Note issued pursuant to the Twenty-First Supplemental Master Trust Indenture in connection with the issuance of the 2009A-3 Bonds, currently outstanding in the principal amount of $103,365,000;

(ii) the Series A of 2012 Master Note issued pursuant to the Twenty-Fourth Supplemental Master Trust Indenture in connection with the issuance of Fixed Rate Revenue Bonds (The Reading Hospital and Medical Center Project), Series A of 2012 (the "*2012A Bonds*"), currently outstanding in the principal amount of $160,065,000;

(iii) the Series B of 2012 Master Note issued pursuant to the Twenty-Fifth Supplemental Master Trust Indenture in connection with the issuance of Variable Rate Revenue Bonds

(The Reading Hospital and Medical Center Project), Series B of 2012 (the "*2012B Bonds*"), currently outstanding in the principal amount of $91,775,000;

(iv) the Series C of 2012 Master Note issued pursuant to the Twenty-Sixth Supplemental Master Trust Indenture in connection with the issuance of Variable Rate Revenue Bonds (The Reading Hospital and Medical Center Project), Series C of 2012 (the "*2012C Bonds*"), currently outstanding in the principal amount of $43,678,550;

(v) the Series A of 2016 Master Note issued pursuant to the Twenty-Eighth Supplemental Master Trust Indenture in connection with the issuance of a 2016A Note for a bank loan, currently outstanding in the principal amount of $50,165,000;

(vi) the Series B of 2016 Master Note issued pursuant to the Twenty-Ninth Supplemental Master Trust Indenture in connection with the issuance of a 2016B Note for a bank loan, currently outstanding in the principal amount of $50,000,000;

(vii) the Series C of 2016 Master Note issued pursuant to the Thirtieth Supplemental Master Trust Indenture in connection with the issuance of a 2016C Note for a bank loan, currently outstanding in the principal amount of $25,000,000;

(viii) the Series D of 2016 Master Note issued pursuant to the Thirty-First Supplemental Master Trust Indenture in connection with the issuance of a 2016D Note for a bank loan, currently outstanding in the principal amount of $50,000,000; and

(ix) the Series A of 2017 Master Note issued pursuant to the Thirty-Second Supplemental Master Trust Indenture in connection with the issuance of a 2017A Note for the bridge loan from Citibank, N.A., currently outstanding in the principal amount of $491,018,052.

Upon the issuance of the 2017 Bonds and the application of the proceeds thereof to refund the Refunded 2009A-3 Bonds and to refinance the bridge loan from Citibank, N.A., the 2009A-3 Bonds will be outstanding in the the principal amount of $58,690,000 and the bridge loan will cease to be outstanding.

ESTIMATED ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth the schedule of the estimated annual debt service requirements on the Indebtedness secured by the Master Indenture Obligations of the Obligated Group subsequent to the issuance of the 2017 Bonds and the refunding of the Refunded 2009A-3 Bonds.

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Fiscal Year (June 30)	2017 Bonds Principal	2017 Bonds Interest	Other Debt Service [1]	Total Debt Service
2018	$0	$13,809,162	$27,850,967	$41,660,129
2019	0	27,465,738	28,559,580	56,025,318
2020	0	27,465,738	28,565,810	56,031,547
2021	0	27,465,738	25,961,562	53,427,299
2022	1,770,000	27,421,488	26,043,270	55,234,758
2023	3,040,000	27,301,238	35,075,324	65,416,561
2024	5,945,000	27,076,613	34,890,889	67,912,502
2025	6,490,000	26,765,738	34,659,120	67,914,858
2026	7,035,000	26,427,613	34,451,528	67,914,140
2027	7,610,000	26,061,488	34,243,938	67,915,425
2028	8,215,000	25,665,863	34,032,104	67,912,967
2029	8,885,000	25,238,363	33,789,612	67,912,975
2030	9,580,000	24,776,738	33,555,587	67,912,324
2031	10,305,000	24,279,613	33,328,030	67,912,642
2032	11,005,000	23,801,888	33,106,413	67,913,300
2033	6,855,000	23,444,688	37,612,381	67,912,068
2034	7,570,000	23,156,188	37,187,566	67,913,753
2035	8,375,000	22,795,413	36,742,488	67,912,901
2036	9,675,000	22,344,163	35,892,174	67,911,336
2037	10,735,000	21,833,913	35,342,463	67,911,376
2038	11,795,000	21,270,663	34,849,462	67,915,124
2039	12,800,000	20,719,788	34,394,370	67,914,158
2040	13,715,000	20,189,488	34,006,043	67,910,531
2041	13,860,000	19,655,313	34,395,025	67,910,338
2042	14,385,000	19,125,719	34,400,325	67,911,044
2043	14,940,000	18,575,875	34,397,875	67,913,750
2044	15,580,000	17,936,750	34,395,750	67,912,500
2045	16,315,000	17,201,625	34,393,875	67,910,500
2046	52,295,000	15,617,625	0	67,912,625
2047	54,770,000	13,144,750	0	67,914,750
2048	57,360,000	10,554,750	0	67,914,750
2049	60,145,000	7,765,875	0	67,910,875
2050	63,150,000	4,765,000	0	67,915,000
2051	66,300,000	1,614,000	0	67,914,000
Total	$590,500,000	$702,734,594	$936,123,530	$2,229,358,124

Totals may not add up due to rounding.
(1) Assumes all variable rate indebtedness pays interest at the most recent 25-Year Revenue Bond Index (3.85%) per the Master Indenture.

DESCRIPTION OF THE 2017 BONDS

General Description

The 2017 Bonds will be issued in the aggregate principal amount of $590,500,000, will be dated the date of delivery of the 2017 Bonds and will be issuable as fully-registered bonds, without coupons, in book-entry form. The 2017 Bonds will be issuable in denominations of $5,000 and any integral multiple thereof and initially will be registered in the name of Cede & Co., as registered owner and nominee for DTC, which will act as securities depository for the 2017 Bonds.

The 2017 Bonds will bear interest from their date of delivery at the rates and mature on the dates set forth on the inside cover page hereof, subject to redemption prior to maturity. Interest on the 2017 Bonds will be payable semiannually on May 1 and November 1 of each year (each, an "*Interest Payment Date*"), commencing May 1, 2018, until maturity or redemption. Interest on the 2017 Bonds will be computed on the basis of a 360-day year composed of twelve 30-day months.

Unless the book-entry system for the 2017 Bonds is discontinued (as described below), prospective purchasers will acquire beneficial ownership interests in the 2017 Bonds, in authorized denominations, as described below, but will not receive 2017 Bond certificates representing such ownership interests.

Payment of Principal and Interest

The principal of any 2017 Bonds will be payable when due to a registered owner upon presentation and surrender of such 2017 Bonds at the designated trust office of the Bond Trustee in Harrisburg, Pennsylvania. Payment of interest on any 2017 Bond on any Interest Payment Date will be made to the Person appearing on the registration books maintained by the Bond Trustee on behalf of the Authority (the "*Bond Register*") as the registered owner thereof the close of business on the 15th day of the calendar month (whether or not a Business Day) next preceding the applicable Interest Payment Date (the "*Record Date*"). Such payments will be made by check mailed on the applicable Interest Payment Date to the registered owner at his or her address as it appears on the Bond Register, or by wire transfer of funds if Cede & Co. or a successor Securities Depository is the registered owner, or, upon written request filed not less than 20 days prior to the applicable Interest Payment Date, by wire transfer of funds to the registered owner, if such registered owner is the owner of 2017 Bonds in an aggregate principal amount of $1,000,000 or more at such wire transfer address as specified in such request. If and to the extent that the Authority fails to make payment or provision for payment of interest on any 2017 Bonds on any Interest Payment Date, such defaulted interest will be payable to the Persons in whose names the 2017 Bonds are registered at the close of business on a special record date (the "Special Record Date") for the payment of such defaulted interest established by notice mailed by the Bond Trustee on behalf of the Authority to the registered owners of the 2017 Bonds not less than 15 days preceding such Special Record Date and not less than 20, but not more than 30, days prior to the interest payment date. Such notice shall be mailed to the Persons in whose names the 2017 Bonds are registered at the close of business on the Business Day preceding the date of mailing.

If the date for payment of the principal of, premium, if any, or interest on the 2017 Bonds is a Saturday, Sunday, legal holiday or a day on which banking institutions in the city where the corporate trust office of the Bond Trustee responsible for the administration of this Indenture is located are authorized or required by law or executive order to close, then the date for such payment will be the next succeeding day which is not a Saturday, Sunday, legal holiday or a day on which such banking institutions are authorized or required to close, and payment on such date will have the same force and effect as if made on the stated date of payment.

As long as DTC or its nominee is the registered owner of the 2017 Bonds, payments of principal or redemption price of, and interest on, the 2017 Bonds will be made directly to DTC or its nominee and all such payments will be valid and effective to fully satisfy and discharge the obligations of the Authority and the Obligated Group with respect to the principal or redemption price of, and interest on, the 2017 Bonds to the extent of the sum or sums so paid. So long as DTC or its nominee is the registered owner of the 2017 Bonds, references herein to the registered owners of the 2017 Bonds will be deemed to refer to DTC or its nominee and not to the owners of beneficial interests in the 2017 Bonds. See "Book-Entry Only System" below.

Redemption Provisions

Optional Redemption. The 2017 Bonds stated to mature on or after November 1, 2028 are subject to redemption by the Authority, at the option and direction of the System, on or after November 1, 2027, in whole or in part at any time, in such order of maturity as the System determines, and by lot within a maturity as selected by the Bond Trustee, at a redemption price equal to 100% of the principal amount thereof, together with accrued interest thereon to the date fixed for redemption.

Sinking Fund Redemption. The 2017 Bonds stated to mature on November 1, 2042, are subject to mandatory redemption on November 1 in each of the years set forth below, at a redemption price equal to 100% of the principal amount thereof plus accrued interest as follows:

Year	Principal Amount
2040	$13,860,000
2041	$14,385,000
2042*	$14,940,000

* Maturity

The 2017 Bonds stated to mature on November 1, 2047 and bearing interest rate of 4.000% (CUSIP† 08451PAW1) are subject to mandatory redemption on November 1 in each of the years set forth below, at a redemption price equal to 100% of the principal amount thereof plus accrued interest as follows:

Year	Principal Amount
2043	$6,100,000
2044	$6,350,000
2045	$19,900,000
2046	$20,850,000
2047*	$21,800,000

* Maturity

The 2017 Bonds stated to mature on November 1, 2047 and bearing interest rate of 5.000% (CUSIP† 08451PAX9) are subject to mandatory redemption on November 1 in each of the years set forth below, at a redemption price equal to 100% of the principal amount thereof plus accrued interest as follows:

Year	Principal Amount
2043	$9,480,000
2044	$9,965,000
2045	$32,395,000
2046	$33,920,000
2047*	$35,560,000

* Maturity

† Registered trademark of American Bankers Association. CUSIP data herein is provided by Standard and Poor's CUSIP Service Bureau, a division of the McGraw Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP service. CUSIP numbers are provided for reference only. Neither the Authority, the Bond Trustee nor the Underwriters take any responsibility for the accuracy of such numbers.

The 2017 Bonds stated to mature on November 1, 2050 and bearing interest rate of 4.000% (CUSIP† 08451PAZ4) are subject to mandatory redemption on November 1 in each of the years set forth below, at a redemption price equal to 100% of the principal amount thereof plus accrued interest as follows:

Year	Principal Amount
2048	$7,950,000
2049	$8,350,000
2050*	$8,700,000

* Maturity

The 2017 Bonds stated to mature on November 1, 2050 and bearing interest rate of 5.000% (CUSIP† 08451PAY7) are subject to mandatory redemption on November 1 in each of the years set forth below, at a redemption price equal to 100% of the principal amount thereof plus accrued interest as follows:

Year	Principal Amount
2048	$52,195,000
2049	$54,800,000
2050*	$57,600,000

* Maturity

Reduction of Sinking Fund Installments. If 2017 Bonds that are subject to sinking fund redemption are purchased by the System or redeemed (except pursuant to a Sinking Fund Installment), the System will determine which Sinking Fund Installments are to be reduced and the amount of any such reduction, provided that the aggregate of such reductions will equal the aggregate principal amount of 2017 Bonds so purchased or redeemed.

Extraordinary Optional Redemption. The 2017 Bonds are subject to extraordinary redemption, at the option of the Authority, at the direction of the System, as a whole, at any time, or, from time to time, in part, in the event of damage to, destruction of or condemnation of the hospital premises, or any part thereof from proceeds of insurance or condemnation that are applied to the prepayment of the System's obligations under the Loan Agreement and the 2017 Master Note, upon payment of a redemption price of 100% of the principal amount to be redeemed, together with interest accrued thereon to the date fixed for redemption, as provided in the Bond Indenture. In the event that less than all of the 2017 Bonds of any particular maturity are to be redeemed, the 2017 Bonds of such maturity will be drawn by lot by the Bond Trustee.

† Registered trademark of American Bankers Association. CUSIP data herein is provided by Standard and Poor's CUSIP Service Bureau, a division of the McGraw Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP service. CUSIP numbers are provided for reference only. Neither the Authority, the Bond Trustee nor the Underwriters take any responsibility for the accuracy of such numbers.

Purchase in Lieu of Redemption. The Authority has granted the System the option to purchase, at any time and from time to time any 2017 Bond which is to be redeemed pursuant to the optional redemption provisions of the Bond Indenture on the dates of such redemption and at a purchase price equal to the redemption price therefor. In order for the System to exercise such option, the System must notify the Bond Trustee not less than ten (10) Business Days prior to the proposed redemption date that amounts available to pay the redemption price of such 2017 Bonds are to be applied to purchase such 2017 Bonds in lieu of redemption. No notice other than the notice of redemption need be given in connection with any such purchase in lieu of redemption. On the day fixed for redemption, following the receipt of a Favorable Opinion, the Bond Trustee will purchase the 2017 Bonds to be redeemed in lieu of such redemption and, following such purchase, the Bond Trustee will cause such 2017 Bonds to be registered in the name of or upon the written direction of the System and deliver them to or as directed by the System. No purchase of 2017 Bonds pursuant to these provisions will operate to extinguish the indebtedness of the Authority evidenced thereby. No Holder may elect to retain a 2017 Bond subject to purchase in lieu of redemption. The provisions in the Bond Indenture described in this paragraph do not apply to mandatory sinking fund redemptions.

Notice of Redemption. Any redemption of 2017 Bonds will be upon not more than 45 days' and not less than 20 days' prior notice by first class mail to the registered owners of 2017 Bonds to be redeemed at their addresses shown on the Bond Register, unless a notice is waived in accordance with the provisions of the Bond Indenture by the registered owners of the 2017 Bonds to be called for redemption, and will be in the manner and under the terms and conditions and with the effect provided in the Bond Indenture. Upon surrender of any 2017 Bond for redemption in part, the Bond Trustee will authenticate and deliver one or more 2017 Bonds in exchange therefor, in an aggregate principal amount equal to the unredeemed portion of the 2017 Bond so surrendered. So long as the 2017 Bonds or any portion thereof are held by DTC, the Bond Trustee is required to send each notice of redemption of such 2017 Bonds to DTC. Failure to mail any such notice or defect in the mailing thereof in respect of any 2017 Bonds will not affect the validity of the redemption of any other 2017 Bonds.

If at the time of mailing of notice of any optional redemption there has not been deposited moneys with the Bond Trustee sufficient to redeem all the 2017 Bonds called for redemption, such notice must state that it is conditional, in that it is subject to the deposit of such redemption moneys with the Bond Trustee not later than the opening of business on the scheduled redemption date, in which case such notice will be of no effect unless such moneys are so deposited. Failure to desposit such moneys shall not constitute an Event of Default under the Bond Indenture.

If less than all 2017 Bonds of any one maturity are to be redeemed, the selection of the particular 2017 Bonds of such maturity to be redeemed will be made by the Bond Trustee by lot in such manner as the Bond Trustee in its discretion may determine. In the case of a partial redemption of 2017 Bonds, when 2017 Bonds of denominations greater than $5,000 are then outstanding, each such 2017 Bond will be treated as representing such number of separate 2017 Bonds, each of the denomination of $5,000, as is obtained by dividing the actual principal amount thereof by $5,000.

Book-Entry Only System

DTC will act as securities depository for the 2017 Bonds. The 2017 Bonds will be issued as fully-registered bonds registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond certificate will be issued for the 2017 Bonds of each maturity, each in the aggregate principal amount of such maturity, and will be deposited with DTC

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

Purchases of the 2017 Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the 2017 Bonds on DTC's records. The ownership interest of each actual purchaser of each 2017 Bond ("*Beneficial Owner*") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the 2017 Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the 2017 Bonds, except in the event that use of the book-entry system for the 2017 Bonds is discontinued.

To facilitate subsequent transfers, all 2017 Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of 2017 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 2017 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such 2017 Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

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 2017 Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the 2017 Bonds, such as redemptions, tenders, defaults, and proposed amendments to the bond documents. For example, Beneficial Owners of the 2017 Bonds may wish to ascertain that the nominee holding the 2017 Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the

alternative, Beneficial Owners may wish to provide their names and addresses to the registrar and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the 2017 Bonds within a maturity 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 Securities 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 as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts 2017 Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Payments of principal, premium, if any, and interest on the 2017 Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Authority or the Bond Trustee, on payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with 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 Bond Trustee, or the Authority, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, premium, if any, and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Authority of the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as depository with respect to the 2017 Bonds at any time by giving reasonable notice to the Authority or the Bond Trustee. Under such circumstances, in the event that a successor depository is not obtained, bond certificates are required to be printed and delivered.

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

SO LONG AS CEDE & CO. IS THE REGISTERED OWNER OF THE 2017 BONDS, AS NOMINEE OF DTC, REFERENCES HEREIN TO THE OWNERS OF THE 2017 BONDS SHALL MEAN CEDE & CO. AND SHALL NOT MEAN THE BENEFICIAL OWNERS OF THE 2017 BONDS. PRINCIPAL, PREMIUM, IF ANY, AND INTEREST PAYMENTS ON THE 2017 BONDS ARE TO BE MADE TO CEDE & CO., AND ALL SUCH PAYMENTS SHALL BE VALID AND EFFECTIVE TO SATISFY FULLY AND TO DISCHARGE THE OBLIGATIONS OF THE AUTHORITY AND THE OBLIGATED GROUP WITH RESPECT TO, AND TO THE EXTENT OF, PRINCIPAL, PREMIUM, IF ANY, AND INTEREST SO PAID.

The Obligated Group and the Authority cannot and do not give any assurances that DTC will distribute to Direct Participants, or that the Direct Participants or others will distribute to the Beneficial Owners payments of principal of, premium, if any, and interest on the 2017 Bonds or any redemption or other notices or that they will do so on a timely basis or will serve and act in the manner described in this Official Statement. Neither the Obligated Group nor the Authority is responsible or liable for the failure

of DTC or any Direct Participant or Indirect Participant to make any payments or give any notice to a Beneficial Owner with respect to the 2017 Bonds or any error or delay relating thereto.

THE INFORMATION IN THIS SECTION CONCERNING DTC AND DTC'S BOOK-ENTRY SYSTEM HAS BEEN OBTAINED FROM SOURCES THAT ARE BELIEVED TO BE RELIABLE, BUT NONE OF THE AUTHORITY, THE OBLIGATED GROUP, THE BOND TRUSTEE AND THE UNDERWRITERS TAKES ANY RESPONSIBILITY FOR THE ACCURACY THEREOF. NO REPRESENTATION IS MADE BY THE AUTHORITY, THE OBLIGATED GROUP, THE BOND TRUSTEE, OR THE UNDERWRITERS AS TO THE COMPLETENESS OR ACCURACY OF SUCH INFORMATION OR AS TO THE ABSENCE OF MATERIAL ADVERSE CHANGES IN SUCH INFORMATION SUBSEQUENT TO THE DATE HEREOF. NO ATTEMPT HAS BEEN MADE BY THE AUTHORITY, THE OBLIGATED GROUP, THE BOND TRUSTEE OR THE UNDERWRITERS TO DETERMINE WHETHER DTC IS OR WILL BE FINANCIALLY OR OTHERWISE CAPABLE OF FULFILLING ITS OBLIGATIONS. NEITHER THE AUTHORITY, THE OBLIGATED GROUP, THE BOND TRUSTEE NOR THE UNDERWRITERS (EXCEPT AS DIRECT PARTICIPANTS) WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS FOR THE 2017 BONDS, OR FOR ANY PRINCIPAL, REDEMPTION PREMIUM, IF ANY, OR INTEREST PAYMENT THEREON.

BONDHOLDERS' RISKS

General

The principal, premium, if any, and interest on the 2017 Bonds are payable solely from amounts payable by the System to the Authority under the Loan Agreement. See "SECURITY FOR THE 2017 BONDS."

The System and the Obligated Group are subject to numerous known and unknown risks many of which are described below and elsewhere in this Official Statement. Any of the events described below could have a material adverse effect on their business, financial conditions and results of operation. Additional risks and uncertainties that the System and the Obligated Group are not aware of, or that they currently deem to be immaterial, could also impact their business and results of operations. The risk factors discussed below should be considered in evaluating the ability of the System and the Obligated Group to make payments in amounts sufficient to meet their obligations under the Master Indenture. This discussion is not, and is not intended to be, exhaustive.

Future Financial Condition of the System and the Obligated Group

The future financial condition of the System and the Obligated Group 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 and professional liability claims and other litigation costs and claims. The occurrence of one or more of these risks could have a material adverse effect on the financial conditions and results of operations of the System and the Obligated Group and, in turn, the ability of the System to make payments under the Loan Agreement. The Underwriters and the Authority have not made any independent investigation of the extent to which any such factors may have an adverse impact on the financial condition of the Members of the Obligated Group.

The health care industry is highly dependent on a number of factors that may limit the ability of the System to meet its obligations under the Loan Agreement, many of which are beyond the System's and the Obligated Group's control. Among other things, participants in the health care industry 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.

The Obligated Group is a health care provider which derives significant portions of its revenues from Medicare, Medicaid, Blue Cross and other third-party payor programs. The Obligated Group is subject to governmental regulation applicable to health care providers, and the receipt of future revenues by the Obligated Group is subject to, among other factors, federal and state policies affecting the health care industry and other conditions which are impossible to predict. Such conditions may include limits on increasing charges and fees charged by the Obligated Group, changes in federal and state laws and regulations affecting payments for health services, the continued increase in managed care or development of new third-party payment policies which reduce revenues, unanticipated competition from other health care providers, and changes in demand for health services.

The receipt of future revenues by the System and the Obligated Group is also subject to demand for hospital services, the ability to provide the services required by patients, management capabilities, physicians' relationships with the Obligated Group, the design and success of strategic plans, economic developments in the service area, the ability to control expenses, maintenance of relationships with third-party payors, competition, rates, costs, third-party reimbursement, legislation and governmental

regulation, receipt of private contributions, the continued funding by the Commonwealth for medically indigent patient care, future economic conditions, and other conditions which are impossible to predict.

No assurances can be given that patient utilization or revenues available to the System and the Obligated Group from their operations will remain stable or increase. The System and the Obligated Group expect that they will experience increases in operating costs due to inflation and other factors. There is no assurance that cost increases will be matched by increased revenue in amounts sufficient to generate an excess of revenues over expenses.

As described in Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP," in alignment with its strategic plan, the System recently completed the acquisition of the five acute care hospitals together with related facilities and assets, added the New Hospital Entities into the Obligated Group and instituted management structures for the transition and integration of the New Hospital Entities into Tower Health. No assurances can be given that all of the strategic benefits from the acquisition of the New Hospital Entities will be ultimately realized.

Patient Protection and Affordable Care Act and Healthcare Reform Initiatives

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the laws are referred to as "*ACA*"). ACA was intended to address disparities in access, cost, quality and the delivery of healthcare to United States residents.

The changes to various aspects of the health care system in the ACA are far-reaching and include substantial adjustments to Medicare reimbursement, establishment of individual and employer mandates for health insurance coverage, extension of Medicaid coverage to certain populations, provision of incentives for employer-provided health care insurance, restrictions on physician-owned hospitals, and increased efficiency and oversight provisions. The implementation of the various provisions of the ACA continues to be subject to legislative or administrative changes or threats thereof.

The ACA changed the sources and methods by which consumers pay for health care and imposed new requirements for employers' provision of health insurance to their employees and dependents. These reforms are expected to expand the base of consumers of health care services. One of the primary goals of the ACA is to provide or make available, or subsidize the premium costs of, health care insurance for consumers who are currently uninsured (or underinsured) and who fall below certain income levels. The ACA is intended to accomplish that objective by a number of means, including:

- Creating state organized insurance markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents;
- Providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels;
- Mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates;
- Establishing insurance reforms that expand coverage generally through such provisions as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; and
- Expanding existing public programs, including Medicaid for individuals and families.

Some of the specific provisions of the ACA that may affect hospital operations, financial performance or financial conditions are described below. The ACA is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws.

- Annual inflation adjustments to Medicare payments have been reduced, and are expected to be lower than historic averages.
- As of 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 Medicare Beneficiaries) have their DSH payments reduced by 75%. A portion of this reduction is potentially offset by new, additional payments based on the volume of uninsured and uncompensated care provided by each such hospital. Medicaid DSH allotments to each state were also reduced based on state-wide reduction in uninsured and uncompensated care.
- Many state Medicaid programs have expanded to a broader population resulting in more Medicaid-eligible patients.
- Medicare began reducing payments to hospitals found to have an excess readmissions ratio for certain conditions and this information will be made available to the public.
- Federal payments to states for Medicaid services related to hospital-acquired conditions were prohibited.
- Beginning in 2013, a value-based purchasing program was established under the Medicare program. Under this program, hospital payments will increase or decrease depending on a hospital's performance vis-à-vis established quality measures.
- To reduce waste, fraud, and abuse in public programs, the ACA provides for 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. It also requires Medicare and Medicaid program providers and suppliers to establish compliance programs. The ACA 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 ACA imposes substantial new data reporting obligations on hospital initiatives to improve the quality of care, reduce errors and improve health outcomes.

The ACA has been subject to opposition in the political and judicial arenas. Multiple challenges to the constitutionality of the ACA were filed by private and state parties in federal courts, culminating in a hearing by the Supreme Court in March 2012 and a decision on June 28, 2012, which largely upheld the ACA as constitutional. The Supreme Court limited the scope of the ACA in one important respect, restricting the federal government's ability to condition Medicaid funding on states' participation in the Medicaid expansion. As a result, states effectively have the option but not the obligation to extend Medicaid coverage to the indigent adult population specified in the ACA. Certain amendments to the ACA were contained in the American Taxpayer Relief Act of 2012 (the "*ATRA*") signed into law by President Obama in January 2013.

Medicaid coverage for Pennsylvania adults earning below 133 percent of the federal poverty line, or about $15,500, began in January 2015. Beginning in 2016, adults earning above the federal poverty line had to pay premiums worth no more than 2 percent of household income.

On June 25, 2015, the United States Supreme Court issued its opinion in *King v. Burwell*, the case challenging whether the IRS can offer tax credit subsidies to individuals enrolled in health insurance through a federally operated exchange. The Court ruled 6-3 that this action is within the IRS's power. The decision meant that low- and middle-income individuals who purchase coverage through a federal exchange will remain eligible for tax credit subsidies. As a result of the decision, Governor Tom Wolf, who took office in January 2015, withdrew his plan to establish a state-run exchange in the Commonwealth, for which he had received permission from HHS. Medicaid expansion in Pennsylvania began in April 2015. According to the Pennsylvania Department of Human Services, as of February 2, 2017, over 700,000 Pennsylvanians had enrolled in HealthChoices, Pennsylvania's managed care Medicaid program.

The ACA and its implementation have been, and remain, politically controversial. Accordingly, the ACA has continually faced legal and legislative challenges, including repeated repeal efforts, since its enactment. Although, the Supreme Court's ruling in 2012 ended much of the uncertainty surrounding the implementation of federal health care reform, legislative repeal is even more of a possibility than before, since the 2016 presidential election. In addition, many of the reductions in reimbursement to health care providers included in the ACA have yet to take full effect, and the increased health care coverage anticipated to derive from the ACA has not yet been realized. The practical consequences of the ACA, as well as of other future federal and state actions affecting the health care delivery system cannot be foreseen.

Management of the Obligated Group cannot predict the impact any major modification or repeal of the ACA, or any replacement health care reform legislation, might have on the Obligated Group's business or financial condition, though such effects could be material. In particular, any legal, legislative or executive action that reduces federal health care program spending, increases the number of individuals without health insurance, reduces the number of people seeking health care, or otherwise significantly alters the health care delivery system or insurance markets could have a material adverse effect on the Obligated Group's business or financial condition.

In November 2015, the Bipartisan Budget Act of 2015 (the "BBA") repealed a provision of the ACA which would require employers that offer one or more health benefit plans and have more than 200 full-time employees to automatically enroll new full-time employees in a health plan.

President Donald J. Trump and Republican leaders of Congress have repeatedly cited health care reform, and particularly, repeal and replacement of the ACA, as a key goal. To that end, Congressional leaders have taken steps to repeal or rescind certain provisions of the ACA, including introducing and voting on various bills aimed at repealing and replacing all or portions of the ACA (generally, the "*Repeal Bills*"). To date, no Repeal Bills have passed both chambers of Congress. The Congressional Budget Office ("*CBO*") has issued reports on versions of the Repeal Bills, estimating increases in the number of uninsured by as much as 24 million people by 2026. Management of the Obligated Group cannot predict the likelihood of any Repeal Bills or other health care reform bill becoming law, or the subsequent effects of any such laws, though such effects could materially impact the Obligated Group's business or financial condition.

Any legislative action that reduces federal health care program spending, increases the number of individuals without health insurance, reduces the number of people seeking health care, or otherwise significantly alters the health care delivery system or insurance markets could have a material adverse effect on the Obligated Group's business or financial condition. Management of the Obligated Group cannot predict whether any of the Repeal Bills will become law.

In addition to the legislative changes discussed above, the ACA implementation and insurance exchange markets can be significantly affected by executive branch actions. On January 20, 2017, President Trump issued an executive order requiring all federal agencies with authorities and responsibilities under the ACA to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay" parts of the ACA that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers. While it is impossible to predict the effect of this broad executive order, the Department of Health and Human Services ("*HHS*") might interpret the executive order to require it to freely grant exemptions from the individual mandate's "shared responsibility payment", which has the potential to significantly impact the insurance exchange market by reducing the number of healthy individuals in the ACA health insurance exchanges. Additionally, should the executive branch: (1) cease defending a pending lawsuit, *United States House of Representatives v. Price*, challenging the legality of cost-sharing subsidies paid by the federal government to insurance companies that offer coverage on the ACA insurance exchanges, or (2) otherwise reduce or stop paying the cost-sharing subsidies (as President Trump has threatened to do), insurers may incur financial losses and stop offering plans through the ACA insurance exchanges. Either action has the potential to significantly impact the insurance exchange market by reducing the number of plans available on the ACA health insurance exchanges and/or increase insurance premiums. Management of the Obligated Group cannot predict the likelihood or effect of any such executive actions on the Obligated Group's business or financial condition, though such effects could be material.

To the extent the ACA remains law, it is difficult to predict the full impact of the ACA on the Obligated Group's future revenues and operations due to uncertainty regarding a number of material factors, including: (1) how many currently uninsured individuals will ultimately obtain and retain insurance coverage as a result of the ACA, (2) what percentage of any newly insured patients will be covered under the Medicaid program versus a commercial plan, (3) the pace at which insurance coverage expands, (4) future changes in the reimbursement rates and methods, (5) the percentage of individuals in the exchanges who select the high deductible plans, (6) the extent to which the enhanced program integrity and fraud and abuse provisions lead to a greater number of civil or criminal actions, (7) the extent to which the ACA puts pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to health care providers, and (8) the extent of lost revenues, if any, resulting from the ACA's quality initiatives.

It is not known which additional proposals may be proposed or adopted or, if adopted, what effect such proposals would have on the Obligated Group's operations or revenue. However, the increase in focus and interest on federal and state health care reform may increase the likelihood of further significant changes affecting the health care industry in the near future. There can be no assurance that recently enacted, currently proposed or future health care legislation, regulation or other changes in the administration or interpretation of governmental health care programs will not have an adverse effect on the Obligated Group. Reductions in funding levels of the Medicare program, changes in payment methods under the Medicare and Medicaid programs, reductions in state funding, or other legislative or regulatory changes could adversely affect the Obligated Group's income.

Investors should continuously review legislative, judicial and regulatory developments relating to the ACA as they occur to assess their potential effects on health care providers and the health care industry.

Overview of Medicare and Medicaid Programs

Medicare and Medicaid are the commonly used names for health care reimbursement or payment programs governed by certain provisions of the federal Social Security Act Amendments of 1965. The federal government, as the country's largest payer of health care services, uses reimbursement as a key

tool to implement health care policies, to allocate health care resources and to control utilization, facility and provider development and expansion, and technology use and development. Health care reform legislation continues these practices. These laws reflect the national policy that persons who are aged and persons who are poor should have access to medical care regardless of ability to pay. The Obligated Group serves this population and it is unlikely that the Obligated Group could attract sufficient numbers of private pay patients to their facilities to become self-sufficient without reimbursement from government sources.

Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, disabled, or qualify for Medicare's End Stage Renal Disease Program. Medicare Part A covers inpatient hospital, home health, nursing home care and certain other services, and Medicare Part B covers certain physicians services, certain outpatient ancillary care services, medical supplies and durable medical equipment. Medicare Part C, the Medicare Advantage program, enables Medicare beneficiaries to choose to obtain their benefits through a variety of private, managed care, risk-based plans.

Medicare Part D makes outpatient prescription drug benefits available to Medicare beneficiaries. The private Medicare Part D plans are funded through premium payments from enrolled Medicare beneficiaries and subsidies from the federal government. Enrollment is available on an ongoing and intermittent basis. While participation in the program is voluntary, those who wait to enroll beyond their initial point of eligibility are penalized with additional surcharges which increase over time. ACA includes changes to the Medicare Part D program, including the gradual reduction of the cost sharing burden by beneficiaries under Medicare Part D (the so-called "donut hole"). Although Medicare Part D reimbursement does not cover inpatient prescriptions, changes in enrollment or program administration could affect the System's and the Obligated Group's revenues. Going forward, an expansion of coverage for outpatient pharmaceutical therapy may reduce the Obligated Group's admissions or shift the characteristics of those patients that are admitted.

Medicaid is designed to pay providers for care given to the indigent and other persons who qualify based on certain conditions. Medicaid is funded by federal and state appropriations and is administered by an agency of the applicable state.

The Obligated Group is highly dependent on the Medicare and Medicaid programs and could be adversely affected by changes to federal or state policy or funding relating to these programs. For fiscal years ended June 30, 2017 and 2016, respectively, approximately 32% and 31% of the net patient revenues of Reading Hospital were derived from the Medicare program, and approximately 11% and 10% were derived from the Medicaid program. For fiscal year ended June 30, 2016, approximately 47% of the Acquired Hospitals' net patient revenues were derived from the Medicare program, and approximately 10% were derived from the Medicaid program. See Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP."

Conditions of Participation. Hospitals must comply with standards called "Conditions of Participation" in order to be eligible for Medicare and Medicaid reimbursement. The Centers for Medicare and Medicaid Services ("*CMS*") of HHS is the federal agency responsible for ensuring that hospitals meet the regulatory Conditions of Participation. Generally, under Medicare rules, hospitals accredited by The Joint Commission (a private nonprofit corporation that accredits health care programs and providers in the United States) and other CMS approved accreditation bodies are deemed to meet the Conditions of Participation. The Obligated Group's facilities are currently accredited by The Joint Commission but there is no guarantee that the Obligated Group will continue to be accredited or will meet the Conditions of Participation in the future. Failure to maintain accreditation or to otherwise comply with the Conditions of Participation could have a materially adverse effect on the continued participation in the Medicare and Medicaid programs, and ultimately on the revenues of the Obligated Group.

Medicare Reimbursement

Overview. Medicare is administered by CMS, which delegates to the states the process for certifying those health care organizations to which CMS will make payment. HHS's rule-making authority is substantial and the rules are extensive and complex. Substantial deference is given by courts to rules promulgated by HHS.

Most Medicare hospital services are paid at a fixed rate per case under the reimbursement methods described below. Some Medicare recipients, however, enroll in Medicare Advantage managed care plans, which reimburse providers on a contractually determined basis. Health care providers that participate in the Medicare program must agree to be bound by the terms and conditions of the program such as meeting the quality standards for rendering covered services and adopting and enforcing policies to protect patients from certain discriminatory practices.

The ACA reduces cost sharing by Medicare beneficiaries for certain preventive services and wellness visits and expands coverage for these services. In addition, the ACA includes programs that link Medicare payments for hospitals and physicians with quality outcomes and the development of new patient care models that stress primary care and community-based care. The objective of these programs is to manage chronic diseases better and to reduce inpatient admissions and other high cost care provided by health care facilities, such as hospitals and nursing homes. While additional governmental reporting, oversight and audits are a certainty, it is difficult to determine what effect the health care reform legislation and its implementation will ultimately have on the financial or operating condition of the System, the Obligated Group or their competitors in the future.

Inpatient Services. Medicare payments for operating expenses incurred in the delivery of inpatient hospital services are based on a prospective payment system ("*PPS*"), which pays hospitals a fixed amount for each Medicare inpatient discharge based upon patient diagnosis and certain other factors used to classify each patient into a Diagnosis Related Group ("*DRG*") or, more recently, the Medical Severity Diagnosis Related Group ("*MS-DRG*"). DRG rates are adjusted annually by the use of an "update factor" based on the projected increase in a market basket inflation index which measures changes in the costs of goods and services purchased by hospitals, but the adjustments historically have not kept pace with inflation. Inpatient psychiatric services are also reimbursed on a case-mix adjusted prospective payment methodology.

With limited exceptions, MS-DRG payments are not adjusted for actual costs, variations in intensity of illness, or length of stay. If a hospital treats a patient and incurs less cost than the applicable MS-DRG-based payment, the hospital is entitled to retain the difference. Conversely, if a hospital's cost for treating the patient exceeds the MS-DRG-based payment, the hospital generally will not be entitled to any additional payment. If a case is unusually complex or expensive, it may qualify for an "outlier" payment, which is added to the MS-DRG-adjusted base rate payment. There can be no assurance that payments under the PPS will be sufficient to cover all actual costs of providing inpatient hospital services to Medicare patients.

Medicare and Medicaid currently make additional payments to hospitals that serve a disproportionate share ("*DSH*") of low-income patients. According to the Medicaid and CHIP Payment and Access Commission, the ACA began to incrementally decrease the federal DSH allotments. Reductions in DSH payments were based on an assumption that the ACA's coverage and access provisions would substantially reduce uncompensated care provided by hospitals. Subsequent to the passage of ACA, other federal legislation has impacted the reduction of DSH payments.

The PPS amount and the DSH adjustments described above are calculated using formulae established by CMS that are revised periodically pursuant to federal budgetary policy. There can be no assurance that payments received by the Obligated Group will be sufficient to cover all actual costs of providing inpatient hospital services to Medicare patients.

Hospitals report certain quality measures under the Hospital Inpatient Quality Initiative. Hospitals that report these measures receive the full DRG inflation update - known as the "hospital market basket", while non-participating hospitals suffer a 2% reduction from the market basket update. The market basket update for federal fiscal year 2016 is 2.4%, and for federal fiscal year 2017 is 2.7%. The hospitals affiliated with the Obligated Group participate in CMS' Inpatient Hospital Quality Initiative. There is no assurance that future updates in DRG payments will keep pace with the increases in providing inpatient hospital services.

Outpatient Services. Medicare payments for hospital outpatient services also are established through a PPS methodology. Under outpatient PPS, procedures, evaluations, management services, drugs and devices in outpatient departments are classified into one of approximately 750 groups called Ambulatory Payment Classifications ("*APCs*"). Services provided within an APC are similar clinically and in terms of the resources they require. Each APC has been assigned a weight derived from the median hospital cost of the services in the group relative to the median hospital cost of the services included in the APC for mid-level clinic visits, adjusted to account for variations in hospital labor costs across geographic regions. Payment rates for each APC are then calculated by multiplying the relative weight for an APC by a conversion factor to arrive at a dollar figure.

Outpatient PPS includes additional adjustments for transitional pass-through payments and outlier payments. Transitional pass-through payments are costs associated with new technology items (drugs, biologicals and medical devices) that were not reflected in the data that CMS used to calculate outpatient PPS payment rates, and are intended to allow for adequate payment of new and innovative technology until there is enough data to incorporate the costs for these items into the base APC group.

APCs include payment for related ancillary services provided in conjunction with a procedure or medical visit. Although hospitals may receive payment for more than one APC for an encounter, payment for multiple surgical APC procedures are subject to substantial discounting.

Outpatient renal dialysis services are reimbursed on the basis of prospective reimbursement, though different rates are paid for hospital-based and free-standing facilities, and are adjusted for geographic differences in labor costs. This composite rate is the same regardless of whether the treatment is furnished in the facility or in the patient's home to incentivize home dialysis, and must be accepted by the facility as payment in full for covered outpatient dialysis.

Under outpatient PPS, a hospital with costs exceeding the applicable payment rate would incur losses on such services provided to Medicare beneficiaries. There can be no assurance that outpatient PPS payments will be sufficient to cover all of the Obligated Group's actual costs of providing hospital outpatient services to Medicare patients.

Physician Payments. Payment for physician services is provided by Medicare Part B. Under Part B, physician services are reimbursed in an amount equal to the lesser of actual charges or the amount determined under a national fee schedule known as the resource-based relative value scale ("*RBRVS*"), which sets a relative value for each physician service, which is then multiplied by a geographic adjustment factor and a nationally-uniform conversion factor to determine the amount Medicare will pay for each service.

The nationally-uniform conversion factor was previously calculated utilizing the sustainable growth rate ("*SGR*") system. The SGR was linked to changes in the United States Gross Domestic Product over a ten-year period. The SGR system was intended to keep spending growth consistent with the national economy; however, because over the last decade federal health care expenditures have continuously exceeded their targets, application of the SGR would have resulted in extreme rate cuts to physicians. As a result, Congress repeatedly enacted legislation to override projected reductions and to at least maintain physician reimbursement rates. In 2015, the SGR was repealed by the Medicare Access and CHIP Reauthorization Act of 2015 ("*MACRA*").

Under MACRA, CMS created a new framework to reward health care providers to provide better care rather than more care, and combined the existing quality reporting programs under one new system: the MACRA Quality Payment Program. The MACRA Quality Payment Program is comprised of the Merit-Based Incentive Payment System ("*MIPS*") and Advanced Alternative Payment Models ("*APMs*"). Both MIPS and APMs went into effect in 2015 and will continue to be implemented over several years. MIPS and APMs are two alternative tracks for physicians. MIPS combines parts of three current programs: the physician quality reporting system, the value based payment modifier program and the EHR Incentive Program (commonly known as the "meaningful use program"). MIPS is comprised of four weighted performance categories that are used to calculate composite performance: quality; resource use (referred to as "cost"); advancing care information; and clinical practice improvement. The weighting of the categories changes over time. Adjustments may be positive or negative, so MIPS could result in significant rate reductions. The adjustments are capped (both positively and negatively) as follows: plus/minus 4% in 2019; plus/minus 5% in 2020; plus/minus 7% in 2021; and plus/minus 9% from 2022 onward.

Eligible APMs include certain accountable care organizations (e.g., Track 2 and 3 of the Medicare Shared Savings Program ACOs; next generation ACOs (f/k/a pioneer ACOs)), certain patient centered medical homes and certain bundled payment models. For 2019 through 2024, physicians who qualify for APMs earn a 5% incentive payment and are excluded from MIPS adjustments. For 2026 and after, physicians who qualify for APMs are excluded from MIPS adjustments and receive higher fee schedule updates. Eligibility for a bonus under the APMs is based on the amount of payments or number of patients, whichever is more favorable, connected with the APMs.

There can be no assurances that the current methodology for calculating physician payments under the RBRVS methodology, following the SGR's repeal, will remain as it is presently structured. Changes to the formulae or otherwise under MACRA may negatively impact the reimbursement amounts received by the Obligated Group members' hospitals for the cost of providing physician services.

Capital Expenditures. Medicare payments for capital costs are based upon a PPS system similar to that applicable to operating costs. Payment for capital related costs for all hospitals are determined based on a standardized amount referred to as the federal rate.

Under PPS, payments for capital costs are calculated by multiplying the federal rate by the DRG weight for each discharge and by a geographical adjustment factor. The payments are subject to further adjustment by a disproportionate share hospital factor that contemplates the increased capital costs associated with providing care to low income patients, and an indirect medical education factor that contemplates the increased capital costs associated with medical education programs. As noted above, ACA includes reductions over time to the disproportionate share payments.

There can be no assurance that payments under the PPS inpatient capital regulations will be sufficient to fully reimburse the System or the Obligated Group for their capital expenditures.

Medical Education Costs. Under PPS, teaching hospitals receive additional payments from Medicare for certain direct and indirect costs related to their graduate medical education ("*GME*") programs. Direct GME payments compensate teaching hospitals for the cost directly related to educating residents. Such costs include the residents' stipends and benefits, the salaries and benefits of supervising faculty, other costs directly attributable to the GME program, and allocated overhead costs. Payment for direct medical education costs are calculated based upon set formulae taking into account hospital-specific medical education costs associated with each resident, the number of full-time equivalent residents, and the proportion of Medicare inpatient days to non-Medicare inpatient days. Indirect GME payments compensate teaching hospitals for the higher patient care costs they incur relative to non-teaching hospitals. Those indirect payments are issued as a percentage adjustment to the PPS payments. The calculation for both the direct part and the indirect part of Medicare payments for GME include certain limitations on the number and classification of full-time equivalent residents reimbursed by Medicare.

The formulae used to determine payments for medical education do not necessarily reflect the actual costs of such education, and the federal government will continue to evaluate its policy on graduate medical education and teaching hospital payments. There can be no assurance that payments to the Obligated Group under the Medicare program will be adequate to cover its direct and indirect costs of providing medical education to interns, residents, fellows and allied health professionals.

Outlier Payments. As previously noted, hospitals are eligible to receive additional payments known as "outlier payments" under the inpatient PPS for individual cases incurring extraordinarily high costs. Costs must exceed a certain threshold in order for the hospital to be eligible to charge for outlier payments. A percentage of costs, based on the marginal cost factor, is then applied to only the costs exceeding the threshold to figure out the payment. Both operating costs and capital (asset) costs are applied when calculating the outlier payments.

After determining that some hospitals might be manipulating current hospital charge data to maximize reimbursement from Medicare for outlier payments, CMS amended the regulations on how outlier payments were to be calculated. The Office of Inspector General for HHS ("*OIG*") scrutinizes outlier payments in an effort to determine whether outlier payments to the hospitals were paid in accordance with Medicare regulations or whether such payments were the result of potentially abusive billing practices. Although the Obligated Group members believe that their outlier payments have been calculated appropriately, there can be no assurance that they will not become the subject of an investigation or audit with respect to their past outlier payments, or that such an audit would not have a material adverse impact on the Obligated Group members. Moreover, there can be no assurance that any future revisions to the formula for calculating outlier payments will not reduce payments to the Obligated Group members, or that any such reduction will not have a material adverse impact on the Obligated Group members.

Medicare Managed Care Program. Every individual entitled to Medicare Part A benefits, and who is enrolled in Medicare Part B, with the exception of individuals who suffer from End Stage Renal Disease, may elect coverage under either the traditional Medicare fee for service program (Parts A and B) or a Medicare managed care (Part C) program, known as the Medicare Advantage Program. The Medicare Advantage program is designed to expand the number and types of private regional plans available to beneficiaries as an alternative to traditional Parts A and B Medicare coverage. Payments for Medicare Advantage plans are based on competitive bids to the government rather than administered pricing.

Public and private health maintenance organizations, preferred provider organizations, fee for service and medical savings account plans may qualify as authorized Medicare Advantage plans. With

limited exceptions, Medicare Advantage plans are risk-bearing programs that accept a fixed annual amount in return for providing beneficiaries with a defined level of benefits (basic or basic plus supplemental), either directly or through arrangements with other providers. All Medicare Advantage plans are required to provide coverage, even if out of network, for emergency services, renal dialysis services provided while the enrollee was temporarily outside of the plan's service area, post-stabilization care services (under limited circumstances) and services for which coverage was denied but, following appeal by the enrollee, were determined to be covered services. Providers wishing to participate in Medicare Advantage plans are subject to specific requirements concerning enrollee protection and accountability.

The shift of Medicare eligible beneficiaries from traditional Part A and Part B coverage to Part C Medicare Advantage programs was intended to increase competitive pressure to improve benefits, reduce premiums and generate cost reductions. However, because the cost to the Medicare Advantage program was on average 114% higher than traditional Medicare, ACA changed some of the Medicare Advantage payment methodologies. The resulting reductions in the Medicare Part C program may have an impact on reimbursement from these insurance plans, which in turn may have a material negative impact upon the revenue of the Obligated Group and its affiliates.

Provider-Based Standards. The Medicare program reimburses certain facilities and services (including, for example, physician offices and clinics) differently, depending upon whether they are "provider-based" or "freestanding." A "provider-based" facility or service is an integral part of another provider, such as a hospital. Certain administrative costs and overhead of the provider organization must be allocated in part to the provider-based organization. "Freestanding" providers are not considered part of another provider for purposes of the Medicare program and stand on their own for reimbursement purposes. For any given facility or service, it is probable that one classification or the other will result in a higher aggregate reimbursement for the system as a whole. However, the BBA changed how CMS reimburses for such provider-based outpatient services that are established on or after November 2, 2015, by excluding new off-campus provider-based outpatient departments from the OPPS starting on January 1, 2017. These sites are instead reimbursed under the applicable non-hospital payment system: the physician fee schedule or the ambulatory surgical center payment system. This may deter the Obligated Group members from establishing any new off-campus provider-based outpatient departments.

If CMS learns that a provider has treated a facility or organization as "provider-based" and the provider had not obtained a determination of that status from CMS, under strict provider-based regulations, the provider may be required to repay overpayments made by CMS due to such erroneous treatment by the provider. CMS may also review a past determination of "provider-based" status if it believes that the past determination was in error, in which case CMS will cease to treat the facility or organization as "provider-based." In the event that the Obligated Group members' outpatient services billed on a provider-based basis are found to be out of compliance with the current provider-based regulations, the Obligated Group members could be liable for Medicare overpayments.

CMS also issued a final rule on November 1, 2016 that further limits operation of existing provider-based departments, including requiring that provider-based departments remain at the same physical location and providing the same services. It is difficult to know what effect the final rule will have on the future operation of any of the Obligated Group members' provider-based departments.

Audits, Exclusions, Fines and Enforcement Actions. Medicare-participating hospitals are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under the Medicare, Medicaid and commercial programs. Although management of the Obligated Group members believes the reserves of the Obligated Group members are adequate, such adjustments could be substantial and could exceed reserves maintained therefor by the Obligated Group members. Medicare

regulations also provide for withholding Medicare payment in certain circumstances, and such withholds could have a material adverse effect on the financial condition of the Obligated Group members. Management of the Obligated Group is not aware of any situation whereby a material Medicare payment is being withheld from the Obligated Group members. See "BONDHOLDERS' RISKS - Fraud and Abuse Laws" for exposure to audits and withholds.

Medicare-participating hospitals are also subject to Recovery Audit Contractor ("*RAC*") audits. RAC auditors are authorized, in most cases, to look back three years from the date the claim was paid, and to review the appropriateness of each claim by applying the same standards and guidance as would a Medicare contractor. The ACA expanded the scope of the RAC program to include Medicare Parts C and D and Medicaid. Medicaid RAC audit programs are overseen by states in accordance with federal guidelines. Medicare RAC recovery amounts have increased substantially over the last couple years. Although RACs are required to identify overpayments and underpayments, RACs have in practice collected significantly more in overpayments from providers than paid out as underpayments to providers. Furthermore, the federal and state governments have developed numerous other audit and fraud enforcement programs over the past decade increasing the likelihood that health care entities, like the Obligated Group members, participating in Medicare and Medicaid may be subject to audits, retroactive audit adjustments and re-payments with respect to reimbursement. Federal and state efforts to take monies back from providers as well as related investigations and, in some cases, criminal prosecutions for overbilling are expected to be prevalent for years to come. It is impossible to predict the effect of such efforts as any resulting future payment adjustments and/or re-payments could be material. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the provider to civil or criminal sanctions. Increased RAC recoupment efforts and other audit programs may have a material impact upon the revenues of the Obligated Group members.

Medicaid Reimbursement and Other State Healthcare Programs

Overview. Medicaid is a partially federal funded state program of medical care for the poor. States obtain federal matching funds for their Medicaid programs by obtaining the approval of CMS for a "state plan" which conforms to Title XIX of the Social Security Act and its implementing regulations. Under broad federal guidelines, each state establishes and administers its own Medicaid program, which includes determining its own eligibility standards, determining the types, amount, duration, and scope of services, and setting the rate of payment for services. After a state plan is approved, the federal government provides federal matching funds for Medicaid expenditures.

The ACA generally revised the Medicaid program by expanding Medicaid coverage, controlling costs and improving Medicaid service delivery for recipients, including those with mental illnesses and disabilities. Under the ACA, states are required to maintain the Medicaid-eligibility standards in effect on March 23, 2010 until the state health insurance exchange (where consumers can comparison shop for health insurance) is deemed by HHS to be fully operational. States are not prevented from making cuts elsewhere in the Medicaid program, such as eliminating optional benefits or reducing provider reimbursement rates.

On June 28, 2012, the United States Supreme Court upheld the ACA's individual mandate provision, revised the Medicaid expansion requirement by giving states a choice to opt out of expanding eligibility without losing the entirety of their federal Medicaid funds, and generally upheld the ACA as a whole. As a result of the ruling, almost every individual in the United States must either obtain health coverage, through an employer, a government-sponsored program such as Medicare or Medicaid, or individual insurance, or pay a penalty. In addition, the provisions of the ACA originally requiring states to expand eligibility requirements for state Medicaid programs to individuals who earn up to 133% of the

federal poverty level are now optional and may not go into effect in all states. Following the Supreme Court's Medicaid expansion ruling, it was uncertain how many states would choose to expand Medicaid. As of July 1, 2017, the District of Columbia and 31 states, including Pennsylvania, expanded Medicaid. During its implementation, the ACA has withstood several legal challenges. As its implementation continues it may face more challenges, and it remains unclear what effect, if any, other legal challenges to certain provisions of the ACA will have as a whole.

Most of the ACA's details are developed through regulations that will continue to be promulgated by HHS and other federal agencies and state insurance departments. Increased access to health insurance coverage may increase the demand for health care and reduce uncompensated care, yet other Medicaid reforms and cost cutting initiatives may negatively impact financial results. These efforts to reform health care, particularly cutting the cost of health care and improving quality, will continue as current health care costs trends are unsustainable.

New legislation proposed to repeal and replace the ACA, if enacted, could result in the substantial amendment, repeal or replacement of many provisions of the ACA, including the expansion of Medicaid. In any event, there can be no guarantee that federal and state programs will continue to be funded at their current rate. Budgetary and financial constraints in Pennsylvania and other states, as well as severe limitations on the method of acquiring increased federal financial participation payments through the use of provider taxes and donations, have called into question the ability of public agencies such as DHS to make adequate and timely payments to providers. Further, while expanded Medicaid coverage will likely result in fewer uninsured patients, rates paid for Medicaid patients have historically not covered the full costs of their care and there is no guarantee that the rates will ever cover the cost of such care. The interim or long-term effects of the ACA, or any legislation amending, repealing or replacing it, on the Obligated Group cannot be predicted with any degree of certainty.

Inpatient Services. Payment for medical and health services is made to hospitals in an amount determined in accordance with procedures and standards established by state law under federal guidelines. In addition to such direct payments, the Obligated Group also receives reimbursement for services to Medicaid patients from certain payers that have contractual arrangements with DHS to provide coverage for such patients. Providers participating in Medicaid must accept Medicaid payment rates as payment in full.

Since 1984, Medicaid payment for operating and capital-related costs of acute care services has been based on a PPS similar to the federal Medicare DRG-based PPS described above. In 2010, when the state plan was amended, Medicaid payment for inpatient hospital services was modernized by establishing a uniform base rate for all hospitals using the most current cost information, and making adjustments for differences in regional labor costs, teaching programs, and Medicaid volume. At the same time, hospital payments through the state's Medicaid managed care program were enhanced, and additional matching Medicaid funds were obtained through the establishment of the Quality Care Assessment, a tax on hospital net inpatient revenues that allows the state to access additional federal dollars. Through Pennsylvania's Act 49 of 2010, DHS was authorized to impose a statewide hospital assessment on the net inpatient revenue of all Pennsylvania licensed acute care hospitals. Act 49 modernized Pennsylvania's inpatient hospital fee-for-service payment system, introduced enhanced hospital payments through Pennsylvania's Medicaid managed care program, and secured additional matching Medicaid funds through the establishment of the Quality Care Assessment.

Next, Pennsylvania's Act 55 of 2013 reauthorized the statewide hospital assessment for an additional three years: July 1, 2013 through June 30, 2016. More recently, Pennsylvania's Act 92 of 2015 reauthorized the statewide hospital assessment through June 30, 2018. Through the significant amount of revenue that the assessment raises, Pennsylvania has been able to maintain an updated inpatient payment

system, make changes to existing DSH payments and supplemental payments and generate new payments where applicable.

In addition, states must make DSH payments to qualified hospitals that provide services to a disproportionately large number of Medicaid, low income and/or uninsured patients. Often DSH payments are insufficient to cover a hospital's costs in providing care to such patients, and in light of the DSH payment reduction, there can be no assurance that any future DSH payments will cover the Obligated Group's costs. There can be no assurance that future Medicaid inpatient reimbursement rates will remain at current levels, or that such rates will cover the Obligated Group's costs of providing inpatient care to Medicaid patients.

Serious, Preventable Events. The ACA required CMS to incorporate nonpayment policies for certain Hospital Acquired Conditions ("*HACs*") into the Medicaid regulations, including non-payment polices for provider preventable conditions. States have discretion to add additional HACs and provider preventable conditions to their non-payment policies. While the Obligated Group's hospitals currently have programs in place to monitor and prevent HACs, given the difficulty inherent in completely eliminating HACs, it is likely that the Obligated Group's hospitals will face reduced reimbursement at some point for costs associated with treating HACs.

Outpatient Services. Medicaid provides payment for hospital outpatient services rendered based on the lower of the usual charge to the general public for the same service or the Medicaid maximum allowable fee.

Medicaid Managed Care. In Pennsylvania, Medicaid recipients may obtain benefits through managed care plans. Under the program known as "HealthChoices," most Medicaid beneficiaries in Pennsylvania, including those in the Obligated Group service area, are required to enroll in a managed care plan that provides services on a prepaid basis. The HealthChoices program has generally resulted in stricter utilization review of Medicaid-reimbursed hospital services and reduced lengths of stay and/or reimbursement compared with the previous fee-for-service system. There can be no assurance that the prepaid rates will cover expenses incurred in providing inpatient hospital care to the Medicaid recipients.

Third-Party Reimbursement

A significant portion of the net patient service revenue of the Obligated Group is received from commercial third-party payors and other non-governmental agencies, which provide third-party reimbursement for patient care on the basis of various formulae. Renegotiations of such formulae and changes in such reimbursement systems may reduce such third-party reimbursements to the Obligated Group. The reimbursement currently paid by third parties is likely to be subject to more restrictions in the future, and there can be no assurance that such payments will be adequate to cover the cost of care for the beneficiaries in the future.

ACA includes insurance market reforms that, among other things, require individual and group health insurance plans to offer coverage (including renewability) on a guaranteed basis. ACA prohibits pre-existing conditions limitations, certain coverage limitations, lifetime and annual dollar limits for essential health benefits, and requires coverage of certain preventive health benefits. ACA requires every individual to enroll in a health plan through an employer, a federal government health program such as Medicare, Medicaid or Tricare (the health care plan for military personnel), or purchase insurance through a health insurance exchange established by each state. Individuals who do not enroll for coverage, and large employers who do not offer affordable and adequate coverage, will be subject to tax penalties. It is unclear at this time whether the tax penalties will result in substantial compliance with the mandate to

obtain insurance, and whether the provision requiring individuals to obtain coverage will withstand court challenges.

ACA establishes the criteria for 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 and gold level. ACA 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 ACA, individuals with family income under 400% of the federal poverty level will be eligible for subsidized premiums, deductibles and co-pays for exchange plan coverage. Initially, only individuals and small employers will be able to access coverage through the exchanges. By 2017, large employers also were able to use the exchanges to provide employer-based coverage to their employees. Although existing health insurance plans may continue to offer coverage as grandfathered plans in the individual and group markets, enrollment in such plans will be limited to those who were currently enrolled and their families. New employees and their families still will be allowed to enroll in grandfathered employer-sponsored coverage. 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 Obligated Group will still need to treat. The use and availability of this state-based exchange and its effect upon the revenues of the Obligated Group, and upon the operations, results of operations and financial condition of the Obligated Group, cannot be predicted at this time.

Currently, most private insurance companies contract with hospitals on an exclusive or preferred-provider basis, and some insurers have introduces plans known as preferred provider organizations ("*PPOs*"). Under these plans, there may be financial incentives for subscribers to use only those hospitals and physicians who contract with those plans. Under an exclusive provider plan, an arrangement that includes most health maintenance organizations ("*HMOs*"), private payors limit coverage to those services provided by network hospitals and physicians. With this contracting authority, private payors may direct patients away from hospitals not in the network by denying coverage for services provided by them.

Currently, most PPOs and HMOs pay hospitals on a discounted fee-for-service basis or on a discounted fixed rate per day of care. The discounts offered to HMOs and PPOs may result in payment at less than actual cost, and the volume of patients directed to a hospital under an HMO or PPO contract may vary significantly from projections. Therefore, the financial consequences of such arrangements cannot be predicted with certainty and may be different from current or prior experience. Some HMOs offer or mandate a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" to, or otherwise directed to receive care at, a particular hospital. In a capitation payment system, the hospital assumes an insurance risk for the cost and scope of care given to the HMO's enrollees. If payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care, or if use by enrollees materially exceeds projections, the financial condition of that hospital may be adversely affected.

HMOs and other third-party payors that contract on a discounted fee-for-service or discounted fixed rate-per-day basis also exert strong controls over the utilization of health care resources. Strong utilization management by managed care plans has led to reduction in the number of hospitalizations and lengths of hospital stays, both of which may reduce patient service revenue to hospitals. Furthermore,

shortened hospital lengths of stay have not necessarily been accompanied with a reduced demand for services while a patient is hospitalized and in fact may lead to more intensive hospital visits and correspondingly increased costs to hospital providers.

The System, the Obligated Group and their affiliates also may be affected by the financial instability of HMOs and other third-party payors from which it receives reimbursement for furnishing health care services. For example, if regulators place a financially-troubled HMO into rehabilitation under state law, or if a third-party payor files for protection under the federal bankruptcy laws, it is unlikely that health care providers will be reimbursed in full for services furnished to enrollees of the HMO or the third-party payor. Health care providers also may be required by law or court order to continue furnishing health care services to the enrollees of an insolvent HMO or third-party payor, even though the providers may not be reimbursed in full for such services.

Employer-sponsored health insurance plans are adopting health care benefits that create incentives for employees to participate in preventative care programs and better manage chronic diseases. These programs may reduce the costs of providing health care benefits and help maintain a healthier workforce. Employers also are adding alternatives to traditional fee for service health insurance programs, by offering a variety of health insurance programs that increase cost sharing by employees or reduce cost by limiting access to only preferred providers. These types of insurance programs are expected to cover an increasing share of health care services being provided in the future.

Per diem rates, other risk-based payment systems and discounts pose major challenges to hospital providers. In order to enter into such contracts, hospitals not only must anticipate the cost of rendering specific services to patients, but also estimate the likelihood and severity of illness or injury within the population which the hospital serves. If payment under a managed care plan contract is insufficient to meet a hospital's costs of caring for the needs of the population it serves, that hospital's financial condition may erode rapidly and significantly. Often, managed care plan contracts are enforceable for the stated term, regardless of provider losses. Furthermore, managed care plan contracts and insurance laws may require that a hospital continue to provide care for enrollees for a certain period of time irrespective of whether the managed care plan has funds to make payment to the hospital.

Physician practice groups, independent practice associations and other physician management companies have become a part of the process of negotiating payment rates to hospitals by managed care plans. This involvement has taken many forms but typically increases the competition for limited payment resources from managed care plans. For example, it is increasingly common for managed care plans to enter into contracts with physicians that may give physicians incentives in patient care decisions which may result in reduced hospital admissions and procedures.

Any payment methods implemented by the Medicare and Medicaid programs in response to ACA provisions are likely to drive similar changes in the private payor market. Programs designed to encourage coordination of care, value-based purchasing and quality outcomes will likely evolve in the private payor market.

There is no assurance that reimbursement contracts of the Obligated Group or its physicians with Blue Cross, HMOs, PPOs or other third-party payors will be maintained, that other similar contracts will be obtained in the future, or that payments from such payors will be sufficient to cover all of the costs the Obligated Group incurs in providing services to their beneficiaries. Failure to execute and maintain such contracts could have the effect of reducing the patient base or revenues of the Obligated Group. Conversely, participation may maintain or increase the patient base, but may result in reduced payments.

Uncompensated Care

Although the Obligated Group attempts to assure payment or reimbursement for most of the care it renders, it provides a substantial amount of uncompensated care to indigents. Obligations to provide uncompensated care can arise from laws and regulations that may require the Obligated Group to provide care without regard to a patient's ability to pay for such care. Increased unemployment or other adverse economic conditions could increase the proportion of patients who are unable to pay all or any of the costs of their care.

The Medicaid and Medicare programs are dependent on the continued availability of federal and state funding, which could be curtailed in the future in response to growing budget deficits at all governmental levels. The continued availability, comprehensiveness of coverage and adequacy of reimbursement for care for the indigent and disabled cannot be assured in the future.

Regulatory Environment

The System, the Obligated Group and their affiliates and the health care industry in general are subject to regulation by a number of governmental agencies, including those that administer the Medicare and Medicaid programs, federal, state and local agencies responsible for administration of health care planning programs, and other federal, state and local governmental agencies. These laws and regulations also require hospitals to meet various detailed standards relating to the adequacy of medical care, equipment, personnel, information technology, patient confidentiality, operating policies and procedures, maintenance of adequate records, utilization, rate setting, compliance with building codes and environmental protection laws, and numerous other matters. Failure to comply with applicable regulations can jeopardize a hospital's licenses, ability to participate in the Medicare and Medicaid programs, and ability to operate as a hospital. These laws and regulations, as well as similar laws and regulations now in effect, and the adoption of additional laws and regulations in these and other areas could have an adverse effect on the operations and financial conditions of the Obligated Group and, in turn, on the System's ability to make payments under the Loan Agreement.

ACA enhanced the Medicare and Medicaid integrity provisions by increasing funding for enhanced fraud and abuse efforts and increasing the fines and penalties for failure to comply. These efforts will be supported by the expansion of access to CMS's integrated claims data repository of CMS, to be used to identify potential fraud, waste and abuse.

There are multiple federal laws concerning the submission of inaccurate or fraudulent claims for reimbursement and errors or misrepresentations on cost reports by hospitals and other health care providers. The coding, billing and reporting obligations of Medicare and Medicaid providers are extensive, complex and highly technical. In some cases, errors and omissions by billing and reporting personnel may result in liability under one of the federal False Claims Acts or similar laws, exposing a health care provider to civil and criminal monetary penalties, as well as exclusion from participation in the Medicare and Medicaid programs.

Some of the laws and regulations affecting the health care industry are discussed below.

The Federal Anti-Kickback Law. The federal Anti-Kickback Law ("*AKS*") is a criminal statute that prohibits the knowing and willful offer, payment or receipt of remuneration in exchange for or as an inducement to make or influence a referral of a patient for the provision of goods or services that may be reimbursed under any federal health care program. The scope of the AKS is very broad, and it potentially implicates many practices and arrangements common in the health care industry. Violation of the AKS is a felony, subject to a maximum fine of $25,000 for each criminal act, imprisonment for up to five years,

both a fine and imprisonment, civil monetary penalties of up to $50,000 per violation or damages equal to three times the amount of the prohibited remuneration, as well as exclusion from the federal health care programs. The ACA clarified the intent requirement to provide that a person need not have actual knowledge of the AKS or specific intent to commit a kickback violation to violate the statute. The result of this change is that the government will have less of a burden to prove a violation under the AKS. In addition, a claim that includes items or services resulting from a violation of the AKS is a false claim for purposes of the federal civil False Claims Act (discussed below).

HHS has issued regulations from time to time setting forth safe harbors that protect limited types of arrangements from prosecution under the statute. Arrangements that do not comply with the strict requirements of the safe harbors, while not necessarily illegal, face an ongoing risk of investigation or prosecution due to the broad language of the statute. The safe harbors described in the regulations are narrow and do not cover many common economic relationships between and among hospitals, including the Obligated Group, physicians and other health care providers. The Obligated Group has arrangements with other health care providers that may not meet all of the requirements of the "safe harbor" regulations. Given the narrowness of the safe harbor regulations and the scarcity of the case law interpreting the AKS, there can be no assurances that the Obligated Group will not be found to have violated the AKS, and if such a violation were found, that any sanctions imposed would not have a material adverse effect upon the operations and financial conditions of the Obligated Group.

Physician Payment Sunshine Act. To increase transparency regarding the financial relationships between hospitals, doctors, and healthcare manufacturing companies, the Physician Payment Sunshine Act requires that manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs must report certain payments and items of value given to physicians and teaching hospitals. This information is publicly available on the CMS website. It is impossible to predict the future impact of this reporting on the Obligated Group or whether the companies that currently provide payments to the Obligated Group will reduce such payments to the Obligated Group or whether the federal government will pursue investigations as a result of such reporting.

Federal False Claims Act. The federal criminal False Claims Act ("*criminal FCA*") makes it illegal to submit or present a claim known to be false, fictitious or fraudulent claim to the federal government. Violation of the criminal FCA can result in imprisonment and a fine. The federal civil False Claims Act ("*civil FCA*"), one of the government's primary weapons against health care fraud, allows the United States government to recover significant damages from persons or entities that submit false or fraudulent claims for payment to any federal agency through actions taken by the U.S. Attorney's Office or the Department of Justice. The civil FCA also permits individuals to initiate actions on behalf of the government in lawsuits called qui tam actions. These qui tam plaintiffs, or "whistleblowers," can share in the damages recovered by the government.

Under the civil FCA, health care providers may be liable if they take steps to obtain improper payments from the government by submitting false claims or failing to refund known overpayments. Civil FCA violations have been alleged solely on the existence of alleged kickback or self-referral arrangements. Even in the absence of evidence that services were not provided or not medically necessary, these cases argue that the improper business relationship tainted the subsequently submitted claims, thereby rendering the claims false under the civil FCA. In 2009, the scope of the civil FCA was expanded to include so-called "reverse false claims," where a provider that knowingly retains a government overpayment is subject to FCA liability. The ACA further requires that any overpayment be reported and repaid within 60 days after the date on which overpayment was identified. Failure to do so will be considered a *per se* false claim under the civil FCA. The ACA also modified the FCA by extending the FCA to AKS violations.

Violations of the civil FCA can result in penalties up to triple the actual damages incurred by the government and monetary penalties currently ranging from $10,957 to $21,916 per claim. Private individuals may also bring suit under the qui tam provisions of the civil FCA and may be eligible for to share in the government's recovery for providing information that leads to recoveries or sanctions that arise in a variety of contexts in which health care providers operate. The ACA also eased the requirements for private individuals to bring suit under the civil FCA. In recent years there has been a significant increase in the number of whistleblower allegations filed under the civil FCA.

While the Obligated Group is not aware of any violations of the criminal FCA or civil FCA, these statutes pose significant risks to all health care organizations. There can be no assurances that he Obligated Group will not be charged with, or found to have violated, the criminal FCA or civil FCA and, if so, that any fines or other penalties would not have a material adverse effect on their operations.

Civil Monetary Penalties Law. The Civil Monetary Penalties Law under the Social Security Act ("*CMP Law*") provides for the imposition of civil monetary penalties for many reasons, including against any person who submits a claim to Medicare, Medicaid or any other federal health care program that the person knows or should know is for items or services not provided as claimed; is false or fraudulent; is for services provided by an unlicensed or uncertified physician or by an excluded person; represents a pattern of claims that are based on a billing code higher than the level of service provided; or is for services that are not medically necessary. The CMP Law, among other things, also prohibits hospitals from paying physicians to limit medically necessary care. Penalties under the CMP Law include up to $10,000 for each item or service claimed, and damages of up to three times the amount claimed for each item or service, and exclusion from participation in the federal health care programs. Depending on the type of violation, different (and in some cases, higher) penalties may apply.

Health care providers may be found liable under the CMP Law even when they did not have actual knowledge of the impropriety of their action. Knowingly undertaking the action is sufficient. The imposition of civil monetary penalties could have a material adverse impact on the Obligated Group' financial condition.

Stark Self-Referral and Payment Prohibitions. The federal Ethics in Patient Referrals Act (known as the "*Stark Law*") prohibits the referral of patients for certain "designated health services" (which include inpatient and outpatient hospital services) payable by Medicare to entities with which the referring physician (or an immediate family member of such physician) has a financial relationship unless an exception applies. The statute also prohibits the entity furnishing the "designated health services" from billing the Medicare or Medicaid program for designated health services furnished pursuant to a prohibited referral. The law requires reporting of financial relationships to CMS. The Stark Law is a strict liability statute.

Violations of the Stark Law can result in refunds of the amounts collected for services rendered pursuant to a prohibited referral, civil monetary penalties of up to approximately $24,000 for each claim arising out of such referral, and exclusion from the Medicare and Medicaid programs. The Stark Law also provides for a civil penalty of up to approximately $159,000 for entering into an arrangement with the intent of circumventing its provisions. In certain circumstances, knowing violations may also create liability under the FCA. Due to the complexity of the Stark Law and related regulatory guidance, there can be no assurance that the Obligated Group will not be found to have violated the Stark Law. If so, a sanction imposed based on such a violation could have a material adverse effect on the operations and/or financial condition of the Obligated Group.

State Fraud and Abuse Laws. In addition to federal fraud and abuse laws, states also have a variety of laws related to kickbacks and referrals, which may be broader than the federal laws.

Pennsylvania does not have a state law similar to the Stark Law that prohibits self-referrals in all circumstances, but it has laws and regulations prohibiting kickbacks, and a Workers' Compensation Act and Medicaid regulations, both of which have self-referral restrictions similar to the federal Stark Law.

The Pennsylvania Workers' Compensation Act prohibits any health care provider from referring a person for physical therapy, rehabilitation and certain other health care services to an entity in which the provider has a financial interest. The Pennsylvania Workers' Compensation Act also prohibits any entity from submitting a claim for payment for any service furnished pursuant to a prohibited referral. Regulations implementing the Pennsylvania Workers' Compensation Act, however, exempt from the Pennsylvania Workers' Compensation Act referrals permitted under any of the Stark Law exceptions or the AKS safe harbors. Violations of the Pennsylvania Workers' Compensation Act referral restrictions may subject the provider to criminal penalties, civil monetary penalties and loss or suspension of licensure.

In addition to the self-referral restrictions in the Pennsylvania Workers' Compensation Act, the Pennsylvania Medicaid regulations prohibit a participating provider from referring a Medicaid recipient to an independent laboratory, pharmacy, radiology or other ancillary medical service in which the practitioner has an ownership interest. Management of the Obligated Group believes that all arrangements currently in place with their physicians have been appropriately structured so as to avoid violating the Pennsylvania Workers' Compensation Law, the Pennsylvania Medicaid regulations or state laws and regulations prohibiting kickbacks. While the Obligated Group is not aware of any violations of applicable state fraud and abuse laws by the Obligated Group or their practitioners, these laws may pose significant risks to the Obligated Group. If violations of state fraud and abuse laws were found to have occurred, any penalties or sanctions imposed could have a material adverse effect upon the future operations and financial condition of the Obligated Group.

Health Insurance Portability and Accountability Act. Providers of health care, such as the Obligated Group, have been impacted by certain health information requirements contained in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("*HIPAA*"), as amended in 2009 by the Health Information Technology for Economic and Clinical Health Act ("*HITECH*"). HIPAA mandates the adoption of detailed standards for maintaining the privacy and security of protected health information ("*PHI*"). HITECH made significant modifications to HIPAA including subjecting business associates to direct regulation and enforcement by the Office of Civil Rights of HHS ("*OCR*"), instituting a breach notification requirement for breaches of unsecured PHI, including a breach of PHI held by a business associate, and strengthening the enforcement tools available to OCR. Additionally, under HIPAA covered entities or business associates must perform risk assessments.

On March 21, 2016, the OCR announced that it was ready to begin Phase Two of its HIPAA audit program, which included business associates. These audits, mandated by HITECH, were primarily comprised of desk audits, scheduled to be completed by the end of December 2016, followed by onsite audits. The OCR explained that some covered entities and business associates who are subject to desk audits may also be subject to onsite audits. According to the OCR, all covered entities and business associates were eligible to be audited. The audits focused on identifying compliance with specific privacy, security and breach notification requirements under HIPAA/HITECH. Subsequent to the audits, the OCR will review and analyze information from audit final reports. This information has not yet been made publicly available. Importantly, if an audit report uncovers significant noncompliance with HIPAA, it could prompt an investigation by the OCR. It is anticipated that more audit activity by the OCR will continue in the future.

The financial costs of continuing compliance with HIPAA regulations are substantial and will increase as a result of HITECH, increased enforcement, and well-publicized breaches. Enforcement of

HIPAA compliance has heightened in recent years and this trend is expected to continue. This includes, but is not limited to, a steady increase in the number of substantial settlements with governmental authorities as a result of breaches. If OCR conducts an investigation (whether as a result of an audit or reporting of such a breach), OCR could impose certain fines and penalties and could also require the Obligated Group to enter into a corrective action plan. The Obligated Group is actively engaged in continuing compliance efforts with HIPAA and HITECH. There are also costs and risks associated with vendors and contractors and it is possible that the Obligated Group could be responsible for HIPAA violations or breaches of its vendors and contractors. The Obligated Group have reported breaches to HHS. No guarantee can be made that the Obligated Group will remain HIPAA/HITECH Act compliant in the future, or that OCR will not conduct an audit or investigation in connection with a reported breach. In addition, as data breaches continue to have greater exposure both inside and outside of the health care industry, and awareness of such breaches continues, private litigation is expected to increase. As a result, no assurances can be given that the Obligated Group or any related entity will not be faced with potential private litigation in the event of a data breach.

Electronic Health Record Incentive Program. HITECH provided funding for various activities intended to promote the adoption and meaningful use of certified electronic health record ("*EHR*") technology. Eligible Medicare and Medicaid providers, including acute care hospitals and other health care professionals, may be eligible to receive EHR payment incentives if they demonstrate the meaningful use of certified EHR technology and meet other program requirements. Starting in 2015, an eligible provider who does not successfully demonstrate meaningful use of certified EHR technology will be subject to reduced physician fee schedule payments. If less than 75% of eligible providers are using certified EHR technology after 2018, then the payment adjustment will decrease by an additional 1% each year until the payment adjustment reaches 95% of the Medicare covered amount. CMS has begun an audit program to assure the veracity of certifications.

There can be no guarantee that the Obligated Group will continue to be able to successfully demonstrate meaningful use of EHR technology, and if the Obligated Group is unable to demonstrate meaningful use in the future, it may be subject to reduced Medicare payments.

Emergency Medical Treatment and Active Labor Act. Congress enacted the Emergency Medical Treatment and Active Labor Act ("*EMTALA*"), in response to allegations of inappropriate hospital transfers of indigent and uninsured emergency patients. EMTALA imposes strict requirements on hospitals in the treatment and transfer of patients with emergency medical conditions.

EMTALA requires hospitals to provide a medical screening examination to any individual who comes to a hospital's emergency department for treatment, without regard to ability to pay, to determine whether the individual suffers from an emergency medical condition within the meaning of EMTALA. A participating hospital may not delay providing a medical screening examination in order to inquire about method of payment or insurance status. If an emergency medical condition is present, the hospital must provide such additional medical examination and treatment as may be required to stabilize the emergency medical condition. If the hospital deems it in the best interest of the individual to transfer the individual to another medical facility, the treating physician must execute a transfer certificate complying with the standards of EMTALA and must provide a medically appropriate transfer.

In regulations, CMS has extended the application of EMTALA beyond the hospital emergency department to any individual who is on hospital property and requests an examination or treatment, including individuals who are anywhere on the hospital's main campus, in a hospital owned ambulance, or in a facility determined by CMS to be an off-campus department of the hospital. Off-campus departments might include, for example, urgent care centers, primary care clinics and physical therapy and radiology facilities.

EMTALA imposes significant costs on hospitals, including the costs of treatment of individuals who may not be able to pay for those services, costs to develop and implement protocols covering medical screening examinations, stabilization and appropriate transfers and, in some cases, costs associated with assuring on-call availability of specialty physicians. In addition, the expansion of the requirements of EMTALA to off-campus departments may result in significant costs in training personnel and the development of protocols for screening, stabilization and transportation of patients.

If a hospital violates EMTALA, whether knowingly or negligently, it is subject to a civil money penalty of up to $50,000 per violation. Failure to satisfy the requirements of EMTALA also may result in termination of the hospital's provider agreement with Medicare. In addition, EMTALA creates a private cause of action for individuals who suffer personal harm as a result of an EMTALA violation, and for any hospital that suffers financial loss as a result of another hospital's violation of EMTALA. Enforcement activity under EMTALA has increased dramatically in recent years. Due to the broad interpretation of the reach of EMTALA, there can be no assurances that any sanctions imposed due to a violation of EMTALA will not have a material adverse effect upon the future operations and financial condition of the Obligated Group.

Quality Reporting Requirements. The Deficit Reduction Act ("*DRA*") also introduced significant new quality reporting initiatives for hospitals. The Obligated Group and its affiliates are required to submit quality performance measures; the penalty for hospitals not reporting quality measures is a two percentage point reduction in the market basket update for that fiscal year. ACA expands those reporting obligations.

DRA Compliance Policy and Employee Training Requirements. The DRA also established requirements for states participating in the Medicaid program to impose obligations on health care providers and others that receive at least $5 million annually in Medicaid payments to establish written policies and procedures designed to educate their employees (and certain contractors and agents) by providing detailed information about: (i) the federal False Claims Act and remedies under the law, (ii) administrative remedies for false claims and statements established by the Federal Program Fraud Civil Remedies Act of 1986, (iii) any state law false claims act and its remedies, (iv) the whistleblower protections provided under such laws, (v) the role of such laws in preventing and detecting fraud, waste and abuse, and (vi) the provider (or other party's) policies and procedures that are in place for the prevention and detection of fraud, waste and abuse. Providers and other covered parties that do not adequately update their compliance policies, handbooks and other training materials or otherwise abide by these requirements run the risk of losing Medicaid reimbursement and risk potential liability under the False Claims Act and other federal and state fraud and abuse laws.

Environmental Laws Affecting Health Care Facilities. Hospitals are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations that address, among other things, hospital operations or facilities and properties owned or operated by hospitals. In their role as owners and/or operators of properties or facilities, hospitals may be subject to liability for investigating and remedying any hazardous substances that have come to be located on the property, including any such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants, or contaminants. For these reasons, hospital operations are particularly susceptible to the practical, financial, and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property, or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; or may trigger investigations, administrative proceedings, penalties or other governmental agency actions. There can be no assurance

that the Obligated Group will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the Obligated Group.

Future Federal Legislation. The System and the Obligated Group anticipate that the federal government's health care reform initiatives will result in further legislation, regulation, and other actions that will continue the trend toward reduced reimbursement for hospital services and more pervasive regulation of operations. At present, no determination can be made concerning whether, or in what form, such legislation could be introduced and enacted into law. Similarly, the impact of future cost control programs and future regulations on the forecasted financial performance of the Obligated Group cannot be determined at this time.

Any future changes to the Medicare and Medicaid programs could result in substantial reductions in the amounts of Medicare and Medicaid payments to hospital providers in the future, which could substantially reduce the revenues available to the Obligated Group, and any reduction in the levels of payment in these government payment programs could adversely affect the Obligated Group's financial condition and its ability to fulfill its obligations with respect to the 2017 Bonds.

Medical Care Availability and Reduction of Error Act. The Medical Care Availability and Reduction of Error Act (the "*Mcare Act*") is a Pennsylvania state law that is the successor to the Medical Professional Liability Catastrophe Loss Fund, better known as the "*CAT Fund*." The Mcare Act established a fund within the state Treasury (the "*Mcare Fun*d") to ensure reasonable compensation for persons injured due to medical negligence. Money in the Mcare Fund is used to pay claims against participating health care providers and eligible entities for losses or damages awarded in medical professional liability actions in excess of basic insurance coverage. Participation in the Mcare Fund is mandatory for most Pennsylvania licensed health care providers.

The Mcare Act also includes significant patient safety initiatives, professional liability tort reforms, professional liability insurance reforms, and administrative requirements. Under the Mcare Act, hospitals are required to develop and implement patient safety plans, appoint patient safety officers, form patient safety committees, and engage in mandatory reporting of serious events, incidents, and infrastructure failures in the hospital. Furthermore, hospitals are required to provide written notice to patients affected by serious events. Failure to comply with the patient safety requirements of the Mcare Act can result in administrative fines of $1,000 per day and could significantly affect the financial condition of the Obligated Group.

Regulatory Inquiries

The laws and regulations governing federal reimbursement programs and the laws governing the health care industry generally (such as the False Claims Act, the Civil Money Penalties Law, the AKS and the Stark Law) are complex and subject to varying interpretations, and the System and the Obligated Group are subject to contractual reviews and program audits in the normal course of business. Penalties for violations of federal regulations governing health care providers can be severe, including treble damages, fines, and suspension from federal reimbursement programs such as Medicare and Medicaid. Federal agencies have initiated nationwide investigations into several areas of concern, including, among others: (a) teaching hospitals, (b) home health care services, (c) investigational devices, (d) laboratory billing, (e) cardioverter defibrillators and (f) cost reporting. The System and the Obligated Group expect that the level of review and audit to which they and other health care providers are subject will increase. ACA includes additional funding and resources to increase enforcement actions.

In contrast to a government-imposed corporate compliance plan that may be instituted pursuant to the federal government's investigation of a health care provider, a voluntary corporate compliance plan is

instituted by a health care provider to put into place effective internal controls that promote adherence to various federal and state laws regulating the health care industry. The Office of Inspector General's *Compliance Program Guidance for Hospitals* was released in 1998 and supplemented in 2005. The OIG believes that the adoption and implementation of voluntary compliance programs by hospitals significantly advances the prevention of fraud, abuse and waste in federal, state and private health plans. In fact, the OIG may consider the existence of an effective compliance plan that was instituted before a governmental investigation when negotiating a settlement with a health care provider. The Obligated Group has compliance programs that are designed to detect and correct potential violations of laws and regulations applicable to its programs.

Regulatory authorities have discretion to assert claims for noncompliance with applicable requirements based upon their interpretation of those requirements. Because these complex program requirements are subject to varying interpretations and because, in some instances (e.g., the AKS and the Stark Law), there is little clear regulatory or judicial guidance, there can be no assurance that regulatory authorities will not challenge the Obligated Group's compliance with these requirements and assert claims or penalties, and it is not possible to determine the impact (if any) any such claims or penalties would have upon the Obligated Group.

Like other health care, educational and research institutions that have contracts with the federal government, the System, the Obligated Group and their affiliates may be subject from time to time to other regulatory inquiries, whistleblower complaints under the False Claims Act and other similar investigations. It is not possible to assess the merits of any such inquiries or investigations, complaints or inquiries at this point and, in any event, no assurances can be given as to what the impact of any such investigations, complaints or inquiries would have upon the operations or consolidated financial position of the System, the Obligated Group and their affiliates.

Licensing, Surveys and Accreditations

Health care facilities, including those of the Obligated Group, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. Those requirements include credentialing and survey requirements relating to Medicare and Medicaid participation and payment, state licensing agencies, private payor participation, The Joint Commission, the National Labor Relations Board and other federal, state and local government agencies. Renewal and continuance of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews. These activities are generally conducted in the normal course of business of health care facilities. Nevertheless, an adverse result could be the cause of loss or reduction in a facility's scope of licensure, certification or accreditation or reduce payments received.

Management of the System and the Obligated Group currently does not anticipate any difficulty in renewing or maintaining currently held licenses, certifications or accreditations that are material to its operations, and does not anticipate a reduction in third-party payments that would materially adversely affect the financial condition, operations, revenues and expenses of the Obligated Group due to licensing, certification or accreditation difficulties. Nevertheless, there can be no assurance that the requirements of present or future laws, regulations, certifications, and licenses will not materially and adversely affect the operations of the Obligated Group. Actions in any of these areas could occur and could result in a reduction in utilization or revenues or both, or the loss of the Obligated Group's ability to operate all or a portion of its health care facilities, and, consequently, could adversely affect the Obligated Group's financial condition, operations, revenues and expenses or its ability to make payments of principal, interest or any premium coming due on the 2017 Bonds.

Physician Contracting

The Obligated Group may contract with physician organizations (such as independent physician associations, and physician-hospital organizations) to arrange for the provision of physician and ancillary services. Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the physician organizations.

The success of the Obligated Group will be partially dependent upon its ability to attract physicians to join the physician organizations and to attract physician organizations to participate in their networks, and upon the ability of the physicians, including employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that the Obligated Group will be able to attract and retain the requisite number of physicians, or that such physicians will deliver high quality healthcare services. Without impaneling a sufficient number and type of providers, the Obligated Group 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 Obligated Group.

Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures

Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as the Obligated Group. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

Medical Professional Liability Insurance Market

Deteriorating underwriting results have generated substantial premium increases and coverage reductions in the medical professional liability insurance marketplace in recent years. A rise in claim severity nationwide, coupled with the lower investment returns available to insurers, have resulted in substantial reductions in medical professional liability insurance capacity. Several major medical professional liability insurance carriers have been forced into rehabilitation and/or liquidation, or have voluntarily withdrawn from this line of business. The insurance carriers who are still writing medical professional liability coverage are requiring substantial premium increases, reductions in the breadth of coverage afforded by the policy(ies), more stringently enforced policy terms, and increases in required deductibles or self-insured retentions. Health care entities that have self-funded programs are also experiencing similar difficulties with respect to fronting carriers, reinsurance on their captive insurance companies and/or with respect to insurance placements excess of the primary coverage layers. Furthermore, insurance carrier insolvencies are forcing health care providers to either repurchase insurance coverage from new carriers at substantially higher rates, or self-insure exposures for which they had previously purchased insurance.

The effect of these developments has been to increase the operating costs of health care providers, including those of the Obligated Group. In addition, the increase in the cost of professional liability

insurance may have the effect of causing established physicians to leave the most heavily affected geographical regions, including Pennsylvania, and of preventing new physicians from establishing their practices in the Obligated Group's service area. There can be no assurance that the unpredictability and increasing severity of jury awards and claims payouts, the reduction of coverage availability, and/or the rising cost of professional liability insurance coverage will not adversely affect the operations or financial condition of the Obligated Group.

The Pennsylvania General Assembly has enacted laws to address these issues, including the Mcare Act and the Fair Share Act. The Mcare Act brought reform to the area of professional liability and created the MCARE fund which, in exchange for premiums from physicians, serves as a source of recovery for claims in excess of the provider's base insurance limits. The Fair Share Act provides that, with some exceptions, a defendant will only be responsible to pay a portion of any judgment equal to the percentage of liability found against that defendant.

Labor Relations and Collective Bargaining

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

Competition

The Obligated Group faces, and will continue to face, competition from other hospitals and physicians that offer comparable health care services. Competition exists from alternative modes of health care delivery that offer lower priced services to the same population. Such alternative modes include ambulatory surgery centers, private laboratories and radiology services, skilled and specialized nursing facilities and home health care. Physicians increasingly offer outpatient ancillary services that compete with certain services offered by hospitals. Further, the Obligated Group competes for patient volume with an increasing number of for-profit hospitals. No assurance can be given that increasing competition and consolidation of providers in the service areas will not have a materially adverse effect on the financial condition and operations of the Obligated Group.

Tax Exemption for Nonprofit Corporations

The tax-exempt status of nonprofit corporations and exclusion of income earned by them from taxation, has been the subject of review by various federal, state and local legislative, regulatory and judicial bodies. This review has included proposals to broaden and strengthen existing federal tax law with respect to unrelated business income of nonprofit corporations. Some have posited that, with the onset of employer-sponsored health insurance and government reimbursement programs, there is no longer any justification for special tax treatment for the not-for-profit health care sector, and the availability of tax-exempt status should be eliminated.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of nonprofit corporations, since such actions and proposals as have been made have been vigorously challenged and contested. There can be no assurance however that future changes in the federal, state and local laws and regulations will not materially and adversely affect the operations and

revenues of the Obligated Group by requiring the Obligated Group to pay additional income or real estate taxes.

The ACA added Section 501(r) to the Code, which contains four specific requirements for hospitals that wish to receive or maintain their tax-exempt status under Section 501(c)(3) of the Code. In addition to the general requirements of Section 501(c)(3) of the Code that hospitals must satisfy in order to safeguard tax-exempt status under Section 501(c)(3), hospitals also must: (i) conduct a "community health needs assessment" at least once every three years and adopt an "implementation strategy" to meet the needs identified by the assessment; (ii) establish, implement, and make widely available written policies regarding emergency medical care and financial assistance; (iii) limit the amount the hospital charges for emergency or other medically necessary care provided to patients eligible for financial assistance to not more than the amounts generally billed to insured patients; and (iv) not take extraordinary collection actions (e.g., lawsuits, liens, or other similar actions) until it has made reasonable efforts to determine whether a patient is eligible for financial assistance.

The ACA also adds new Sections 4959 and 6033(b)(15) to the Code. New Section 4959 imposes a $50,000 excise tax for any taxable year in which a tax-exempt hospital fails to meet the needs assessment requirement of new Section 501(r). New Section 6033(b)(15) imposes new reporting requirements on a tax-exempt hospital. Now a hospital will have to provide a description of how the organization is addressing the needs identified in the community health needs assessment and a description of any such needs that are not being addressed, together with the reasons why such needs are not being addressed. Hospitals will have to provide this report and their audited financial statements as attachments to the IRS Form 990. The ACA requires a hospital to conduct a community needs assessment every three years in order to maintain its tax-exempt status.

Other legislative changes or judicial actions with respect to the tax-exempt status of nonprofit corporations, including the provision of free care to indigents and the exemption from property taxes of such corporations, could be enacted. There can be no assurance that future changes in federal, state or local laws, rules, regulations and policies governing tax-exempt entities will not have adverse effects on the future operations of the Obligated Group.

Recently, the Internal Revenue Service ("*IRS*") has devoted additional resources to the auditing of federally tax-exempt organizations, including tax-exempt health care organizations. The IRS intends to focus on, among other matters, the unrelated business income producing activities of health care organizations. The IRS has significantly revised Form 990, Return of Organization Exempt from Income Tax, which greatly increases the disclosure requirement of tax exempt hospitals. The expanded information gathered by the IRS will allow the IRS to more closely monitor the activities of tax-exempt organizations. In addition, this information will be made available to Congress to form the basis for possible future legislation in this area. The Obligated Group members are exempt from federal income taxes under Section 501(c)(3) of the Code.

The IRS has not frequently revoked the 501(c)(3) status of nonprofit health care corporations, but it could do so in the future. Loss of tax-exempt status by the Obligated Group members could result in loss of tax exemption of the interest on the 2017 Bonds and of any other tax-exempt bond-related debt of the System, and defaults in other tax-exempt debt would likely be triggered. Loss of tax-exempt status by the Obligated Group members could also result in substantial tax liabilities on taxable income that would likely have material adverse consequences on their financial condition.

Additionally, organizations described in Section 501(c)(3) of the Code ("*Tax-Exempt Organizations*") may be subject to "intermediate sanctions" if they engage in transactions that result in private inurement. Intermediate sanctions rules permit the IRS to impose a penalty tax on (i) "disqualified

persons," such as officers, directors, trustees and other key employees who receive "excess benefits," such as excessive compensation, from Tax-Exempt Organizations; and (ii) managers of Tax-Exempt Organizations who knowingly participate in transactions that result in the payment of excess benefits to insiders. A penalty tax is imposed on the insiders or managers personally and not on the Tax-Exempt Organization. Management of the Obligated Group is not aware of any transactions that would subject the Obligated Group to intermediate sanctions, but there can be no guarantee that any members of the Obligated Group will not be found to have engaged in such transactions in the future, which could subject the Obligated Group members to intermediate sanctions and reduced revenue.

Legislation Affecting Tax Exempt Status of Interest on the Bonds

Proposals for various amendments to the Code have been considered in connection with federal tax reform. No assurance can be given that amendments to the Code or other federal legislation will not be introduced and/or enacted which would cause the interest on the 2017 Bonds to be subject, directly or indirectly, to federal income taxation or adversely affect the market price of the 2017 Bonds or otherwise prevent the holders of the 2017 Bonds from realizing the full current benefit of the federal tax status of the interest thereon.

Local Tax Assessments

In recent years, a number of local taxing authorities in the Commonwealth have sought to subject the facilities of non-profit hospitals and other traditionally exempt organizations to local real estate and business privilege taxes, primarily by challenging their status as “institutions of purely public charity” as described in the Pennsylvania Constitution, notwithstanding the fact that Pennsylvania nonprofit hospital facilities historically have been viewed as exempt from such taxes. The Pennsylvania constitutional test is very subjective and frequently difficult to satisfy. Pennsylvania court decisions have been highly fact-specific and do not provide clear overall guidance on the question. In addition, the Pennsylvania law sets forth additional standards that must be satisfied for tax exemption. Therefore, there is no assurance that under current Pennsylvania law that the members of the Obligated Group will be exempt from real estate and other local taxes. If the tax exemption of the members of the Obligated Group is challenged, notwithstanding that the Obligated Group believes that it properly is exempt from real estate tax and other local taxes, to achieve certainty about its potential tax liability, the members of the Obligated Group might consider entering into a payment in lieu of taxes agreement and agreeing to make some payments to the taxing authorities.

Other Legislative and Regulatory Actions

The Obligated Group members are subject to regulation, certification and accreditation by various federal, state and local government agencies and by certain nongovernmental agencies such as The Joint Commission and the American Medical Association. No assurance can be given as to the effect on future hospital operations of existing laws, regulations and standards for certification or accreditation or of any future changes in such laws, regulations and standards.

Legislative proposals which could have an adverse effect on the Obligated Group include: (a) any change in the taxation of not for profit corporations or in the scope of their exemption from income or property taxes; (b) limitations on the amount or availability of tax-exempt financing for charitable organizations described in Section 501(c)(3) of the Code; (c) possible non-access to tax-exempt debt by hospitals described in Section 501(c)(3) of the Code; (d) regulatory limitations affecting the ability of the System and the Obligated Group to undertake capital projects or develop new services; and (e) a requirement that nonprofit health care institutions pay real estate property tax and sales tax on the same basis as for-profit entities.

Antitrust

The Obligated Group and its affiliates, like other providers of health care services, are subject to antitrust laws. Those laws generally prohibit agreements that restrain trade and prohibit the acquisition or maintenance of a monopoly through anticompetitive practices. The legality of particular conduct under the antitrust laws generally depends on the specific facts and circumstances and, in some circumstances, cannot be predicted in advance. Antitrust actions against health care providers have become increasingly common in recent years. Antitrust liability can arise in a number of different contexts, including medical staff privilege disputes, third-party payor contracting, joint ventures and affiliations between health care providers, and mergers and acquisitions by health care providers. Actions can be brought by federal and state enforcement agencies seeking criminal and civil penalties and, in some instances, by private plaintiffs seeking damages for harm from allegedly anticompetitive behavior.

Judicial decisions have permitted physicians who are subject to disciplinary or other adverse actions by a hospital at which they practice, including denial or revocation of medical staff privileges, to seek treble damages from the hospital under the federal antitrust laws. The Federal Health Care Quality Improvement Act of 1986 provides immunity from liability for discipline of physicians by hospitals under certain circumstances, but courts have differed over the nature and scope of this immunity. In addition, hospitals occasionally indemnify medical staff members who incur costs as defendants in lawsuits involving medical staff privilege decisions. Recent court decisions have also permitted recovery by competitors claiming harm from a hospital's use of its market power to obtain unfair competitive advantage in expanding into ancillary health care businesses. Antitrust liability in any of these contexts can be substantial, depending upon the facts and circumstances involved.

In 1993, the United States Department of Justice and the Federal Trade Commission issued "Statements of Antitrust Enforcement Policy in the Health Care Area." The statements, which have been revised from time to time, generally describe certain analytical principles which the agencies will apply to certain factual situations and also establish certain "antitrust safety zones." Conduct within the safety zones will not be challenged by the agencies, absent extraordinary circumstances. Many activities frequently engaged in by health care providers fall outside of the zones but are not challenged, and failure to fall within a safety zone does not mean that a participant will be investigated or prosecuted, or even that the activity violated the antitrust laws. There can be no assurances that enforcement authorities or private parties will not assert that a Member of the Obligated Group, or any transaction in which such Member is involved, is in violation of the antitrust laws.

Cyber Attacks

The Obligated Group relies on IT systems, including electronic health records, to process, transmit and store sensitive and confidential data, including the PHI and personally identifiable information of its patients and employees, and proprietary and confidential business performance data. Although the Obligated Group routinely monitors and tests its security systems and processes and implements appropriate security measures designed to protect confidential information, IT systems are often subject to computer viruses, cyber-attacks by hackers, or breaches due to employee error or malfeasance. Cyber-attacks have been occurring more frequently and have specifically targeted health systems. Any breach or cyber-attack that comprises patient data could result in negative press and substantial fines or penalties for violation of HIPAA or similar state privacy laws that may harm the Obligated Group's business or financial condition. Although management of the Obligated Group is not currently aware of having experienced a material breach of its IT systems, the Obligated Group's IT security measures may not be sufficient to prevent cyber-attacks in the future. Additionally, as cybersecurity threats continue to evolve, the Obligated Group may not be able to anticipate certain attack methods in order to implement effective protective measures, and may be required to expend significant

additional resources to continue to modify and strengthen security measures, investigate and remediate any vulnerabilities, or invest in new technology designed to mitigate security risks. The Obligated Group's IT systems routinely interface with and rely on third party systems who are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting a third party service provider could harm the Obligated Group's business or financial condition. Although the Obligated Group has insurance against some cyber risks and attacks, it may not be sufficient to offset the impact of a material loss event.

Construction Risks

From time to time, members of the Obligated Group undertake significant construction projects. There are certain risks inherent in any major construction project that could affect the timing and completion and the overall cost of such projects, including delays in the issuance of required building and occupancy permits, strikes, shortages of materials and adverse weather conditions. Such events could result in delaying occupancy of such projects and thus the revenue flow therefrom.

General Commercial and Economic Factors

General. The recent domestic and international economic downturn has had, and may continue to have, negative impacts upon the national and global economies, including a tightening of credit, decreased confidence in the financial sector, volatility in the financial markets, increase in interest rates, reduced business activity, increased business failures and increased consumer and business bankruptcies. The ongoing repercussions of the economic downturn may adversely affect the Obligated Groups expenses and, consequently, its ability pay debt service on its debt.

The current conditions in credit markets may cause the System's and the Obligated Group's ability to borrow to fund capital expenditures to be more limited and more expensive. The credit market situation has also caused a number of financial institutions to restrict lending, including extending the term of liquidity and credit facilities. No assurance can be given that any of the financial institutions currently providing liquidity facilities or credit facilities for Obligated Group debt will renew or extend those facilities or that the Obligated will be able to obtain alternate liquidity for certain of its variable rate bonds on comparable terms.

Market Value of Investments. Earnings on investments have historically provided the Obligated Group an important source of cash flow and capital appreciation to support their programs and services, to finance capital expenditure investments and to build cash reserves. Historically the value of both debt and equity securities has fluctuated and, in some instances, the fluctuations have been quite significant. Diversification of securities holdings may diminish the impact of these fluctuations. However, no assurances can be given that the market value of the investments of the Obligated Group will grow, or even remain at current levels and there is no assurance that such market value will not decline.

Pension Funding Impact. Changes in market interest rates and debt and equity market fluctuations also potentially could have an impact on the System's and the Obligated Group's pension fund liabilities and its requirements for funding its related pension expenses. Like any other entity with pension fund liabilities, the Members of the Obligated Group find that increases or decreases in interest rates have an impact on the assumed earnings rates on pension assets needed to match pension fund liabilities, which accordingly affects the levels of actuarial pension investment assets required to meet future pension obligations. Consequently, any substantial and sustained decline in long-term interest rates could have the effect of increasing the Obligated Groups current pension funding requirements. In addition, the Pension Protection Act of 2006 (the "*PPA*") has accelerated the minimum funding

requirements for many defined benefit pension plans. This change, together with new rules for measuring pension plan assets and liabilities, including new actuarial assumptions and asset valuation rules included in the PPA, has generally increased employers' required minimum funding contributions to pension plans. No assurance can be given that the System or the Obligated Group will not be required to make increased pension funding payments in these or other circumstances.

Interest Rate Swap Agreements. The Obligated Group has entered into certain interest rate swap agreements to hedge interest rate risk. Changes in the market value of such agreements could negatively or positively impact the Obligated Group's operating results and financial condition, and such impact could be material. Any such agreement may be subject to early termination upon the occurrence of certain specified events. If either the Obligated Group or the counterparty were to terminate such an agreement when the agreement had a negative value to the Obligated Group, the Obligated Group could be obligated to make a termination payment to the counterparty in the amount of such negative value, and such payment could be substantial. For a further discussion of the interest rate swap agreements the Obligated Group has entered into, see Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP."

Additional Debt

The Master Indenture permits the Obligated Group to incur Additional Indebtedness which may be equally and ratably secured with the 2017 Master Note and the other outstanding Master Indenture Obligations. Any such Additional Indebtedness would be entitled to share ratably with the holders of the 2017 Master Note in any moneys realized from the exercise of remedies in the event of a default by the Obligated Group and in the proceeds of certain insurance and condemnation awards. There is no assurance that, despite compliance with the conditions upon which Additional Indebtedness may be incurred at the time such debt is created, the ability of the Obligated Group to make the necessary payments to repay the 2017 Master Note will not be materially, adversely affected upon the incurrence of Additional Indebtedness.

Supplements to the Master Indenture entered into in connection with the issuance of additional Master Indenture Obligations may contain additional covenants for the benefit of the Holders of such additional Master Indenture Obligations, including financial covenants that are more restrictive than the covenants otherwise contained in the Master Indenture. In the case of an Event of Default related to failure to comply with such covenants, the Holders of such Master Indenture Obligations, to the extent permitted under the terms of the Supplemental Master Indenture pursuant to which such Master Indenture Obligation is issued, could direct an acceleration of all Master Indenture Obligations, including the 2017 Master Note. See Appendix D – "SUMMARY OF THE MASTER INDENTURE."

Fraudulent Conveyances and Preferences

The financial statements of the Members of the Obligated Group 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 issuance of additional indebtedness) are met, notwithstanding uncertainties as to the enforceability under certain circumstances of the joint and several liability of all Members of the Obligated Group for each Obligation, including the 2017 Master Note, issued under the Master Indenture. The obligations described herein of the Members of the Obligated Group with respect to the 2017 Bonds and the Master Indenture are, in the opinion of counsel to the Members of the Obligated Group, enforceable under the laws of Pennsylvania, subject to the qualifications that the enforcement thereof may be limited by laws relating to bankruptcy, insolvency, reorganization, moratorium, fraudulent conveyances or other similar laws or equitable principles relating to or affecting debtors' obligations or creditors' rights generally.

The current Members of the Obligated Group and any future Member of the Obligated Group will be jointly and severally liable for all Obligations issued pursuant to the Master Indenture. As indicated above, the enforcement of such liability may be limited to the extent that any payment or transfer by a Member of the Obligated Group would render it insolvent or would conflict with, not be permitted by or be subject to recovery for the benefit of other creditors of such member under applicable laws or would be prohibited by or would render any Obligation or portion thereof void or voidable under applicable usury or similar laws. There is no clear precedent in the law as to whether such payments by a Member of the Obligated Group in order to pay debt service on an Obligation may be voided by third-party creditors in an action brought pursuant to the Pennsylvania Fraudulent Transfer Act. Under the Pennsylvania Fraudulent Transfer Act, a creditor of a related guarantor may avoid any obligation incurred by a related guarantor if, among other bases therefor, (a) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty or grossly inadequate consideration is received for the guaranty, and the guarantor is insolvent, as defined in the Pennsylvania Fraudulent Transfer Act, or (b) the guaranty renders the guarantor undercapitalized.

Judicial application of the tests of "insolvency," "reasonably equivalent value," "fair consideration," "valuable consideration" and "grossly inadequate consideration" has resulted in a conflicting body of case law. It is possible that a court may determine that a Member of the Obligated Group has no liability to satisfy an Obligation issued by another Member of the Obligated Group in the event it is determined that the Member of the Obligated Group from whom payment is sought did not receive sufficient consideration for such undertaking and that the incurrence of such liability has rendered or will render such Member of the Obligated Group insolvent.

In addition, a court could determine, in the event of the bankruptcy of a Member of the Obligated Group, that payments made under the Master Indenture or with respect to the 2017 Bonds by the bankrupt member or the other Members of the Obligated Group could constitute preferential payments to or for the benefit of an insider, within the meaning of Section 547(b) of the Federal Bankruptcy Code, which payments, if made during the one year period prior to the date of the filing of the petition in bankruptcy with respect to the bankrupt Member of the Obligated Group, could be recovered by the trustee in bankruptcy from the holders of the 2017 Bonds.

Limitations on Security Interests in the Members of the Obligated Group's Revenues

The effectiveness of the security interest in the Gross Revenues of the Obligated Group created by the Master Indenture may be limited by a number of factors, including: (1) provisions of the Social Security Act that may limit the ability of the Master Trustee to enforce directly the security interest in any of the Gross Revenues in the form of reimbursement due under the Medicaid programs and any other statutory or contractual provisions, grant award conditions, regulations or judicial decisions which may have a comparable effect with respect to any of the Gross Revenues in the form of governmental appropriations, or governmental or private research services; (2) commingling of some or all of the Gross Revenues and other moneys of the Members of the Obligated Group not so pledged; (3) present and future statutory liens; (4) rights arising in favor of the United States of America or any agency thereof; (5) rights of third parties in revenues not yet expended; (6) constructive trusts, equitable or other rights impressed or conferred by federal or state courts in the exercise of equitable jurisdiction; (7) the factors described above under "Fraudulent Conveyances and Preferences"; and (8) rights of third parties in Gross Revenues not in possession of the Master Trustee.

Other Factors

The following, among others, may adversely affect future operations of health care, educational and research institutions, including the Obligated Group and the System, to an extent that cannot be determined at this time:

- Imposition of wage or price controls on the health care industry by state or federal government.
- Adoption of a national healthcare program.
- Repeal or modification of federal health care reform legislation.
- Potential depletion of the Medicare trust fund.
- Continued availability of governmental and private funding for medical research activities conducted by the Obligated Group or its affiliates.
- Increased medical malpractice claims (affecting the Obligated Group or in general) which affect the cost and availability of professional liability insurance, and sufficiency of self-insurance reserves.
- Employee strikes and other adverse labor actions that could result in a substantial reduction in revenues without corresponding decreases in costs.
- Reduced need for hospitalization or other medical services arising from future medical and scientific advances.
- Increased unemployment or other adverse economic conditions which would increase the proportion of patients who are unable to pay fully for the cost of their care.
- Cost and availability of energy.
- Efforts by insurers and governmental agencies to limit the cost of hospital services and to reduce the utilization of health care facilities by such means as preventive medicine, improved occupational health and safety and outpatient care.
- Any inability to obtain any required governmental approvals for necessary capital expenditures.
- The occurrence of terrorist activities or natural disasters, including floods and earthquakes, may damage the facilities of the Obligated Group, interrupt utility service to the facilities, or otherwise impair the operation of the Obligated Group and the generation of revenues from the facilities.

LITIGATION

There is not now pending nor, to the knowledge of the Authority or the Obligated Group, threatened against the Authority or the Obligated Group, respectively, any litigation, administrative action, or proceeding seeking to restrain or enjoin the issuance, sale, execution or delivery of the 2017 Bonds or in any way, contesting the proceedings and the authority under which the 2017 Bonds have been

authorized and are to be issued, sold, executed, delivered or the validity of the 2017 Bonds. There is no litigation pending or, to its knowledge, threatened against the Authority which in any manner questions the right of the Authority to enter into the Bond Indenture or the Loan Agreement, or to issue or secure the 2017 Bonds in the manner provided in the Bond Indenture and the Act. See Appendix A – "TOWER HEALTH AND THE OBLIGATED GROUP" hereto for a discussion of certain legal matters affecting the Obligated Group.

CONTINUING DISCLOSURE

The Authority has determined that no financial or operating data concerning the Authority is material to an evaluation of the offering of the 2017 Bonds or to any decision to purchase, hold or sell the 2017 Bonds, and the Authority will not provide any such information. The Obligated Group has undertaken all responsibilities for any continuing disclosure to Bondholders as described below, and the Authority shall have no liability to the holders of the 2017 Bonds or any other person with respect to Rule 15c2-12(b)(5) (the "*Rule*") promulgated by the United States Securities and Exchange Commission (the "*SEC*") pursuant to the Securities and Exchange Act of 1934, as amended (the "*Exchange Act*").

The Obligated Group will covenant in a written agreement (the "*Continuing Disclosure Agreement*") for the benefit of holders and beneficial owners of the 2017 Bonds to provide to the Municipal Securities Rulemaking Board through its Electronic Municipal Market Access ("*EMMA*") system, certain financial information and operating data relating to the Obligated Group, including, but not limited to, the System's annual audited consolidated financial statements, by not later than 150 days following the end of the Obligated Group's Fiscal Year (which currently ends June 30) (the "*Annual Report*") and the Obligated Group's quarterly unaudited consolidated financial statements, by no later than 60 days following the end of each of the Obligated Group's fiscal quarters, and to provide notices of the occurrence of certain enumerated events. These covenants have been made in order to assist the Underwriters in complying with the Rule. Failure to comply with the Continuing Disclosure Agreement shall not constitute an Event of Default under the Bond Indenture or the Master Indenture but must be reported in accordance with the Rule. The proposed form of the Continuing Disclosure Agreement is attached hereto as Appendix F.

The Obligated Group believes it is in material compliance with its previous continuing disclosure undertakings pursuant to the Rule within the last five years.

APPROVAL OF LEGALITY

Legal matters incident to the issuance of the 2017 Bonds are subject to the approving opinion of Stevens & Lee, P.C., Reading, Pennsylvania, Bond Counsel. Certain legal matters were passed upon for the Authority by its counsel, Georgeadis Setley LLC, Wyomissing, Pennsylvania; for the System and the Obligated Group, by their counsel Stevens & Lee, P.C., Reading, Pennsylvania; and for the Underwriters by their counsel, Kutak Rock LLP, Washington, D.C., none of which firms is passing upon the legality of the 2017 Bonds.

TAX EXEMPTION AND OTHER TAX MATTERS

In the opinion of Stevens & Lee, P.C., Reading, Pennsylvania, Bond Counsel, based upon an analysis of existing laws, regulations, rulings and court decisions, and assuming, among other matters, the accuracy of certain representations and compliance with certain covenants, interest on the 2017 Bonds is not includable in gross income for federal income tax purposes under Section 103(a) of the Code. Bond Counsel is of the further opinion that interest on the 2017 Bonds is not a specific preference item for purposes of the federal individual or corporate alternative minimum taxes, although Bond Counsel

observes that such interest is included in adjusted current earnings when calculating federal corporate alternative minimum taxable income.

Bond Counsel, is also of the opinion that, under the laws of the Commonwealth, the 2017 Bonds and interest on the 2017 Bonds shall be free from taxation for State and local purposes within the Commonwealth, but this exemption does not extend to gift, estate, succession or inheritance taxes, or any other taxes not levied directly on the 2017 Bonds or the interest thereon. Under the laws of the Commonwealth, profits, gains, or income derived from the sale, exchange or other disposition of the 2017 Bonds are subject to State and local taxation within the Commonwealth.

The 2017 Bonds maturing on November 1, 2042 have been offered at a discount ("*original issue discount*") equal generally to the difference between public offering price and principal amount. For federal income tax purposes, original issue discount on a 2017 Bond accrues periodically over the term of the 2017 Bond as interest with the same tax exemption and alternative minimum tax status as regular interest. The accrual of original issue discount increases the holder's tax basis in the 2017 Bond for determining taxable gain or loss from sale or from redemption prior to maturity. Holders should consult their tax advisers for an explanation of the accrual rules.

The 2017 Bonds other than those maturing on November 1, 2042 have been offered at a premium ("*original issue premium*") over their principal amount. For federal income tax purposes, original issue premium is amortizable periodically over the term of a 2017 Bond through reductions in the holder's tax basis for the 2017 Bond for determining taxable gain or loss from sale or from redemption prior to maturity. Amortizable premium is accounted for as reducing the tax-exempt interest on the 2017 Bond rather than creating a deductible expense or loss. Holders should consult their tax advisers for an explanation of the amortization rules.

The Code imposes various restrictions, conditions and requirements relating to the exclusion from gross income for federal income tax purposes of interest on obligations such as the 2017 Bonds. The Authority and the Obligated Group have made certain representations and covenanted to comply with certain restrictions designed to insure that interest on the 2017 Bonds will not be included in federal gross income. Inaccuracy of these representations and failure to comply with these covenants may result in interest on the 2017 Bonds being included in gross income for federal income tax purposes, possibly from the date of original issuance of the 2017 Bonds. The opinion of Bond Counsel assumes the accuracy of these representations and compliance with these covenants. Bond Counsel has not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring), or any other matters coming to Bond Counsel's attention after the date of issuance of the 2017 Bonds may adversely affect the value of, or the tax status of interest on, the 2017 Bonds.

Bond Counsel has assumed that the proceeds of the 2017 Bonds will be expended as required by and described in the Loan Agreement, the Bond Indenture and the Nonarbitrage Certificate and Compliance Agreement and the other relevant documents, agreements, instruments and certificates executed and delivered in connection with the issuance of the 2017 Bonds (collectively, the "*Bond Documents*"). Bond Counsel has also assumed that each party to the Bond Documents will carry out all obligations imposed on such party by the Bond Documents in accordance with the terms thereof and that all representations and certifications contained in the Bond Documents are accurate, true and complete.

Certain requirements and procedures contained or referred to in the Bond Documents and other relevant documents may be changed and certain actions (including, without limitation, defeasance of the 2017 Bonds) may be taken or omitted under the circumstances and subject to the terms and conditions set forth in those documents. Bond Counsel expresses no opinion as to any 2017 Bond or the interest thereon

if any such change occurs or action is taken or omitted upon the advice or approval of bond counsel other than Stevens & Lee, P.C.

Although Bond Counsel is of the opinion that interest on the 2017 Bonds is not includable in gross income for federal income tax purposes and is exempt from certain state taxes as described above, the ownership or disposition of, or the accrual or receipt of interest on, the 2017 Bonds may otherwise affect a Beneficial Owner's federal or state tax liability. The nature and extent of these other tax consequences will depend upon the particular tax status of the Beneficial Owner or the Beneficial Owner's other items of income or deduction. Bond Counsel expresses no opinion regarding any such other tax consequences.

Proposals to alter or eliminate the exclusion of interest on tax-exempt bonds from gross income for some or all taxpayers have been made in the past and may be made again in the future. Proposals to change tax rates (and the resulting change in the value of tax-exempt bonds) have also been made. Future legislation, if enacted into law, or clarification of the Code may cause interest on the 2017 Bonds to be subject, directly or indirectly, to federal income taxation, or otherwise prevent Beneficial Owners from realizing the full current benefit of the tax status of such interest. The introduction or enactment of any such future legislation or clarification of the Code may also affect the market price for, or marketability of, the 2017 Bonds. PROSPECTIVE PURCHASERS OF THE 2017 BONDS SHOULD CONSULT THEIR OWN TAX ADVISERS REGARDING ANY PROPOSED FEDERAL TAX LEGISLATION.

The opinion of Bond Counsel is based on current legal authority, covers certain matters not directly addressed by such authorities, and represents Bond Counsel's judgment as to the proper treatment of the 2017 Bonds for federal income tax purposes. It is not binding on the IRS or the courts.

Bond Counsel's engagement with respect to the 2017 Bonds ends with the issuance of the 2017 Bonds.

UNDERWRITING

Pursuant to a Bond Purchase Agreement among the Authority, the Obligated Group, and Citigroup Global Markets Inc., as representative on behalf of itself and Barclays Capital, Inc. (collectively, the "*Underwriters*"), the Underwriters have agreed to purchase from the Authority, upon the satisfaction of certain conditions, all of the 2017 Bonds at a purchase price equal to the aggregate principal amount of the 2017 Bonds, plus net original issue premium of $56,150,682.75, less an underwriting discount of $2,619,625.00. In addition, the Obligated Group has agreed to pay for the out-of-pocket expenses of the Underwriters, including their legal counsel. Pursuant to the Bond Purchase Agreement, each Member of the Obligated Group has agreed to indemnify each of the Underwriters and the Authority against losses, claims, damages and liabilities to third parties arising out of any materially incorrect or incomplete statements of information contained in this Official Statement pertaining to the Obligated Group, their hospital facilities or certain other matters. The initial public offering prices set forth on the inside cover page of this Official Statement may be changed by the Underwriters, and the Underwriters may offer and sell the 2017 Bonds to certain dealers (including dealers depositing 2017 Bonds into investment trusts) and others at prices lower than the offering prices set forth on the inside cover page.

The Underwriters and their respective affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage activities. The Underwriters and their respective affiliates have, from time to time, performed, and may in the future

perform, various investment banking and consulting services for the Authority or the Obligated Group for which they received or will receive customary fees and expenses.

Affiliates of the Underwriters in the aggregate will receive more than 10% of the proceeds of the 2017 Bonds. Citibank, N.A., an affiliate of Citigroup Global Markets Inc., has extended a bridge loan to the System in the the principal amount of $491,018,052 which will be refinanced with proceeds of the 2017 Bonds.

In the ordinary course of their various business activities, the Underwriters and their respective affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities) and financial instruments (which may include bank loans and/or credit default swaps) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of the Authority or the Obligated Group.

RATINGS

S&P Global Ratings, a business of Standard & Poor's Financial Services, LLC ("*S&P*"), Moody's Investors Service ("*Moody's*") and Fitch Ratings, Inc. ("*Fitch*") have assigned the 2017 Bonds ratings of "A" (stable outlook), "A3" (negative outlook) and "A" (stable outlook), respectively. It is a condition of delivery of the 2017 Bonds that they carry an equivalent rating as of the date of delivery.

Such ratings reflect only the views of S&P, Moody's and Fitch, respectively, and any explanation of the significance of such ratings may only be obtained from the rating agency furnishing the same. The Obligated Group has furnished such rating agencies with certain information and materials relating to the Series 2017 Bonds and the Obligated Group that have not been included in this Official Statement. Generally, rating agencies base their ratings on the information and materials so furnished and on investigations, studies, and assumptions by the rating agencies. Such ratings are not a recommendation to buy, sell or hold the Series 2017 Bonds and may be subject to revision or withdrawal at any time. There is no assurance that a particular rating will be maintained for any given period of time or that it will not be lowered or withdrawn entirely if, in the judgment of the agency originally establishing the rating, circumstances so warrant. None of the Authority, the Underwriters or the Obligated Group has undertaken any responsibility to oppose any proposed revision or withdrawal of the ratings of the Series 2017 Bonds. Neither of the Authority nor the Underwriters has undertaken any responsibility to bring to the attention of the holders of the Series 2017 Bonds any such proposed revision or withdrawal. Any such revision or withdrawal of such ratings could have an adverse effect on the market price for and marketability of the Series 2017 Bonds.

INDEPENDENT ACCOUNTANTS

The consolidated financial statements and supplementary consolidating information as of June 30, 2017 and 2016 and for the years then ended, included in Appendix B hereto, have been audited by KPMG LLP, independent accountants, as stated in their report appearing in Appendix B.

FINANCIAL ADVISOR

Hammond Hanlon Camp LLC through its wholly-owned subsidiary, H2C Securities Inc. (the "Financial Advisor") which is a member of FINRA/SIPC and registered with the Municipal Securities Rulemaking Board and the Securities and Exchange Commission as an independent registered municipal advisor, has served as financial advisor to the System for the purpose of assisting with the structuring of the 2017 Bonds. The Financial Advisor is not obligated to undertake, and has not undertaken, an

independent verification of, nor does the Financial Advisor assume responsibility for the accuracy, completeness, or fairness of the information contained in this Official Statement. The Financial Advisor has not been engaged in the underwriting or distribution of the 2017 Bonds. The Financial Advisor's fees are payable contingent upon issuance of the 2017 Bonds.

VERIFICATION OF MATHEMATICAL COMPUTATIONS

The accuracy of the mathematical computations of the adequacy of the maturing principal amounts of and interest on the investments held in escrow to pay the principal of and interest and any redemption premium on the Refunded 2009A-3 Bonds when due and on the Redemption Date, will be verified solely as to mathematical accuracy by Causey Demgen & Moore P.C., certified public accountants.

CERTAIN RELATIONSHIPS

Stevens & Lee, P.C., serves as Bond Counsel and counsel to the Obligated Group in connection with the issuance of the 2017 Bonds, and from time to time, as counsel to the Obligated Group in matters unrelated to the issuance of the 2017 Bonds. One shareholder of Stevens & Lee, P.C., serves on the Boards of Directors of the System and Reading Hospital.

MISCELLANEOUS

The references herein to the Master Indenture, the Bond Indenture, and the Loan Agreement and the summary of the Bond Indenture and Loan Agreement provided in Appendix C – "SUMMARY OF THE BOND INDENTURE AND THE LOAN AGREEMENT" and the summary of the Master Indenture provided in Appendix D – "SUMMARY OF THE MASTER INDENTURE" attached hereto are brief outlines of certain provisions thereof. Such outlines do not purport to be complete, and for full and complete statements of such provisions, reference is made to such instruments, documents and other materials, copies of which, as executed and delivered, will be on file at the principal corporate trust office of the Bond Trustee. Copies may be obtained at the expense of the person requesting the same.

The appendices attached hereto are an integral part of this Official Statement and must be read together with all of the foregoing statements.

All information contained herein relating to the Obligated Group has been provided and approved by the Obligated Group for use within the Official Statement.

All estimates and other statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact. This Official Statement is not to be construed as a contract or agreement between any of the Authority, the Obligated Group and the purchasers or owners of any of the 2017 Bonds.

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The Authority has duly authorized the execution and delivery of, and the System, on behalf of the Obligated Group, has approved this Official Statement.

BERKS COUNTY INDUSTRIAL
DEVELOPMENT AUTHORITY

By: /s/ Ken W. Seidel
Chairman

Approved:

TOWER HEALTH

By: /s/ Clint Matthews
President and Chief Executive Officer

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APPENDIX A

TOWER HEALTH AND THE OBLIGATED GROUP

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TABLE OF CONTENTS

INTRODUCTION

History and Mission of Tower Health

Tower Health, formerly known as Reading Health System ("Tower Health" or the "System"), is a Pennsylvania nonprofit corporation that serves as the parent organization of Reading Hospital and five recently acquired acute care hospitals and related facilities that will form an integrated healthcare system located in the Counties of Berks, Chester and Montgomery, Pennsylvania and the City of Philadelphia, Pennsylvania. The primary corporate purpose of Tower Health is to support the charitable, educational and scientific purposes of the six acute care hospitals, Tower Health Medical Group and other affiliated entities described herein. Tower Health together with Reading Hospital, Brandywine Hospital, LLC, Chestnut Hill Hospital, LLC, Jennersville Hospital, LLC, Phoenixville Hospital, LLC and Pottstown Hospital, LLC comprise the Tower Obligated Group. See "CORPORATE ORGANIZATION – Tower Obligated Group" herein. Effective as of the acquisition of the five recently acquired acute care hospitals and related facilities, the Tower Health system is comprised of 1,458 licensed beds, with over 63,000 admissions, 277,000 emergency room visits, 5,100 newborn deliveries and 57,000 surgeries.

In 1868, medical and business leaders from the local community partnered to establish the first permanent hospital in Berks County. Then called "The Reading Dispensary," this facility grew in size and services as the community's health needs changed, evolving into the regional health provider now called Reading Hospital ("Reading Hospital" or "RH"). Reading Hospital is a nonprofit hospital providing a full continuum of acute and tertiary health care services at its main campus in West Reading, Pennsylvania and over 60 satellite locations throughout Berks County, Pennsylvania. Its mission is:

- to provide compassionate, accessible, high-quality, cost-effective health care to the community;
- to promote health;
- to educate healthcare professionals; and
- to participate in appropriate clinical research.

Reading Hospital is Pennsylvania's largest single hospital between Philadelphia and Pittsburgh. Reading Hospital had 714-licensed beds in fiscal year ended June 30, 2017. Reading Hospital's inpatient discharges account for approximately 65% of all hospital-reported discharges in its primary service area. During the year ended June 30, 2017, Reading Hospital treated approximately 133,559 individuals in the emergency department and had approximately 34,158 inpatient admissions (excluding nursery and neonatal).

In alignment with its strategic plan, on May 30, 2017, the System entered into an Asset Purchase Agreement with subsidiaries of Community Health Systems ("CHS") for the System to acquire five Pennsylvania hospitals (the "Acquired Hospitals") to be owned and operated by five newly created wholly owned subsidiaries of the System (the "New Hospital Entities"). The Acquired Hospitals include: Brandywine Hospital in Coatesville, Phoenixville Hospital in Phoenixville, Pottstown Memorial Medical Center in Pottstown, Jennersville Regional Hospital in West Grove, and Chestnut Hill Hospital in Philadelphia. The System completed the acquisition of the Acquired Hospitals together with related facilities on October 1, 2017. The System assumed no liabilities at closing other than approximately $27 million in capitalized leases and future obligations under assumed contracts. The System was rebranded effective October 1, 2017 to Tower Health. The Tower Health name preserves the enduring legacy of the iconic clock tower of the Reading Hospital as a symbol of strength and caring for the healthcare needs of

the Reading community and expands this mission to the new hospitals as part of a unifying commitment to high quality, high value care to each of the local communities.

A portion of the proceeds of the 2017 Bonds will be used to retire a bridge loan, the proceeds of which funded the acquisition cost of the Acquired Hospitals and the reimbursement of certain capital expenditures of the System related to the development and construction of the Reading HealthPlex as described below, which will provide the System with initial working capital.

Brandywine Hospital is an acute care hospital with 169 licensed beds located in Coatesville, Pennsylvania and has been serving the needs of the residents of Chester County, Pennsylvania since 1899.

Chestnut Hill Hospital is an acute care hospital with 148 licensed beds located in Philadelphia, Pennsylvania. Services include inpatient and outpatient services, including minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology and orthopedics among others. Chestnut Hill Hospital has offsite ambulatory locations including two Women's Centers, an off-site physical therapy center and several primary care physician practice locations.

Jennersville Regional Hospital is an acute care hospital with 63 licensed beds located in West Grove, Pennsylvania. Jennersville Regional Hospital is an all-private room facility which offers inpatient and outpatient, emergency, surgical and diagnostic care.

Phoenixville Hospital is an acute care hospital with 139 licensed beds located in Phoenixville, Pennsylvania with an award-winning cardiovascular program, a fully accredited cancer center and one of the area's largest Robotic Surgery Centers. Phoenixville Hospital has several strategically located ambulatory care sites, including three ambulatory surgery centers and several employed physician practice locations.

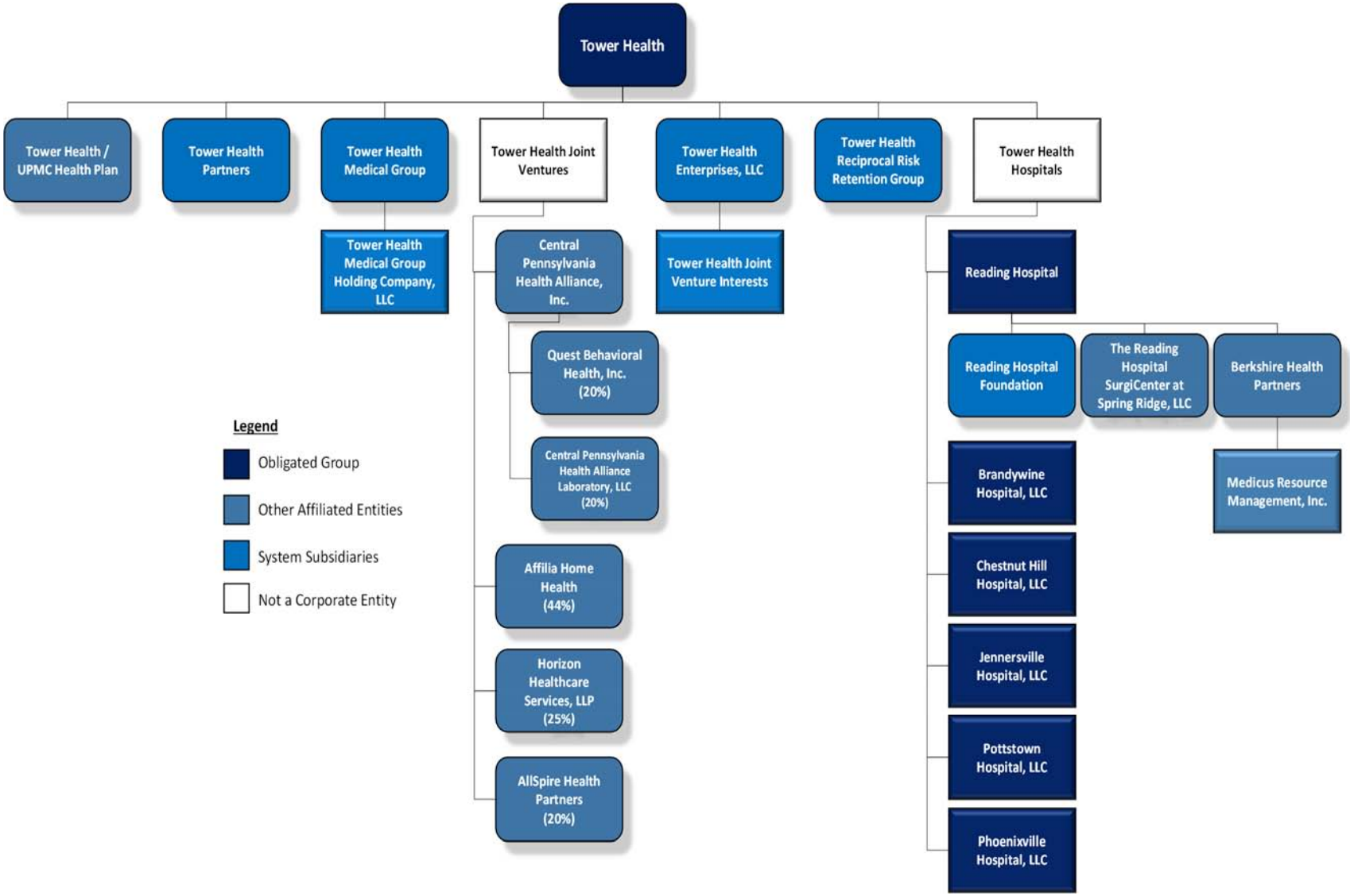
Pottstown Memorial Medical Center is an acute care hospital with 232 licensed beds located in Pottstown, Pennsylvania. Pottstown Memorial Medical Center offers a full range of inpatient and outpatient medical treatments, including among others, surgical, diagnostic, emergency care, cardiac care and a cancer center.

Prior to the acquisition of the Acquired Hospitals, Reading Hospital's primary service area was comprised of the Boroughs of West Reading and Wyomissing, Pennsylvania, the City of Reading, Pennsylvania and the surrounding communities in Berks County with a population of approximately 285,000. After the acquisition of the Acquired Hospitals, the Tower Health's primary service area will now include portions of the Counties of Berks, Montgomery and Chester as well as the northern western portions of the City of Philadelphia, with a total population of approximately 2.5 million. See "SERVICE AREA AND MARKET DATA" herein.

CORPORATE ORGANIZATION

As illustrated in the organizational chart on the following page, Tower Health, Reading Hospital and the New Hospital Entities, which together comprise the Tower Obligated Group, are affiliated with various controlled and non-controlled entities none of which are members of the Tower Obligated Group.

Tower Health Organizational Chart



Tower Obligated Group

The original Obligated Group created under the Master Indenture was comprised of Reading Health System, now known as Tower Health, a Pennsylvania nonprofit, non-member corporation, an organization described in Section 501(c)(3), and a public charity under Section 509(a)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and Reading Hospital, a Pennsylvania nonprofit membership corporation, an organization described in Section 501(c)(3) and a public charity under Section 509(a)(3) of the Code (collectively, the "Reading Health Obligated Group"). Pursuant to a Joinder Agreement dated September 29, 2017 (the "Joinder Agreement"), each of the New Hospital Entities described below have joined the Tower Obligated Group. Tower Health, Reading Hospital and each of the New Hospital Entities are the current members of the Obligated Group and are collectively referred to herein as the "Tower Obligated Group". Tower Health wholly owns and controls Reading Hospital and each of the New Hospital Entities.

Tower Health. The primary corporate purpose of Tower Health is to support the charitable, educational and scientific purposes of Reading Hospital, Tower Health Medical Group, the New Hospital Entities and other affiliated entities.

Reading Hospital. The main campus of Reading Hospital houses the Miller Regional Heart Center, The McGlinn Cancer Institute, a Level II Trauma Center, inpatient and outpatient surgical centers, a stroke center, a heart failure program, critical care units for newborns and adults, and acute and rehabilitation nursing units.

New Hospital Entities

Brandywine Hospital, LLC, is a tax-exempt single member limited liability company of which Tower Health is the sole member and which was organized to own and operate the newly acquired Brandywine Hospital.

Chestnut Hill Hospital, LLC, is a tax-exempt single member limited liability company of which Tower Health is the sole member and which was organized to own and operate the newly acquired Chestnut Hill Hospital.

Jennersville Hospital, LLC, is a tax-exempt single member limited liability company of which Tower Health is the sole member and which was organized to own and operate the newly acquired Jennersville Hospital (formerly known as Jennersville Regional Hospital).

Phoenixville Hospital, LLC, is a tax-exempt single member limited liability company of which Tower Health is the sole member and which was organized to own and operate the newly acquired Phoenixville Hospital.

Pottstown Hospital, LLC, is a tax-exempt single member limited liability company of which Tower Health is the sole member and which was organized to own and operate the newly acquired Pottstown Hospital (formerly known as Pottstown Memorial Medical Center).

THE AUDITED FINANCIAL STATEMENTS INCLUDED IN APPENDIX B TO THIS OFFICIAL STATEMENT CONTAIN THE CONSOLIDATED FINANCIAL STATEMENTS OF READING HEALTH SYSTEM (NOW KNOWN AS TOWER HEALTH) AND ITS SUBSIDIARIES PRIOR TO THE ACQUISITION OF THE ACQUIRED HOSPITALS. SUCH CONSOLIDATED FINANCIAL STATEMENTS INCLUDE SUBSIDIARIES THAT ARE NOT MEMBERS OF THE READING HEALTH OBLIGATED GROUP. THE READING HEALTH OBLIGATED GROUP ACCOUNTED FOR 88.6% AND 89.0% OF CONSOLIDATED REVENUES OF READING HEALTH

SYSTEM AND ITS SUBSIDIARIES FOR THE FISCAL YEARS ENDED JUNE 30, 2016 AND 2017, RESPECTIVELY, AND ACCOUNTED FOR 93.4% AND 93.0% OF THE CONSOLIDATED ASSETS OF READING HEALTH SYSTEM AND ITS SUBSIDIARIES REPORTED IN THE FINANCIAL STATEMENTS AT JUNE 30, 2017 AND 2016, RESPECTIVELY. ON A PRO FORMA BASIS ASSUMING THE ACQUISITION OF THE ACQUIRED HOSPITALS HAD OCCURRED ON JULY 1, 2015, THE TOWER OBLIGATED GROUP WOULD HAVE ACCOUNTED FOR 90.3%, AND 90.5% OF CONSOLIDATED REVENUES OF TOWER HEALTH AND ITS SUBSIDIARIES FOR THE YEARS ENDED JUNE 30, 2016 AND 2017, RESPECTIVELY. SEE "SUMMARY OF FINANCIAL INFORMATION - UNAUDITED PRO FORMA COMBINED STATEMENTS OF OPERATIONS" BELOW.

Affiliated Entities Outside the Tower Obligated Group

System Subsidiaries.

Tower Health Partners (THP), formerly known as Reading Health Partners, is a non-profit Pennsylvania single member limited liability company and a clinically-integrated organization, with over 680 participating physicians, that manages clinical integration for the physicians of Tower Health both employed and independent.

Tower Health Medical Group (THMG) (formerly Reading Health Physicians Network) is a Pennsylvania nonprofit corporation, an organization described in Section 501(c)(3) and a public charity under Section 509(a)(3) of the Code. In 2013, TRHMG and RPS began doing business as Reading Health Physician Network. Tower Health Medical Group employed 614 physician and advanced care practitioners as of June 30, 2017.

Tower Health Medical Group Holding Company, LLC, is a Pennsylvania limited liability company, which was formed to own 100% membership interests in fourteen physician practices acquired as part of the acquisition of the Acquired Hospitals. Those physician practices collectively employ approximately 125 physicians and include: Chestnut Hill Clinic Company, LLC, Coatesville Cardiology Clinic, LLC, Coatesville Clinic Company, LLC, Coventry Clinic Company, LLC, Jennersville Family Medicine, LLC, Phoenixville Clinic Company, LLC, Phoenixville Orthopedic Specialists, LLC, Phoenixville Specialty Clinics, LLC, Pottstown Clinic Company, LLC, Pottstown Professional Services, LLC, Schuylkill Internal Medicine Associates, LLC, Village Medical Center Associates, LLC, West Grove Clinic Company, LLC and West Grove Family Practice, LLC.

Tower Health Reciprocal Risk Retention Group, Inc. ("Tower RRG") was formed by Tower Health to insure all of its hospitals, employed physicians and other operations for healthcare professional liability ("PL") and general liability ("GL"). Tower RRG will permit Tower Health to provide Mcare-qualifying coverage for all its hospitals and individual providers. Tower RRG was formed as a reciprocal under South Carolina law, and each material insured entity within Tower Health will be a subscriber to the RRG. No entities other than Tower Health subsidiaries will be subscribers and no unaffiliated persons will participate in the RRG. Tower Health retains governance control. Senior officers of Tower Health will comprise the subscribers' advisory committee of the reciprocal RRG. The attorney-in-fact will be Tower Health.

Tower Health Enterprises, LLC, is a Pennsylvania limited liability company, which was formed to hold the interests in joint ventures acquired as part of the acquisition of the Acquired Hospitals, many of which are minority interests. These include: Boyertown Medical Services, L.P., Commonwealth Cyberknife, LLC, Pottstown Medical Specialists, Inc., SE PA Medical Imaging, Southern Chester County Medical Building I, Southern Chester County Medical Building II and USRC Montgomery Partners, LLC.

Reading Hospital Foundation, formerly known as Reading Health System Foundation ("Foundation"), is a Pennsylvania nonprofit corporation, an organization described in Section 501(c)(3) and a public charity as a Type I supporting organization under Section 509(a)(3) of the Code. The purpose of the Foundation is to raise funds that support the mission of Reading Health and its affiliates to benefit the health and well-being of the community through innovation, education and research. Tower Health has representatives on the Foundation's Board of Directors. The Foundation filed Articles of Incorporation with the Secretary of the Commonwealth of Pennsylvania on January 21, 2015.

Other Affiliated Entities. One or both of Tower Health and Reading Hospital are affiliated with the following non-controlled entities.

The Reading Hospital SurgiCenter at Spring Ridge, LLC, a Delaware limited liability company located in Wyomissing, Pennsylvania, provides ambulatory surgery services to the surrounding community. Reading Hospital is a 50% owner of The Reading Hospital SurgiCenter at Spring Ridge, LLC.

Central Pennsylvania Alliance Laboratories; Quest Behavioral Health, Inc. Tower Health, along with several other acute care service health systems throughout the central Pennsylvania area, is a member of the Central Pennsylvania Health Alliance. As such, Tower Health has contributed capital to and has become a 20% owner of Central Pennsylvania Alliance Laboratories, which is a joint venture to provide diagnostic laboratory services, and a 20% owner of QUEST Behavioral Health, which is a joint venture that provides mental health benefits to Tower Health and other health systems in the area.

Affilia Home Health (formerly Central Pennsylvania Homecare, Inc. or VNA Community Services), a Pennsylvania nonprofit corporation, an organization described in Section 501(c)(3) and a public charity under Section 509(a)(3) of the Code, is a home care company operating in a ten county area of Pennsylvania that provides visiting home nursing services to outpatients. Tower Health is a 44% owner of Affilia Home Health.

Horizon Healthcare Services, LLP ("Horizon"), a Pennsylvania for-profit limited liability partnership, is an in-home infusion and specialty pharmacy company located in Lancaster, Pennsylvania. Horizon, which serves patients throughout 30 counties in Pennsylvania, is wholly owned by four nonprofit acute care providers, including Tower Health, which holds a 25% partnership interest.

Allspire Health Partners, LLC ("Allspire") is a collaboration among five regional health systems to achieve best clinical practices and to increase purchasing power. There were originally seven members; however, Lancaster General Health left the collaboration after it merged with Penn Medicine, and Hackensack University Health Network and Meridian Health merged with each other. Tower Health holds a 20% share of Allspire. The other members of Allspire Health Partners include Atlantic Health System, Hackensack Meridian Health, Lehigh Valley Health Network and WellSpan Health.

Berkshire Health Partners ("BHP"), a Pennsylvania nonprofit corporation, and its wholly owned subsidiary, Medicus Resource Management, Inc. ("Medicus"), a Pennsylvania for-profit corporation, provide network access, population health management services, provider credentialing and enrollment, and assist in developing preferred provider relationships. While BHP is exempt from state income taxes, it is a taxable entity for federal tax purposes.

Tower Health-UPMC Joint Venture, LLC is a provider-payer joint venture that offers a full line of health coverage and related services to individuals as well as employers and their employees in Tower Health's service area. In January 2017, Tower Health-UPMC Joint Venture, LLC began providing

Third Party Administrator (TPA) and FSA Flexible Spending Account (FSA) administration services for Tower Health's employee benefits plan that services more than 11,000 individuals. The joint venture plans to provide a full spectrum of health insurance offerings, including Medicare Advantage, Administrative Services Only (ASO) for self-insured employers, Individual (Exchange), and Commercial Group, Special Needs Plans (SNP), Managed Medical Assistance, and Children's Health Insurance Program (CHIP).

Former System Subsidiary

The Highlands at Wyomissing ("The Highlands") is a Pennsylvania nonprofit corporation, an organization described in Section 501(c)(3) and a public charity under Section 509(a)(3) of the Code. The purpose of The Highlands is to develop, build, own and operate a continuing care retirement community, including residential, recreational and health care facilities and services specially designed to meet the physical, social and psychological needs of elderly persons and to support the purposes. On June 19, 2017, the System and The Highlands announced plans for The Highlands to operate independently of the System, pending regulatory approval. Settlement for the transaction was completed on September 29, 2017 on which date The Highlands paid the System $69,100,000 to obtain independent control. The Highlands accounted for 2.73% and 2.75% of consolidated revenues for the fiscal years ended June 30, 2017 and 2016, respectively.

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GOVERNANCE AND MANAGEMENT

Tower Health Board of Directors; Committees

Tower Health is served by a 14-member Board of Directors (the "Tower Health Board"). Tower Health's President and Chief Executive Officer is a voting member of the Tower Health Board for a period coterminous with that office. Candidates for election to the Tower Health Board are nominated by the Governance Committee in accordance with the Bylaws. Election of Directors is made by the Tower Health Board at the annual meeting acting upon recommendations from the Governance Committee.

Directors are elected for a term of three years beginning on July 1 and ending on June 30 and may serve no more than four consecutive three-year terms. A Director may not be re-elected after having served four consecutive three-year terms, or be elected otherwise to fill a vacancy on the Board, until the Director has had a break in service as a Director for a period of at least one year.

Pursuant to Tower Health's Bylaws, a 13-member Executive Committee of the Tower Health Board is vested with all the executive, administrative and supervisory powers of the Board. The Executive Committee also provides oversight to Tower Health's strategic planning. In addition, the Tower Health Board has the following other standing committees: Audit and Compliance, Community Benefit, Executive, Executive Compensation, Finance, Governance, Investment and Quality.

The current members of the Tower Health Board and their principal occupations are as shown below.

Name	Profession or Occupation	Company	Current Term Ends	Years of Service
Barbara Arner	Past President	Arner's Restaurants	2019	24
Charles Barbera, MD	Chief, Emergency Medicine	Reading Hospital	2019	2
John Casey, MD	Orthopedic Surgeon	Orthopaedic Associates of Reading	2019	4
Anne Flynn, MD	Retired Surgeon	Flynn & Hanley Surgical Specialties	2019	4
Thomas Flynn, Ph.D.	President	Alvernia University	2018	6
Christ Kraras	President	White Star Tours	2018	11
Clint Matthews	President	Reading Hospital		
Glenn Moyer	Retired	PA Dept. of Banking	2018	2
Meg Mueller	SVP	Fulton Financial	2018	2
Karen A. Rightmire	Executive Director	The Wyomissing Foundation	2019	6
Brent J. Wagner, MD(1)	President	West Reading Radiology Associates	2018	7
John P. Weidenhammer(2)	President	Weidenhammer Systems	2018	6
C. Thomas Work, Esq.	Partner	Stevens & Lee, P.C.	2020	11
Benjamin J. Zintak, III	President	Zeeco, Inc.	2018	6

(1) Mr. Wagner currently serves as the Chairman of the Board of Directors through June 30, 2018.
(2) Mr. Weidenhammer currently serves as the Vice Chairman of the Board of Directors through June 30, 2018.

Certain Relationships

C. Thomas Work, Esquire, a member of the Tower Health Board, is a shareholder of Stevens & Lee, P.C., Reading, Pennsylvania, which serves as Bond Counsel and counsel to the Tower Obligated Group in connection with the issuance of the Series 2017 Bonds.

Governing Bodies of Tower Obligated Group Members

Tower Health utilizes a centralized management structure with the Tower Health Board serving as the overall governing arm of each affiliated entity. This structure will also apply to the management of each of the members of the Tower Obligated Group. Reading Hospital, Brandywine Hospital, LLC, Chestnut Hill Hospital, LLC, Jennersville Hospital, LLC, Phoenixville Hospital, LLC and Pottstown Hospital, LLC each will utilize a regional Board of Trustees to provide insight on quality, safety and the healthcare needs of the communities in which they serve and benefit.

Conflict of Interest Policy

The Bylaws of each of Tower Health and Reading Hospital contain specific provisions governing conflicts of interest by any director, officer or committee member. Pursuant to the Bylaws, directors, officers and committee members have an affirmative duty to disclose in a timely fashion any relationship or interest, financial or otherwise, which they or any other corporation, partnership, association or other organization in which they have any interest, may have in any contract or transaction to which the System or Reading Hospital is, or is about to become, a party.

In addition, Tower Health and Reading Hospital have adopted a conflict of interest policy that governs certain transactions and contracts, including a proposal to discuss, negotiate or enter into a contract or transaction, in which their officers, directors and members of committees, including community members, may have a direct or indirect interest. Under the policy, a director, officer or member of a committee who has or might have a financial or other interest in a matter is required to disclose the details of that interest to the chair of the Board of Directors or committee that is addressing the matter. After disclosure of the conflict or potential conflict of interest and a determination that a conflict exists by the applicable Board of Directors or committee, the Board of Directors or committee is required to determine (a) whether Tower Health can address the matter more advantageously by means that avoid the conflict of interest and (b) if the matter cannot be addressed more advantageously by means that avoid the conflict of interest, or if other approaches to resolution are impractical under the circumstances, (i) whether the proposed transaction or contract is in Tower Health's best interests, (ii) whether it is fair and reasonable, and (iii) whether to enter into it. Violation of the conflict of interest policy may be grounds for removal.

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Management

The Tower Health Board is committed to ensuring the System's continuing prominence as a regional healthcare leader by recruiting and retaining an experienced senior management team. As charged by the Board, the executive team is focused on expanding clinical capabilities, bolstering its medical and administrative staff, and enhancing the quality of care and service to patients.

Clint Matthews, President and Chief Executive Officer. Clint Matthews, age 64, has served as Chief Executive Officer of Tower Health since January 1, 2012. With over forty years in healthcare, Mr. Matthews has served in executive leadership positions in both for-profit and nonprofit organizations. These include experiences as a managing director of FTI Healthcare, strategic assessment and tactical/operational improvement of FTI Healthcare clients nationwide, sometimes serving as the chief executive officer of various size systems in urban and suburban environments; CEO of for-profit facilities in Texas and Florida; President & CEO of MDPhysicians, Inc., a vertically and horizontally integrated health plan and physician organization; and other executive-level positions for regional health systems. Mr. Matthews has an undergraduate degree in nursing from the University of Texas and a master's degree in health care administration from Texas Woman's University.

Gary F. Conner, Executive Vice President and Chief Financial Officer. Gary F. Conner, age 63, has served as Chief Financial Officer of Tower Health since July 6, 2015. Prior to joining Tower Health, Mr. Conner served as Executive Vice President and Chief Financial Officer at Southcoast Health System in New Bedford, Massachusetts. He was also Chief Financial Officer at City of Hope Cancer Center, Duarte California, and his career included senior level positions at Catholic Healthcare West, Pasadena, California, and Hospital Corporation of America, San Diego, California. He holds a Master's Degree in Business Administration from Sonoma State University in Rhonert Park, California and a Bachelor of Arts in Business Management from California Lutheran University in Thousand Oaks, California.

Therese Sucher, Executive Vice President and Chief Operating Officer. Therese Sucher, age 64, has served as Chief Operating Officer of Tower Health since January 1, 2012. Ms. Sucher previously served as a managing director in the FTI Healthcare Group of the FTI Corporate Finance practice where she provided interim project management services to hospitals and health systems throughout the United States. Ms. Sucher's previous positions include senior manager and practice leader for the Process/Quality Consulting practice at Plante & Moran in Southfield, Michigan; manager in the Healthcare Business Consulting practice of Arthur Andersen in Chicago, Illinois; and vice president of operations at Kaiser Permanente in Cleveland, Ohio. Ms. Sucher received a master's degree in organizational development from Case Western Reserve University and a Bachelor of Science in Nursing from Ursuline College of Cleveland. Ms. Sucher is a licensed registered nurse in Ohio.

Gregory Sorensen, MD, Senior Vice President and Chief Medical Officer. Gregory Sorensen, MD, age 67, has served as Chief Medical Officer of Tower Health since November 2012. He previously served as Chief Medical Officer and VP of Medical Affairs at Bon Secours Health System; as Executive Director at Swedish Medical Center in Seattle, Washington; and as director of pediatric cardiac anesthesiology and critical care at Seattle Children's Hospital. Dr. Sorensen received his medical degree from the University of Nebraska, where he had previously earned a bachelor's degree in pharmacy. His postgraduate education included a pediatric residency at the University of Washington, a fellowship in pediatric cardiology at Vanderbilt University, and a fellowship in neonatal and respiratory diseases followed by a residency in anesthesiology. He is a diplomat of the American Board of Pediatrics and the American Board of Anesthesiology, and a member of the American College of Physician Executives.

Daniel Ahern, Executive Vice President of Business Development and Strategy. Daniel Ahern, age 57, has served as SVP of Business Development and Strategy of Tower Health since May 2014. He previously served at Mercy Health System in Conshohocken, Pennsylvania, as Senior Vice President, Strategy and Business Development. Mr. Ahern started his career at Fitzgerald Mercy, then moved to Albert Einstein Healthcare Network where he served in financial leadership roles throughout the system. He returned to Mercy Health System as Executive Director of the Physician Practice Plan, and moved to the role of Senior Vice President Strategy and Business Development. Mr. Ahern is a graduate of Villanova University with a Master of Business Administration and a Bachelor of Science in Business Administration/Finance.

Mary Agnew, Vice President and Chief Nursing Officer. Mary Agnew, RN, BSN, NEA-BC, age 62, has served as Chief Nursing Officer of Tower Health since September, 2012. She previously served as Chief Nursing Officer for the 506-bed Crouse Hospital in Syracuse since 2007, and also held the positions of Vice President of Patient Care Services for the 204-bed Cayuga Medical Center; Executive Director for the Alcohol and Drug Council of Tompkins County; and Director of Behavioral Services at Cayuga Medical Center, all based in Ithaca, New York. Ms. Agnew is a graduate of the Wharton School of Management for Nurse Executives at the University of Pennsylvania and Cornell University's Executive Development Program. She holds a master's degree in psychiatric/mental health nursing from Syracuse University, and received her BSN from the State University of New York at Buffalo.

Amit Powar, M.D., Chief Executive Officer, Tower Health Medical Group. Amit Powar, M.D., MHSA, age 43, has served as Chief Executive Officer of Tower Health Medical Group since November, 2015. Dr. Powar previously served as the Vice President of the Affiliated Network and Regional Operation for the North Shore-LIJ Health System in New York. Dr. Powar joined the North Shore-LIJ in June 2003 as an administrative fellow. He is trained as a Six Sigma Black Belt and has held numerous leadership roles within the System. Born and raised in Mumbai, India, Dr. Powar completed his Obstetrics and Gynecology residency from the University of Mumbai, India. He obtained his Master in Health Services Administration from The George Washington University in Washington, DC. He serves on the executive committee of the American Association of Physicians of Indian origin.

Other key leaders include:

Peter Savini, Senior Vice President, Revenue Cycle. Peter Savini, age 54, has served as VP of Revenue Cycle since September 2015. He previously served as Vice President, Revenue Cycle Management, at Catholic Health Services of Long Island in Rockville Centre, New York. There he was responsible for designing, developing and implementing the health systems revenue management function. He was also Vice President, Revenue Cycle Management and Director, Patient Financial Services at Catholic Health Initiatives, Denver, Colorado. His career also included positions at Crozier/Keystone Health System, Upland, Pennsylvania, and Germantown Hospital and Medical Center, Philadelphia, Pennsylvania. Mr. Savini holds a Master's Degree in Health Administration from Widener University and a Bachelor of Arts from Villanova University.

David Schlappy, Vice President and Chief Quality and Transformation Officer. David Schlappy, age 48, has served as VP of Quality since November 2014. He previously served as VP, Quality and Medical Staff Services for Silver Cross Health Care System in New Lenox, Illinois, and senior-level positions at Methodist LeBonheur Healthcare System in Tennessee and Cook Children's Health Care System in Fort Worth, Texas. Mr. Schlappy holds a Master of Science degree in biostatistics from The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, and a Bachelor of Science degree in statistics from Brigham Young University.

Darr Hall, Vice President of Financial Operations. Darr Hall, age 62, has served as Vice President of Financial Operations since November 1, 2015. Prior to this position, he served as a Director of Decision Support and Budget for the System from 2012 to 2015. Prior to 2012, Mr. Hall occupied CFO roles with Nanticoke Memorial Hospital in Delaware, Pikeville Methodist Hospital in Kentucky, HCA El Dorado Hospital in Arizona, HCA Davis Hospital in North Carolina, and South Fulton Medical Center in Georgia. Mr. Hall is a Certified Public Accountant and has an undergraduate degree from the University of Tennessee, Knoxville.

David LeKites, Senior Director, Treasury Services. David LeKites, age 54, has served as Senior Director, Treasury Services of Tower Health since February 2012. Mr. LeKites began his treasury career in banking, primarily in Delaware and London, UK with Beneficial National Bank USA, Fleet Bank, American Express, and Nat West Bank. Mr. LeKites transitioned to corporate treasury services with companies such as Rohm and Haas, Aventis, Exelon and Novell, Inc. Mr. LeKites has a Bachelor of Science degree in finance from the University of Delaware, in Newark, Delaware and has been a holder of the Charted Financial Analyst (CFA) designation since 2000.

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STRATEGIC PLANS AND CAPITAL SPENDING

Strategic planning is managed by Tower Health senior management and includes representatives from the Tower Health Board and physicians. Reading Hospital began formal strategic planning as far back as 2009. The 2009 strategic plan focused on improving core clinical services in the communities it serves as well as improving the operational infrastructure, clinical information systems and communications. The next strategic plan in 2012 focused on three goals: (a) identifying what was needed to make Reading Hospital a top 100 hospital in the United States; (b) improving the health status of the people it served; and (c) improving the financial strength of the organization. The plan developed new metrics for measuring progress and outlined strategic, tactical, and operational plans to achieve the above goals.

As a result of the 2012 strategic plan, Reading Hospital developed a clinically integrated infrastructure in concert with physicians in order to improve quality, manage the cost of health care, improve access and maximize outcomes. Specifically a decision was made to install the Epic System throughout all operating entities of the Reading Health System, which was completed in 2015. The Epic System project resulted in one electronic health record accessible anywhere within the Reading Health System by any appropriate care giver, facilitating provider order entry and documentation by physicians and other care givers. The Epic System was made available to non-employed members of the medical staff as well as employed. The installation of the Epic System enabled Reading Hospital to meet Meaningful Use criteria for the System and its employed physicians, and also allowed remote access to patient records by caregivers and patients. Reading Hospital invested approximately $150 million to purchase and implement the Epic System. The HIMSS (Healthcare Information and Management Systems Society) Analytics Electronic Medical Record Adoption Model incorporates methodology and algorithms to automatically score hospitals around the world relative to their Electronic Medical Records (EMR) capabilities. This eight-stage (0-7) model measures the adoption and utilization of EMR functions to support optimized patient care. Reading Hospital has achieved the highest level at stage 7.

Also included as a component of the 2012 strategic plan was the development and construction of major facility improvements including the construction of the *Reading HealthPlex for Advanced Surgical & Patient Care*. The System unveiled the Reading HealthPlex, a 476,000 square foot facility, in January, 2017. The Reading Healthplex is a new surgical and inpatient facility which integrates advanced technology, leading-edge facility design, and surroundings that promote healing, all designed to enhance the highly skilled, compassionate care System physicians and staff already provide. Reading HealthPlex took three years to construct and was the result of transformational strategic planning. Reading HealthPlex effectively combines Reading Hospital's many surgical services into one of the most sophisticated, progressive surgical centers in the region. Highlights of the facility include:

- 24 surgical suites, including six hybrid-capable operating rooms that enable surgeons to proceed from medical imaging to surgery in the same room,
- 150 private patient rooms,
- 16 emergency treatment rooms and three additional trauma bays, to enhance patient flow and expedite critical care in one of the country's busiest emergency departments, and
- An 88,000-square-foot green roof that provides patients and visitors with convenient access to natural space, the largest in Pennsylvania.

In August of 2016, the System engaged McKinsey & Company, a global management consulting firm, to partner with the System in a comprehensive strategic planning initiative. This initiative spanned a four month period in which the System and McKinsey:

- Assessed the healthcare market and the System's performance and positioning;
- Collected input from clinical and non-clinical employees, physicians, the community, the System's leadership and the Tower Health Board;
- Identified key success factors needed for the System to remain strong in the future under various potential scenarios;
- Developed a menu of strategic options to be considered;
- Conducted visioning sessions with the Tower Health Board, leadership and physicians to solidify and define the overarching vision for the System;
- Prioritized opportunities and decided which to pursue in the near future;
- Developed corresponding financial models and a Capital Plan; and
- Developed a 3-Year Roadmap to guide the System into the future.

The strategic planning process culminated in a strategic retreat with the Tower Health Board members and leadership. System Management and the Tower Health Board worked with McKinsey & Company to establish a higher growth rate by diversifying Reading Hospital's business over a wider geographic area and expanding service offerings. Management has pursued three major initiatives as a result of the 2016 strategic plan. The first two initiatives resulting from the strategic plan are the provider-payer partnership and growth investments in the targeted markets.

In November 2016, the System and UPMC Health Plan announced an agreement to form a provider-payer joint venture that offers a full line of health coverage and related services to individuals as well as employers and their employees in the defined nine county joint venture service area. The service area includes: Berks, Bucks, Carbon, Chester, Lancaster, Lehigh, Montgomery, Northampton and Schuylkill counties. The Tower Health-UPMC Health Plan enterprise combines access to the System's high-quality clinical care, expert providers, and advanced healthcare facilities with UPMC Health Plan's experience, expertise and advanced analytics to improve the health of the community. In January 2017, the Tower Health-UPMC Health Plan began providing Third Party Administrator (TPA) and FSA Flexible Spending Account (FSA) administration services for the System's employee benefits plan that services more than 11,000 individuals. Throughout 2017, the new partnership has been strategically introducing a full spectrum of health insurance that includes Medicare Advantage, Administrative Services Only (ASO) for self-insured employers, Individual (Exchange), and Commercial Group, Special Needs Plans (SNP), Managed Medical Assistance and Children's Health Insurance Program (CHIP).

Also, the System identified a variety of growth opportunities for FY 2018 through FY 2022 that are unrelated to the acquisition of the Acquired Hospitals. Although preliminarily, approximately $151 million was targeted for these investments, with the acquisition of the Acquired Hospitals, the amount, nature and timing of future growth investments need to be reviewed. The strategic growth opportunities will be rigorously analyzed with feasibility analyses and business plans.

Tower Health's strategic plan has charted a pathway for future aligned growth in key service lines and continuum services, in new geographic markets such as the Southeast Pennsylvania service area and in expanded ambulatory services to care for communities and effectively position Tower Health in the regional market. Tower Health management has established a Capital Allocation Committee that has set up an approval and budgeting process for allocating capital. Management will update its Integrated Strategic Financial Plan (ISFB) to inform the budgeting process for FY 2018. The Capital Allocation

Committee will analyze each project with a view toward allocating capital to those projects that generate a financial "return" that is higher than the cost to create the return and aligns with the strategic plan.

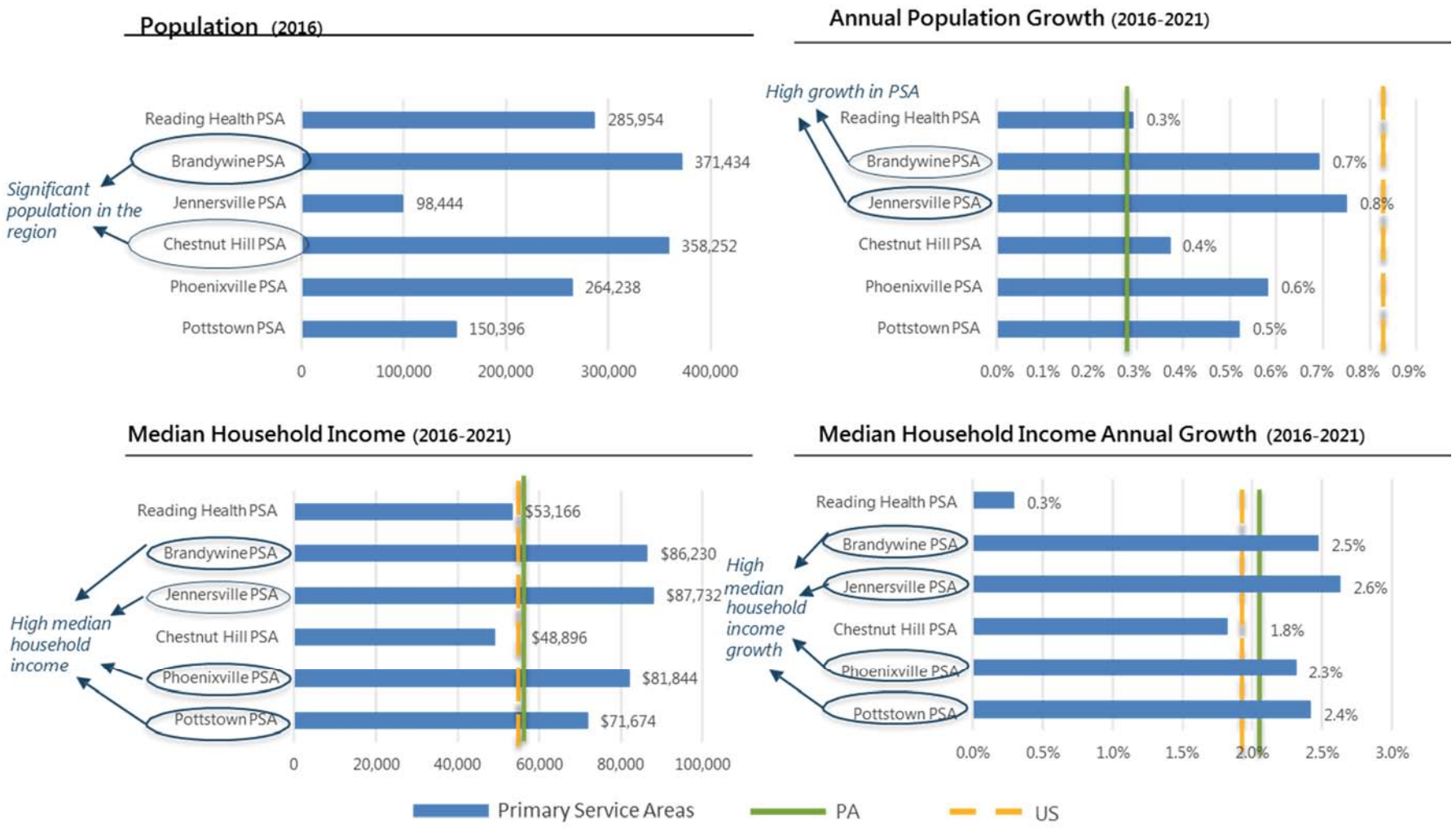
The third major initiative resulting from the 2016 strategic plan was the acquisition of the Acquired Hospitals. The recent acquisition of the Acquired Hospitals enables Tower Health to accelerate its growth plans in targeted markets and develop a more substantial footprint more quickly than other options being considered and enables Tower Health to support the provider-payer partnership described above. The strategic benefits of the addition of the Acquired Hospitals align with identified growth options in the demographically favorable Southeastern Pennsylvania service area, provides additional access points and an expanded high quality provider and physician network for the joint venture health plan, positions Tower Health at a regional scale consistent with other large regional health systems and expands the integrated clinical continuum of high quality, high value services to a broader geography serving 2.5 million people. Furthermore, the System has entered into a nonbinding letter of intent to acquire a 200+ bed hospital in a strategic market. The hospital generates approximately $200 million of annual revenue. The System is conducting due diligence and expects to make a decision by mid-November whether a transaction will be pursued.

Management has launched a Transition and Integration Management ("TIM") structure designed to facilitate the transition, assimilation, and integration of the Acquired Hopsitals while ensuring focus remains on driving strong operating performance at the local level. In addition, Tower Health has retained FTI Consultants to work with the TIM to ensure transition and integration processes, timelines, and goals are achieved. TIM includes members of senior management and department heads, as well as FTI, and is chaired by the President and CEO of Tower Health. TIM supervises integration teams related to legal and regulatory transition, support services, clinical services, quality, physician enterprise and medical staff administration, human resources, finance, revenue cycle, supply chain, central billing office, IT, population health, and culture.

In April of 2017, the System entered into a joint venture partnership with a national for-profit behavioral health organization to develop an inpatient behavioral health facility in the Tower Health area. Tower Health will contribute the current Reading Hospital Behavioral Health operations to the joint venture and the for-profit partner will contribute development capital. Both parties will participate equally in governance of the joint venture. Tower Health will own a 33% equity share of the new entity. The new facility is scheduled to be operational during the first quarter of calendar year 2019.

The graphics on the following page highlight the projected demographics of the population served by the New Hospital Entities.

Demographics of population served by New Hospital Entities



Source: Esri demographic data

SERVICE AREA AND MARKET DATA

Primary and Secondary Service Areas

Tower Health's primary service area ("PSA") is comprised of the communities served by Reading Hospital and the Acquired Hospitals described below. As shown on the following chart, assuming that the acquisition of the Acquired Hospitals occurred as of July 1, 2013, Tower Health would have the leading market share in the PSA for each of the fiscal years ended June 30, 2014, 2015 and 2016 based upon total inpatient discharges.

Inpatient Discharges in Primary Service Area
Fiscal Years Ended June 30, 2014, 2015 and 2016

	Years Ended June 30					
	2014		2015		2016	
Hospital	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Tower Health	**50,545**	**38.5%**	**50,274**	**38.4%**	**49,858**	**38.4%**
Reading Hospital	24,264	18.5%	23,936	18.3%	24,756	19.0%
Pottstown Hospital	7,087	5.4%	7,141	5.5%	6,815	5.2%
Phoenixville Hospital	5,484	4.2%	5,655	4.3%	5,408	4.2%
Brandywine Hospital	5,691	4.3%	5,320	4.1%	5,362	4.1%
Chestnut Hill Hospital	5,390	4.1%	5,788	4.4%	5,321	4.1%
Jennersville Hospital	2,629	2.0%	2,434	1.9%	2,196	1.7%
Chester County Hospital	11,514	8.8%	12,094	9.2%	12,266	9.4%
Main Line Hsp - Paoli	7,414	5.7%	7,731	5.9%	7,201	5.5%
Albert Einstein Med Ctr	6,812	5.2%	6,784	5.2%	6,697	5.2%
Saint Joseph Med Ctr	6,328	4.8%	6,262	4.8%	5,824	4.5%
Einstein Med Ctr -Montgomery	3,620	2.8%	3,630	2.8%	4,192	3.2%
Abington Mem Hospital	3,777	2.9%	3,888	3.0%	3,816	2.9%
Hospital of the Univ. of PA	3,693	2.8%	3,497	2.7%	3,613	2.8%
Thomas Jefferson Univ. Hsp	3,480	2.7%	3,465	2.6%	3,286	2.5%
All others less than 2.0%						

Source: Pennsylvania Health Care Cost Containment Council (PHC4) Inpatient Discharge Data. Excludes normal newborns.

Tower Health's secondary service area ("SSA") is comprised of the remainder of the Counties of Berks, Chester and Montgomery as well as parts of the City of Philadelphia and Lebanon, Lehigh, Lancaster and Schuylkill counties.

Several major highway systems connect the Tower Health PSA and SSA with major business hubs in New York City, Boston, Philadelphia, Baltimore, Washington, and Pittsburgh. Interstate Routes 78 and 76 run east to west through Pennsylvania, passing through the PSA. U.S. Routes 422, 222, 61 and 476 run north and south through the PSA.

Reading Hospital is located in the south central part of Berks County in West Reading, Pennsylvania, which adjoins the City of Reading. Based on patient origin data obtained from Reading Hospital's admissions records, Reading Hospital's primary service area is comprised of the City of Reading and the surrounding Berks County communities of Birdsboro, Blandon, Exeter, Fleetwood, Laureldale, Mohnton, Shillington, Sinking Spring, Temple, Wernersville, West Lawn, West Reading and

Wyomissing. Reading Hospital receives approximately 76% of its total inpatient discharges from these communities. The communities served by Reading Hospital in its primary service area are referred to herein as the "RHPSA". Reading Hospital's secondary service area ("RHSSA") is comprised of the remainder of Berks County, and portions of Schuylkill, Lebanon, Lancaster and Montgomery Counties and accounts for approximately 22% of Reading Hospital's inpatient discharges in the fiscal year ending June 30, 2016.

Brandywine Hospital is located in the west central part of Chester County in Coatesville, Pennsylvania. Based on patient origin data obtained from Brandywine Hospital's admissions records, Brandywine Hospital's primary service area is comprised of the City of Coatesville and the surrounding communities of Downingtown, Honey Brook, Parkesburg, West Chester, Glenmoore, Elverson, Phoenixville, Oxford, Gap, Exton, Atglen, Christiana, Thorndale, West Grove and Chester Springs. Brandywine Hospital receives approximately 80% of its total inpatient discharges from these communities.

Chestnut Hill Hospital is located in the Chestnut Hill section of the City of Philadelphia. Based on patient origin data obtained from Chestnut Hill Hospital's admissions records, Chestnut Hill Hospital's primary service area is comprised of the northern section of the City of Philadelphia and the surrounding communities of Glenside, Lafayette Hill, Flourtown, Plymouth Meeting and Ambler. Chestnut Hill Hospital receives approximately 80% of its total inpatient discharges from these communities.

Jennersville Hospital is located in the southern part of Chester County in West Grove, Pennsylvania. Based on patient origin data obtained from Jennersville Hospital's admissions records, Jennersville Hospital's primary service area is comprised of the Borough of West Grove and the surrounding communities of Oxford, Nottingham, Lincoln University, Kennett Square, Avondale, Cochranville and Landenberg. Jennersville Hospital receives approximately 80% of its total inpatient discharges from these communities.

Phoenixville Hospital is located in the west central part of Chester County in Phoenixville, Pennsylvania. Based on patient origin data obtained from Phoenixville Hospital's admissions records, Phoenixville Hospital's primary service area is comprised of the Borough of Phoenixville and the surrounding communities of Royersford, Pottstown, Spring City, Collegeville, Norristown, Schwenksville and Gilbertsville. Phoenixville Hospital receives approximately 80% of its total inpatient discharges from these communities.

Pottstown Hospital is located in north western part of Montgomery County in Pottstown, Pennsylvania. Based on patient origin data obtained from Pottstown Hospital's admissions records, Pottstown Hospital's primary service area is comprised of the Borough of Pottstown and the surrounding communities of Boyertown, Royersford, Gilbertsville, Douglassville and Spring City. Pottstown Hospital receives approximately 80% of its total inpatient discharges from these communities.

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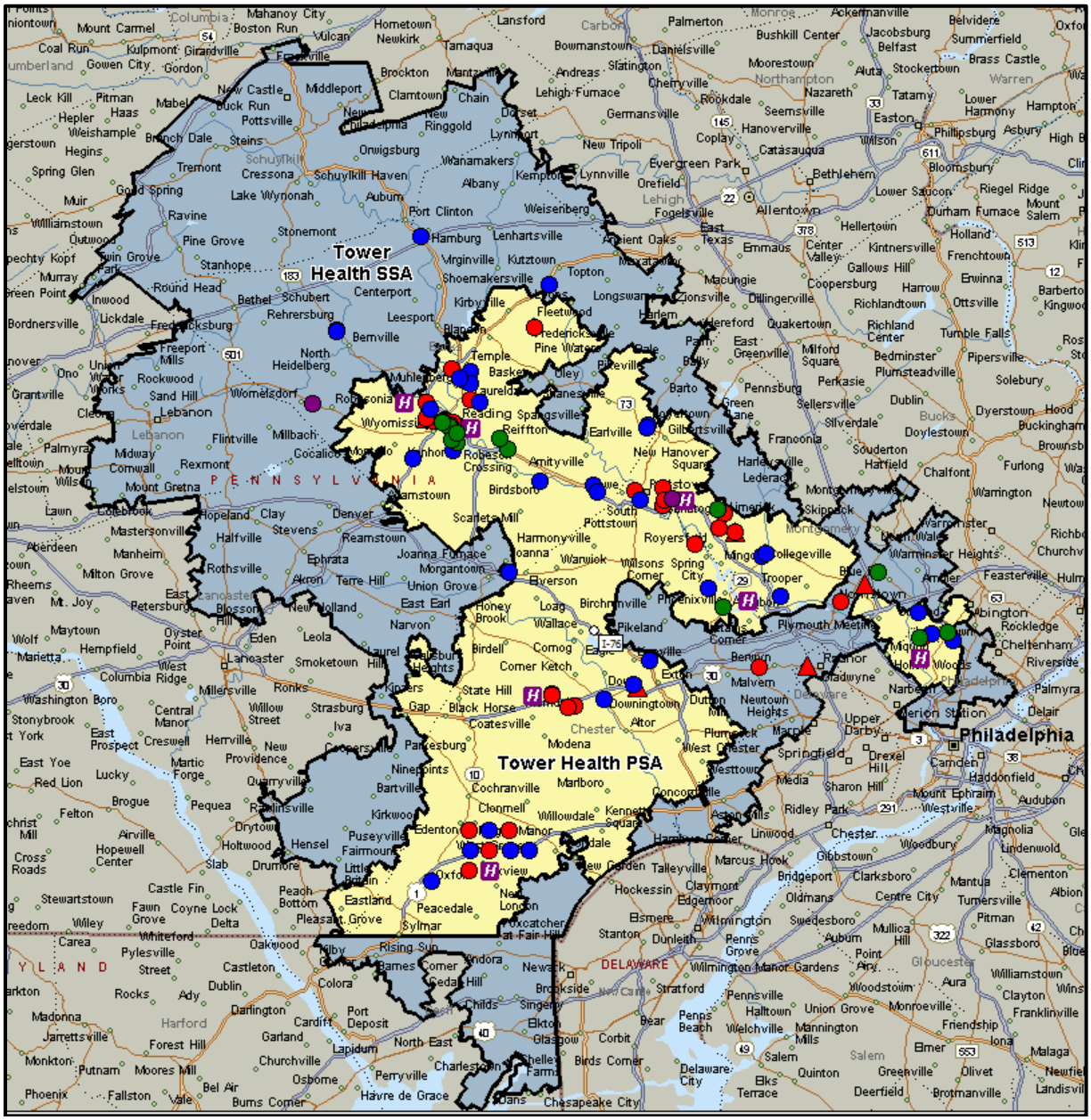
The map below shows Tower Health's PSA and SSA.[1]



1. The designated Tower Health Hospitals include Reading Hospital Rehabilitation at Wyomissing located in Berks County, Pennsylvania.

Sources of Patient Discharges

The following table sets forth the distribution of Reading Hospital's inpatient discharges by service area for the fiscal year ended June 30, 2016.

Distribution of Reading Hospital Inpatient Discharges by Service Area
Fiscal Year Ended June 30, 2016

Service Area	Discharges	Percent of Discharges
RHPSA	23,199	75.56%
RHSSA	6,743	21.96
Outside RHPSA and RHSSA	761	2.48
Total Discharges	30,703	100.0%

Source: PHC4 Inpatient Discharge Data. Excludes normal newborns.

Market Share

With 714-licensed beds during the fiscal year ended June 30, 2016, Reading Hospital is the largest hospital in the RHPSA.

Inpatient Discharges. Reading Hospital's inpatient discharges comprise 65% of all hospital-reported discharges in the RHPSA. As shown in the tables below, from 2014 through 2016, Reading Hospital's market share improved with respect to inpatient discharges and overall discharges in both the RHPSA and RHSSA.

The following table summarizes Reading Hospital's market share of inpatient discharges in the RHPSA, the RHSSA, and combined RHPSA and RHSSA for fiscal years ended June 30, 2014, 2015 and 2016 based upon all hospital-reported inpatient discharges.

Reading Hospital Market Share of Inpatient Discharges by Service Area

	Fiscal Year Ended June 30,		
Service Area	**2014**	**2015**	**2016**
RHPSA	63.5%	63.5%	65.1%
RHSSA	7.7	7.7	8.0
Total Service Area (combined RHPSA and RHSSA)	24.4	24.2	25.0

Source: PHC4 Inpatient Discharge Data.
Excludes normal newborns.

The following table shows market share trends, based on total inpatient discharges, for Reading Hospital and its competitors within the RHPSA for the fiscal years ended June 30, 2014, 2015 and 2016.

Market Share Trends in RHPSA
Inpatient Discharges

	Year Ended June 30,					
	2014		2015		2016	
Hospital	**Discharges**	**Share**	**Discharges**	**Share**	**Discharges**	**Share**
Reading Hospital	**22,766**	**63.5%**	**22,492**	**63.5%**	**23,199**	**65.1%**
St. Joseph Med Ctr/Reading	6,071	16.9%	6,023	17.0%	5,582	15.7%
Healthsouth Reading Rehab Hospital	684	1.9%	644	1.8%	773	2.8%
Milton S. Hershey Medical Center	775	2.2%	818	2.3%	764	2.1%
Haven Behavioral Hosp Of Eastern Pa	870	2.4%	723	2.0%	609	1.7%
Lehigh Valley Hospital/Allentown	661	1.8%	607	1.7%	544	1.5%
Surgical Institute Of Reading	368	1.0%	455	1.3%	485	1.4%
Pottstown Memorial Med Ctr	**261**	**0.7%**	**276**	**0.8%**	**274**	**0.8%**
Kidspeace Hospital, Inc.	179	0.5%	220	0.6%	245	0.7%
Other Providers	1,338	3.7%	1,361	3.8%	1,445	4.0%
All Hospitals*	35,868	100.0%	35,450	100.0%	35,642	100.0%

Source: PHC4 Inpatient Discharge Data. Excludes normal newborns.
*Totals may not add due to rounding.

The following table shows market share trends, based on discharges, for the fiscal years ended June 30, 2014, 2015 and 2016 for Reading Hospital and its competitors within the RHSSA.

Market Share Trends in RHSSA
Inpatient Discharges

	2014		2015		2016		2014-2016
Hospital	**Discharges**	**Share**	**Discharges**	**Share**	**Discharges**	**Share**	**Change**
Pottstown Memorial Med Ctr	**7,499**	**8.9%**	**7,510**	**8.9%**	**7,260**	**8.6%**	**-0.3%**
Reading Hospital	**6,461**	**7.7%**	**6,482**	**7.7%**	**6,743**	**8.0%**	**0.3%**
Good Samaritan Hospital/Lebanon	5,695	6.8%	5,897	7.0%	5,712	6.8%	0.0%
Phoenixville Hospital	**5,372**	**6.4%**	**5,511**	**6.5%**	**5,358**	**6.4%**	**-0.0%**
Ephrata Community Hospital	4,845	5.8%	5,147	6.1%	5,216	6.2%	0.4%
Lehigh Valley Hospital/Allentown	5,038	6.0%	4,992	5.9%	5,126	6.1%	0.1%
Lancaster General Hospital	4,766	5.7%	4,746	5.6%	4,689	5.6%	-0.1%
Chester County Hospital	4,308	5.1%	4,522	5.4%	4,586	5.5%	0.3%
Main Line Hospital Paoli	4,683	5.6%	4,837	5.7%	4,366	5.2%	-0.4%
Brandywine Hospital	**4,697**	**5.6%**	**4,329**	**5.1%**	**4,362**	**5.2%**	**-0.4%**
Milton S. Hershey Medical Center	3,944	4.7%	4,012	4.8%	3,832	4.6%	-0.1%
Schuylkill Med Ctr-S Jackson St	3,825	4.6%	3,424	4.1%	3,124	3.7%	-0.8%
Schuylkill Med Ctr-E Norwegian St	2,794	3.3%	2,620	3.1%	2,702	3.2%	-0.1%
St. Joseph Med Ctr/Reading	1,811	2.2%	1,832	2.2%	1,912	2.3%	0.1%
Hospital Of The University Of Pennsylvania	1,385	1.7%	1,346	1.6%	1,443	1.7%	0.1%
Einstein Medical Center Montgomery	964	1.2%	1,001	1.2%	1,236	1.5%	0.3%
Other Providers	15,856	18.9%	16,024	19.0%	16,347	19.5%	0.6%
All*	83,943	100.0%	84,232	100.0%	84,014	100.0%	

Source: PHC4 Inpatient Discharge Data. Excludes normal newborns.

* Totals may not add due to rounding.

Outpatient Procedures. Reading Hospital's outpatient procedures (performed at the Hospital or the Spring Ridge SurgiCenter) comprise 41% of all reported outpatient procedures in the RHPSA. The following table summarizes Reading Hospital's share of outpatient procedures in the RHPSA, the RHSSA, and combined RHPSA and RHSSA for the fiscal years ended June 30, 2014, 2015 and 2016.

Reading Hospital Market Share of Outpatient Procedures by Service Area

	Fiscal Year Ended June 30,		
Service Area	**2014**	**2015**	**2016**
RHPSA	41.5%	41.0%	40.9%
RHSSA	5.0	5.2	5.2
Total Service Area (combined RHPSA and RHSSA)	15.2	15.6	15.7

Source: PHC4 Inpatient Discharge Data. Represents only outpatient procedures that are required to be reported to PHC4

The following table shows market share trends, based on total outpatient procedures, for Reading Hospital and its competitors within the RHPSA for the fiscal years ended June 30, 2014, 2015 and 2016.

Market Share Trends in RHPSA Outpatient Procedures

	Fiscal Year Ended June 30,					
	2014		**2015**		**2016**	
Facility	**Procedures**	**Share**	**Procedures**	**Share**	**Procedures**	**Share**
The Reading Hospital	**30,760**	**41.5%**	**32,527**	**41.0%**	**35,105**	**40.9%**
Reading Hospital	**25,472**	**34.4%**	**27,230**	**34.4%**	**29,440**	**34.3%**
Reading Hospital SurgiCenters	**5,288**	**7.1%**	**5,297**	**6.7%**	**5,665**	**6.6%**
Berks Center for Digestive Health, LP	7,229	9.8%	10,680	13.5%	12,361	14.4%
Surgical Institute of Reading	4,782	6.5%	4,918	6.2%	4,781	5.6%
Reading Surg Ctr Of Surgical Inst Of Reading	4,818	6.5%	4,446	5.6%	4,522	5.3%
St. Joseph Med Ctr/Reading	3,363	4.5%	3,144	4.0%	4,024	4.7%
Berks Urologic Surgery Center, LLC	3,396	4.6%	3,344	4.2%	3,307	3.9%
Pa Eye And Ear Surgery Center, LLC	2,634	3.6%	2,829	3.6%	3,017	3.5%
Milton S. Hershey Medical Center	2,662	3.6%	2,652	3.4%	2,899	3.4%
Berkshire Eye Surgery Center	2,123	2.9%	2,248	2.8%	2,260	2.6%
Wyomissing Surgical Services, Inc.	2,139	2.9%	2,103	2.7%	2,242	2.6%
Lehigh Valley Hospital/Allentown	853	1.2%	1,182	1.5%	1,073	1.3%
State Hill Surgicenter LLC	949	1.3%	965	1.2%	977	1.1%
Other Facilities	8,456	11.4%	8,209	10.4%	9,274	10.8%
All Facilities	74,164	100.0%	79,247	100.0%	85,842	100.0%

Source: PHC4 Ambulatory Procedure Data. Represents only outpatient procedures that are required to be reported to PHC4.
Note: Does not include procedures done in physician offices

Competitor Profiles

Tower Health has regional competitors at the scale level with organizations such as Lehigh Valley Health Network, Penn State Health, Main Line Health System, Penn Medicine and St. Luke's University Health Network. At the local level each hospital has both unique competitors and system competitors depending upon the service area and clinical services.

Reading Hospital's highest market share competitor in the RHPSA is St. Joseph Medical Center (Penn State St. Joseph), which is a community hospital owned by Penn State Health. This facility is in a 180-bed facility in Bern Township, Berks County, and also provides services at its Community Health Center and Family Practice in the City of Reading. Haven Behavioral Health opened in 2010 on property vacated by St. Joseph Medical Center in the City of Reading. With 48 inpatient acute and partial care beds, Haven provides inpatient psychiatric care for adults suffering from schizophrenia, bipolar disorder, depression and anxiety disorders. In addition, Reading Rehabilitation Hospital, owned by HealthSouth, Inc., is located in Berks County, has 60 beds, and provides rehabilitation services in the area.

Additional competitors of Reading Hospital include Lehigh Valley Health System and Hershey Medical Center, both of which are located outside of the RHPSA and RHSSA and offer primary and referral levels of service, as well as trauma care.

Brandywine Hospital's highest market share competitor is Chester County Hospital – Penn Medicine, which is a 248-licensed bed facility located in West Chester, Pennsylvania. As of December 31, 2016, Brandywine Hospital had a 18.3% market share in its primary service area and Chester County Hospital had a 36.5% market share. Jennersville Hospital's highest market share competitor is also Chester County Hospital. As of December 31, 2016, Jennersville Hospital had a 32.7% market share in its primary service area and Chester County Hospital had a 36.5% market share.

Chestnut Hill Hospital's highest market share competitor is Albert Einstein Medical Center, which is a 750-licensed bed facility located in Philadelphia, Pennsylvania. As of December 31, 2016, Chestnut Hill Hospital had a 15.8% market share in its primary service area and Albert Einstein Medical Center had a 19.4% market share.

As of December 31, 2016, Pottstown Hospital and Phoenixville Hospital were the market leaders, respectively, in their primary service areas, with a 39.4% and 20.21% market share, respectively.

Listed below are the primary acute care competitors of Tower Health in the Tower Health PSA.

	Chester County Medical	**Main Line Hospital[(1)]**	**Albert Einstein Medical Center**	**St. Joseph Medical Center**	**Einstein Medical Center Montgomery**
Location	West Chester, Chester County	Chester and Montgomery Counties	Philadelphia, Pennsylvania	Reading, Berks County	East Norriton, Montgomery County
Control	Not-for-profit	Not-for-profit	Not-for-profit	Not-for-profit	Not-for-profit
Acute Care Beds[(2)]	248	888	750	204	171
Active Medical Staff Members[(3)]	438	1,533	519	346	396

Source: Pennsylvania Department of Health, 2015-2016 Annual Survey of Hospitals

(1) Data for Main Line Hospital's Paoli, Bryn Mawr and Lankenau facilities combined

(2) Represents licensed beds as of December 31, 2016.

(3) As of December 31, 2016.

TOWER HEALTH FACILITIES

Effective as of the acquisition of the Acquired Hospitals, the Tower Health system is comprised of 1,458 licensed beds, with over 63,000 admissions, 277,000 emergency room visits, 5,100 newborn deliveries and 57,000 surgeries.

Reading Hospital

Reading Hospital's main campus, situated on 39 acres in West Reading, Pennsylvania, is the site for inpatient care, research, and education, as well as the hub for major outpatient services. Facilities on this campus include 20 buildings, 12 of which are devoted to patient care. An important new clinical building is the new HealthPlex for Advanced Surgical & Patient Care that opened in January, 2017. This 476,000 square foot addition includes 24 state-of-the-art operating rooms and five patient floors with 30 private patient rooms on each floor. In addition, this facility incorporates the expansion of the emergency department and trauma services along with the relocation of the psychiatric evaluation unit.

In addition to the West Reading location, Reading Hospital maintains multiple locations that provide the following services: laboratory, imaging, occupational health, behavioral health, rehabilitation medicine and speech and hearing throughout the community.

In addition, Reading Hospital owns a seven-acre site in nearby Spring Township, approximately three miles from West Reading, that houses an ambulatory center, imaging center and lab testing satellite, wound healing and hyperbaric medicine center, and weight management center. A second site in Spring Township is where Reading Hospital's Rehabilitation Hospital operates. This site houses an inpatient rehabilitation center and a licensed transitional care unit.

In addition to these locations, Reading Hospital has acquired several other properties to meet future needs and extend its market reach. These include:

- A third location in Spring Township consisting of 104 acres
- Douglassville, Amity Township, 23 acres
- Kutztown, Maxatawny Township, 15 acres
- New Morgan Township, 32 acres
- Muhlenberg Township, 6.4 acres

New Hospital Entities

With the acquisition of the Acquired Hospitals and associated facilities, Tower Health has gained, five acute cate hospitals, three ambulatory surgery centers, six outpatient centers / medical office buildings, twenty primary care sites, thirty-three specialty care sites, one pediatric care site, six obstetrics/gynaecology sites, six imaging sites, one lab site, two hospital-based sleep labs, one cardiac rehabilitation site, seven outpatient therapy sites, one ambulatory radiation oncology center and two ambulatory veterans' centers.

Brandywine Hospital is a 169-licensed bed acute care hospital with a main campus located in Coatesville, Pennsylvania approximately 39 miles west of Philadelphia in Chester, County.

Chestnut Hill Hospital is a 148 licensed-bed acute care hospital with a main campus located in the Chestnut Hill neighborhood of Philadelphia, Pennsylvania.

Jennersville Hospital is a 63-licensed bed acute care hospital with a main campus located in West Grove, Pennsylvania.

Phoenixville Hospital is a 139 licensed-bed acute care hospital with a main campus located in Phoenixville, Pennsylvania.

Pottstown Hospital is a 232-licensed bed full service acute care hospital with a main campus located in Pottstown, Pennsylvania.

PATIENT SERVICES

Overview

Reading Hospital is a major regional healthcare provider, offering a full range of inpatient and outpatient, general and specialized, acute and post-acute medical programs. Reading Hospital provides acute inpatient care in clinical specialty fields ranging from maternity and newborn care through complex neurosurgical and orthopedic services, from comprehensive cardiac and vascular procedures to radiosurgery and advanced interventional radiology. It also houses Berks County's only accredited trauma center, the Miller Regional Heart Center, and the McGlinn Cancer Institute.

In the area of post-acute care, Reading Hospital maintains a CARF-accredited rehabilitation center, transitional care center, and home care services, through its joint venture with Affilia Home Health.

Brandywine Hospital was recognized by the Joint Commission in 2014 as a Top Performer in Heart Attack, Heart Failure, Surgical Care and Immunization. Additionally, there are several physician practices and a transportation company within the hospital.

Specialties and services at Brandywine Hospital include Behavioral Health Services, Cancer Care, Cardiology, Diabetic Education, Diagnostic Imaging, Eating Disorders, Emergency Department, GI/Endoscopy Services, Neuroscience Spine, Neurology, Orthopedic Surgery, Pain Management, Physical Therapy, Primary Care, Sleep Wellness Center, Surgical Services, Urology, Women's Health, Wound Care and Women's Imaging Center.

Chestnut Hill Hospital has inpatient and outpatient services, including minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology, and orthopedics among others. Additionally, the hospital has offsite ambulatory locations including two Women's Centers, an off-site physical therapy center, and several primary care physician practices.

Specialties at Chestnut Hill Hospital include Allergy/Immunology, Anesthesiology, Bariatric Surgery, Cardiology, Dermatology, Emergency Medicine, Endocrinology, Family Practice, Gastroenterology, GYN Oncology, Hematology, Infectious Disease, Internal Medicine, Interventional Radiology, Nephrology, Neurology, Oncology, Ophthalmology, Oral/Maxillofacial Surgery, Orthopedics/Surgery, Otolaryngology, Pain Management, Pathology, Plastic Surgery, Podiatry, Psychiatry, Pulmonology, Radiation Oncology, Radiology, Rheumatology, Thoracic Surgery, Urogynecology, Urology and Vascular Surgery.

Jennersville Hospital is an all-private-room facility, which offers inpatient and outpatient, emergency, surgical, and diagnostic care. The hospital recently completed a multi-million dollar renovation and expansion. The hospital serves the Southern Chester County area of Philadelphia and includes several physician practices.

Specialties and services at Jennersville Hospital include Anesthesiology, Cardiology, Emergency Medicine, Family Practice, Gastroenterology, General Surgery, Gynecology, Hematology, Internal Medicine, Nephrology, Neurology, Obstetrics, Oncology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Physical Medicine and Rehabilitation, Plastic Surgery, Podiatry, Pulmonology, Urology, Vascular Surgery and Wound Care.

Phoenixville Hospital has an award-winning cardiovascular program, a fully accredited cancer center and one of the area's largest Robotic Surgery Centers. Phoenixville Hospital has several strategically located ambulatory care sites, including three ambulatory surgery centers and several employed physician practice locations.

Specialties at Phoenixville Hospital include Breast Surgery, Cardiology, Endocrinology, Family Practice, Gastroenterology, General Surgery, Gynecologic Oncology, Hematology, Internal Medicine, Nephrology, Obstetrics, Ophthalmology, Oral/Maxillofacial Surgery, Otolaryngology, Pain Management, Plastic Surgery, Podiatry, Radiation Oncology, Radiology, Rheumatology and Vascular Surgery.

Pottstown Hospital services include a full range of inpatient and outpatient medical treatments, including among others, surgical, diagnostic, emergency care, cardiac care and a cancer center. Pottstown Hospital was a Joint commission Top Performer on Key Quality Measures in 2015 for Heart Attack, Heart Failure, Pneumonia and Surgical Care. Additionally, within the hospital there are several physician practices, surgery centers, an ambulatory company, and an imaging company.

Specialties at Pottstown Hospital include Behavioral Health Services, Cancer Care, Cardiac Care, Diabetes Care, Diagnostic Imaging, Emergency Department, Joint Replacement, Maternity Services, Occupational Health Services, Orthopedic Services, Pediatrics, Family Care, Pulmonary and Respiratory Health, Rehabilitation Services, Stroke Center, Surgical Services, Travel medicine, Tri County Lab, Tri County Neurology, Weight Loss Surgery, Women's Health and Wound Care.

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Reading Hospital provides the following clinical services:

❖ Inpatient Care

Medical Division
- Discharge Center
- Oncology Unit
- 2 General Medical Units
- Advanced Primary Stroke Center

Cardiac/Respiratory Division
- Cardiac Progressive Care Unit
- Cardiac/Respiratory Acute Care Unit
- Heart Failure Unit
- COPD/Pneumonia Unit

Surgical Division
- Joint Replacement Center
- Orthopaedic/Trauma Acute Care Unit
- 2 Surgical Acute Care Units

Psychiatric Division
- Inpatient Spruce Pavilion
- Willows program for Geriatric Patients
- Adolescent Unit
- Evaluation/Transition Center

Maternal/Child Health Division
- 2 Postpartum Acute Care Units and Nurseries
- Pediatrics Unit
- Triage Center
- Labor & Delivery Suite
- Procedure Suite
- Neonatal Intensive Care Unit

Critical Care
- Medical Intensive Care Unit
- Surgical Intensive Care Unit
- Neuro ICU
- Trauma Progressive Care Unit
- Infusion Center
- Hemodialysis Center

Post-Acute Care
- Inpatient Rehabilitation Center
- Inpatient Skilled Nursing Center

Special Programs
- Hospitalists
- Pediatric Hospitalists
- Intensivists
- Neurointensivists
- SNF-ists
- Central Monitoring
- Admission and Transfer Center
- PICC Team
- Lactation Support
- Palliative Care
- Hospice Care
- Case Management
- Social Service Department
- Chaplaincy Services Department

❖ Outpatient Clinics

- Adult Medical Clinic
- Center for Public Health
- Children's Health Center
- Employee Health Center
- Occupational Health
- Midwifery/Birthing Center
- Specialty Clinics
- Trauma Clinic
- Women's Health Center
- Specialty Clinics (Arthritis, Cardiology, Dermatology, Endocrine, Eye, GI, GU, Infectious Disease, Neurology, Podiatry, Pulmonary, Surgical, Trauma
- Pediatric Specialty Clinics through *St. Chris Care* (Cardiology, Endocrinology, GI, Neurology, Orthopedics, Pulmonary)

❖ Perioperative Services

- Department of Surgery
  - Bariatric, Cardiothoracic, General, Lithotripsy, Neurologic, Ophthalmology, Orthopaedic, Otolaryngology, Plastic and Reconstructive, Podiatric, Trauma, Urology, and Vascular
  - Support to: gynecologic oncology, gynecology, oral and maxillofacial surgery, reproductive endocrinology/infertility, urogynecology
- Department of Anesthesiology
- GI Lab
- Pain Management Center
- Pre-Admission Testing Center
- 2 DaVinci Surgical Robotic Systems
- 2 Outpatient SurgiCenters
- Hybrid OR

❖ Therapy Services

- Inpatient and Outpatient Occupational Therapy
- Inpatient and Outpatient Physical Therapy
- Rehabilitation Clinic for Post-Acute Recovery
- Speech Pathology/Therapy Services
- Cardiopulmonary rehabilitation
- STAR program for Oncology rehabilitation

❖ **McGlinn Cancer Institute**

- Cancer Risk Assessment Program
- Chemotherapy Infusion Center
- Clinical Trials/Protocols (Partnership with Johns Hopkins)
- Diagnostic Services, including PET/CT Scan
- Gynecologic Oncology Center
- Image Recovery Center
- Institute for Radiosurgery
- Integrative Medicine Program
- Medical Oncology Program
- Multidisciplinary Cancer Clinics
- Multidisciplinary Cancer Committees
- Nurse Navigators
- Radiation Oncology (Trilogy System – faster than CyberKnife)
- STAR certified rehabilitation program
- Survivorship program
- Tumor Board/Cancer Registry

❖ **Miller Regional Heart Center**

- Diagnostic services
- Cardiac Catheterization Laboratory
- Cardiac Rehabilitation Center
- Accredited Chest Pain Center
- ECHMO
- Vascular Services Procedure Suite
- High-Risk Valve Center
- Cardiac Surgical Program
- In-house and EKG satellite locations

❖ **Emergency Services**

- Level II Trauma Center (certified by PTSF)
- Full Service Emergency Department
- Emergency Observation Center
- Dedicated CT scanners
- Psychiatric Emergency Services
- Pediatrics Center
- 4 Quick Care Centers
- Accredited Chest Pain Center
- Transfer Center

❖ **Laboratory Services**

- Inpatient and outpatient testing
- Pathology Department
- Research Laboratory

❖ **Radiology Services**

- Advanced Interventional Radiology Center
- General Diagnostic Services
- CT Scanners
- MRIs
- Nuclear Medicine Department
- PET/CT Scanner
- Radiation Oncology Department

❖ **Neurosciences**

- Advanced Interventional Radiology center
- Neurointerventional Radiology program
- Advanced Primary Stroke Center
- Secure Brain Injury Rehabilitation Unit
- Epilepsy Monitoring Center
- Full range of diagnostic and therapeutic services

❖ **Psychiatric Services**

- Behavioral Medicine Center
- Outpatient Center for Mental Health
- Group Center Partial Hospitalization Program
- Residential Drug and Alcohol Center
- Dual Diagnosis Program
- Assertive Community Treatment Program
- Psychiatric Emergency Services
- Willows Program for Geriatric Care
- Senior Assessment Program
- Partners Adolescent Partial Hospitalization Program
- Inpatient Care Spruce Pavilion
- Medically Complex Unit
- Integrative Medicine Program

❖ **Respiratory Care**

- Inpatient/Outpatient Diagnostic Services & Therapy
- Pulmonary Function Lab
- Pulmonary Rehabilitation Program
- Sleep Center
- COPD/Pneumonia Inpatient Units
- Tobacco-Free Wellness Initiative

- **Speech and Hearing Center**
  - Inpatient newborn hearing screening program
  - Cochlear implant program
  - Outpatient Audiology Services
  - Speech Pathology/Therapy Services
- **Pharmacy Services**
- **Diabetes & Endocrinology Services**
- **Epidemiology, Infection Control, and Prevention**
- **Travel Immunization Service**
- **Home Care**
- **Weight Management Center**

Hospitalist Program

In 2001, Reading Hospital established a hospitalist program (the "Hospitalist Program") in response to physician requests for a different care model. Today, the Hospitalist Program employs 64 full-time, four part-time and two per diem physicians, managed by a Medical Director who also works clinical shifts. Reading Hospital also contracts with numerous locum hospitalists to provide additional coverage. The Hospitalist Program provides coverage 24 hours a day, seven days a week, with 21 hospitalists working during the day shift, six hospitalists working the night shift, and two swing shift admitters.

The Hospitalist Program utilizes advanced practitioners in the observation unit as well as stroke and heart failure unit, with continued usage of nurse practitioners for surgical co-management. Hospitalist Services employed its first pain specialty nurse practitioner in August 2014, and by the end of 2016 had hired an additional two nurse practitioners to work within the department, as well as a physician specializing in pain management. This has been a valuable service to the Hospital and community, increasing patient satisfaction and decreasing Length-of-Stay. In March 2016, Reading Hospital began utilizing nurse practitioners and a dedicated hospitalist to staff the new IMU int.

In addition to surgical co-management, the Hospitalist program utilizes physicians to provide several additional services. In September 2014, a Hospitalist-based physician advisor program was started for utilization review, correct patient status, denial management and clinical documentation improvement. In April 2015, Hospitalist Services assumed physician staffing of the Observation unit. Unit-based clinical leadership and team-based care has been implemented by the Hospitalist team on the medical units for increased efficiency and patient satisfaction.

In 2016 the Hospitalist Program had 15,552 admissions, not including observation patients, and the actual mortality rate was 1.5%.

MEDICAL STAFF

As of the acquisition of the Acquired Hospitals, Reading Hospital and the New Hospital Entities will have approximately 1,625 medical staff practitioners serving its six acute care hospitals.

Reading Hospital

As of June 30, 2017, Reading Hospital's medical staff consisted of 757 practitioners in eleven departments. Of the 757 physicians on staff, over 94% are board certified. The physicians serving on the Medical Staff are divided into two categories, as shown below:

Physician Status[1]	Number	% of Total
Active	697	92.07%
Affiliate	52	6.87
Community	8	1.06
Total	**757**	**100.00%**

[1] This chart does not include the medical staff of the New Hospital Entities.

Appointees to Active Staff must have served on the medical staff for one year as a provisional member, be involved in 24 patient contacts (i.e., a patient contact is defined as an inpatient admission, consultation, outpatient surgical procedure and/or an outpatient ancillary referral) at Reading Hospital and/or its affiliates and subsidiaries per two-year period, except as expressly waived for practitioners with at least 20 years of service in the active category or for those qualified practitioners who document their efforts to support the Hospital's patient care mission to the satisfaction of the Medical Staff Executive Committee and the Tower Health Board. Active Staff members are eligible to hold office and vote on all matters presented by the medical staff.

Appointment to Affiliate Staff is reserved for practitioners who do not meet the eligibility requirements for the active category. Appointees to this category must serve on the medical staff for one year as a provisional member. Practitioners assigned to this category are typically involved in fewer than 24 patient contacts (*i.e.*, a patient contact is defined as an inpatient admission, consultation, outpatient surgical procedure and/or an outpatient ancillary referral) at Reading Hospital and/or its affiliates and subsidiaries per two year period, except as expressly waived for practitioners with at least 20 years of services in the affiliate category or for those practitioners who document their efforts to support the Reading Hospital's patient care mission to the satisfaction of the Medical Staff Executive Committee and the Tower Health Board.

Practitioners assigned to the Community Staff category work primarily at the Berks Community Health Center and do not have privileges at Reading Hospital.

As stated in the Medical Staff Bylaws, each applicant for appointment to the medical staff must demonstrate that he/she has:

- successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, or holds a doctorate degree in psychology;
- a current unrestricted license; possess a current, valid unrestricted drug enforcement administration (DEA) number, if applicable; and

- recent clinical performance and competence within the last 12 months with an active clinical practice in the area in which clinical privileges are sought.

The following table summarizes the number and average age of Active Medical Staff by category of medical practices, as of June 30, 2017.

Active Medical Staff by Medical/Surgery Specialty[1]

Department	Number of Physicians	Average Age
Medicine		
Anesthesiology	31	52
Dentistry	16	49
Emergency Medicine	46	47
Family & Community Medicine	102	53
Medicine	239	47
OB/GYN	45	55
Pathology	12	60
Pediatrics	66	48
Physical Medicine & Rehabilitation	12	57
Psychiatry	31	52
Radiology	32	50
Medicine Total	**632**	
Surgery		
Cardiology Surgery	5	47
General Surgery	12	51
Neurologic Surgery	5	48
Ophthalmology	23	52
Orthopedic Surgery	15	55
Otolaryngology	10	58
Plastic Surgery	8	54
Podiatry Surgery	23	50
Trauma & Surgical Critical Care	12	48
Urological Surgery	7	55
Vascular Surgery	5	58
Surgery Total	**117**	
Combined Totals	**757**	**52**

[1] This chart does not include the medical staff of the New Hospital Entities.

The following table sets forth the top ten admitting physicians, with their age, specialties, and affiliations for the year ended June 30, 2017.

Top Ten Admitting Physicians[1]

Specialty	Ages	Discharges	% of Discharges	Employment Status
Internal Medicine	51	881	2.4%	Employed by RH
Orthopedic Surgery	56	669	1.8%	Independent
Internal Medicine	34	563	1.5%	Employed by RH
Internal Medicine	31	504	1.3%	Employed by RH
Internal Medicine	37	476	1.3%	Independent
Internal Medicine	46	454	1.2%	Employed by RH
Internal Medicine	35	403	1.1%	Employed by RH
Orthopedic Surgery	38	399	1.1%	Independent
Internal Medicine	53	378	1.0%	Employed by RH
Internal Medicine	52	367	1.0%	Employed by RH
Total		**5094**	**13.6%**	

[1]This chart does not include the admitting physicians for the New Hospital Entities.

New Hospital Entities

As of June 30, 2015, the Acquired Hospitals had a combined board certified medical staff consisting 868 practitioners. The following table summarizes the number of Active Medical Staff by category of medical practices, as of June 30, 2015.

Active Medical Staff by Medical/Surgery Specialty

Specialty	Brandywine	Chestnut Hill	Jennersville	Phoenixville	Pottstown	Total
Allergy/Immunology	0	1	0	0	0	1
Anesthesia	12	13	6	10	18	59
Cardiology	7	18	8	13	13	59
Colon/Rectal	0	2	0	1	0	3
Dentistry	1	2	2	0	0	5
Dermatology	2	4	0	0	0	6
Emergency Medicine	10	13	11	7	14	55
Family Practice	14	30	12	1	6	63
Internal Medicine	19	29	11	30	23	112
Neurological Surgery	1	6	7	1	1	16
Nuclear Medicine	0	0	0	0	0	0
Obstetrics/Gynecology	1	6	1	11	7	26
Oncology	3	9	8	4	3	27
Ophthalmology	0	20	6	0	2	28
Oral Surgery	1	1	2	0	4	8
Orthopedic Surgery	4	15	6	12	6	43
Otolaryngology	7	8	5	5	5	30
Pathology	4	5	3	2	2	16
Pediatrics	0	3	2	14	7	26
Physical Medicine/Rehab	1	8	0	2	4	15
Plastic Surgery	4	6	2	2	3	17
Podiatry	3	13	5	2	7	30
Preventive Medicine	0	0	0	0	0	0
Psychiatry/Neurology	6	7	5	1	3	22

Radiology	9	43	25	9	12	98
Surgery	3	5	3	14	2	27
Thoracic Surgery	3	2	0	0	0	5
Urology	5	8	2	3	7	25
All Others	20	0	17	0	9	46
TOTAL	**140**	**277**	**149**	**144**	**158**	**868**

Physician Recruitment Plan

Tower Health's most recent physician needs assessment was carried out in the fall of 2015 by Insight Health Partners ("IHP"). The methodology used by IHP was based upon national standards that are endorsed by the Internal Revenue Service and the Department of Health and Human Services. IHP utilized medical staff interviews, key stakeholder interviews and an actuarially based model to project future physician needs. This analysis included consideration of factors such as demographic shifts, physician retirements, payor mix and level of physician commitment to the Hospital. The resultant Physician Resource Plan identified community and Hospital physician needs by specialty over the next three years. These needs were translated into an actionable plan for the Health System which addresses strategic priorities (service line growth, geographic expansion, cost effectiveness, etc.) through recruitment and retention of physicians and advanced practice clinicians (APCs) by specialty.

To address these identified needs, as well as other recruitment needs that may arise, the physician enterprise, Tower Health Medical Group, has a team of physician recruitment professionals who are responsible for coordinating and carrying out all employed physician searches. On occasion, they will engage outside recruiting firms to assist with difficult searches. As part of the annual budgeting process, the leadership of Tower Health Medical Group and Tower Health establish the recruitment goals for the upcoming fiscal year. Throughout the year, refinements are made to the approved search assignments to account for unforeseen developments, such as unexpected physician attrition or increased demand for particular services.

Employed Physicians

Reading Hospital has 757 physicians on its medical staff. Of those, over 367 are employed by Tower Health Medical Group (THMG) which is the physician enterprise of Tower Health. The remainder of the medical staff consists of independent, private practitioners. Additionally, Tower Health contracts with some providers for other services.

THMG has an eleven member Board of Directors, eight of whom are physicians. There are six Subcommittees of the Board and a management team led by a Chief Executive Officer, Amit Powar, MD.

At this time, THMG employs physicians in primary care as well as many medical and surgical specialties and sub specialties. Physicians currently employed by THMG are in the specialties of psychiatry, obstetrics and gynecology, endocrinology, general internal medicine, infectious disease, interventional radiology, neonatology, neurology, physical medicine, plastic and reconstructive surgery, neurosurgery, vascular surgery, bariatric surgery, pediatrics, family medicine, occupational medicine, pathology, emergency medicine, hematology/oncology, geriatric medicine, and wound healing/hyperbaric medicine, addiction medicine, cardiology, cardiothoracic surgery, dermatology, maternal fetal medicine, neurocritical care, palliative medicine, pulmonary medicine, reproductive & fertility medicine, rheumatology and urogynecology. THMG offers services in over 40 locations across Berks County.

EMPLOYEES

Effective as of the acquisition of the Acquired Hospitals, the Tower Health system will employ 11,040 employees, which equates to 9,221 full-time equivalent (FTE) employees.

Reading Hospital

As of June 30, 2017, Reading Hospital, Tower Health Medical Group, and Tower Health Partners employed 6,879 employees, which equates to 5,937 full-time equivalent (FTE) employees. The nursing staff comprises 27% of Tower Health's employees, while technical and professional staff comprises 54.4%; management staff makes up 5%; and all other staff makes up 13.6%. The employee complement is made up of 62.3% full-time and 37.7% part-time employees.

Company	Total Employees	Total Full-Time Equivalent
RH	5,526	4,701
THP	6	6
THMG	1,347	1,230
Total	6,879	5,937

*As of June 30, 2017. This chart does not include the employees for the New Hospital Entities.

Management believes that Tower Health provides compensation and a comprehensive package of fringe benefits that are competitive with other hospitals in the area. Regular salary and benefits surveys are conducted by Human Resources to ensure Tower Health compensates it employees at levels competitive with other healthcare systems locally and regionally. The employee benefit plans include a pension plan, life insurance, health and dental insurance and a Section 403(b) benefit plan.

At the present time, there are no employees covered by collective bargaining agreements nor is management aware of any union organizing activities among any of Reading Hospital's employees.

The number of FTE's employed in nursing roles is listed below:

Employed FTE Category*	RH
Registered Nurse	1,651
Licensed Practical Nurse	99
Medical Assistant	153
Total	1,904

*As of June 30, 2017. This chart does not include the nursing staff for the New Hospital Entities.

Tower Health utilizes agency registered nurses, as needed, to support vacancies in inpatient, peri-operative, and Emergency Department. The utilization of agency registered nurses has been at 4% during this fiscal year, which is low, based on national averages. An internal float pool is being developed that will increase internal resources to cover vacancies and periodic increases in patient volume. The national vacancy rate for registered nurses is currently at 8.1%; System-wide, the vacancy rate is 5.5%.

The retention and recruitment of registered nurses is one of Tower Health's highest priorities. Tower Health has an active shared governance model in nursing that allows for input on key decisions at the staff level. This model also provides for more collaboration in quality and improved patient outcomes.

Acquired Hospitals

As of December 31, 2016, the Acquired Hospitals employed 3,228 employees, including 102 physicians.

Hospital	Total Employees	Employed Physicians
Brandywine Hosptial	610	17
Chestnut Hill Hospital	697	16
Jennersville Hospital	262	9
Phoenixville Hospital	732	14
Pottstown Hospital	927	26
Total	3,228	102

Chestnut Hill Hospital, Jennersville Hospital and Pottstown Hospital currently have collective bargaining agreements in place with SEIU Healthcare Pennsylvania which covers 138, 102 and 276 service and technical employees at the three hospitals, respectively. The contract at Chestnut Hill Hospital expires on June 30, 2019, the contract at Jennersville Hospital expires on August 31, 2019 and the contract at Pottstown Hospital expires on August 31, 2018.

On August 8, 2016, the Pennsylvania Association of Staff Nurses and Allied Professional (PASNAP) filed a Petition for Certification of Representative in connection with Pottstown Hospital's registered nurses. PASNAP prevailed in the September 7, 2016 election, and on September 19, 2016, the Regional Director issued a Certification of Representative in PASNAP's favor. Pottstown Hospital tested Certification and accepted the Regional Director's position and held its initial bargaining session on January 24, 2017. Negotiations with PASNAP are ongoing.

EDUCATION AFFILIATIONS AND RESEARCH PROGRAMS

Currently, Reading Hospital offers residency programs in Emergency Medicine, Internal Medicine, Family Medicine, Obstetrics/Gynecology, Transitional Year Medicine, Podiatry and Pharmacy. Reading Hospital maintains affiliated residencies in General Surgery, Neurosurgery, Surgical Critical Care, and Plastic Surgery with Philadelphia College of Osteopathic Medicine and affiliated fellowships in Cardiology, Pulmonary Critical Care, and Hematology Oncology with Thomas Jefferson University. At any one time there are approximately 100 residents in training at Reading Hospital. Reading Hospital provides a clinical setting for medical students from several medical schools and provides a training experience for approximately 400 students yearly. The health system also serves as a training site for physician assistant and nurse practitioner students from several schools in the region.

From its inception, Reading Hospital has made a commitment to medical education, nursing education and allied healthcare training. The training programs have been central to the mission of the organization. Over one third of current primary care, hospitalist, and obstetric gynecology staff are graduates of Reading Hospital's training programs. In the past year, residents and faculty have presented or published over 150 peer reviewed reports at regional or national levels. The faculty and residents have developed key skills in process improvement and have been integrally involved in Reading Hospital's Patient Safety and Quality programs.

The Academic Affairs office, which oversees undergraduate and graduate education at Reading Hospital, also assures extensive high level continuing medical education for the medical staff and provides support for resident and staff research initiatives. Reading Hospital maintains a major academic affiliation with Thomas Jefferson University and is a partner in the Jefferson Coordinating Center for Clinical Research. In addition, an academic partnership with the Jefferson Kimmel Cancer Center

supplements Reading Hospital's education, clinical and research programs. The organization maintains contractual educational relationships with multiple schools of higher learning. Reading Hospital is also a major partner in the Johns Hopkins Clinical Research Network.

In addition to medical education, Reading Hospital offers multiple hospital based educational programs through its School of Health Sciences. Reading Hospital's healthcare educational programs are unified under the name of Reading Hospital School of Health Sciences (RHSHS). RHSHS has engaged in a collaborative agreement with Alvernia University to provide the general educational requirements for the programs and dual enrollment Associate Degrees for several programs. Courses in physical, biological, and behavioral sciences, along with English composition are taught at the School of Health Sciences by Alvernia University faculty.

Registered Nursing Program. Instituted in 1889, the school was one of the first schools in the country to be accredited by the National League for Nursing. To date, over 6500 students have graduated from the Nursing Program. Currently, 250 students are enrolled in the Nursing Program.

The Nursing Program, in collaboration with Alvernia University, offers a three year dual enrollment educational tract leading to both a diploma in nursing from RHSHS and an Associate Degree in Applied Health from Alvernia University. New classes are accepted each August. Currently accredited by the Accreditation Commission for Education in Nursing (ACEN), the Nursing Program includes education in specialization areas, including medical surgical nursing, pediatrics, maternity, oncology, and intensive care. Graduates from the RHSHS Nursing Program can then complete an additional 34 credits at Alvernia University to earn a BSN degree.

Reading Hospital retains a percentage of graduates on its nursing staff providing workforce security, in contrast to the nursing shortages affecting hospitals across the country. To maintain this renewable source of professionals, Reading Hospital offers financial support to cover the cost of operating the Nursing Program.

Surgical Technology Program. For almost 40 years, the Surgical Technology Program has prepared qualified professionals for a technical role on the surgical team. The Mission of the Surgical Technology Program of Reading Hospital School of Health Sciences is to prepare competent, entry-level surgical technologists in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains. Combining instructional lectures and clinical experience, the dual enrollment program prepares students for the national certification examination and to assume entry level positions as surgical technologists. Graduates concurrently earn a certificate in Surgical Technology from RHSHS along with a certificate in surgical robotics, and an Associate Degree from Alvernia University. Currently 14 Surgical Technology students are enrolled.

Emergency Management Services Programs. The Emergency Medical Services (EMS) program consists of several sectors including EMT, Advanced EMT, Paramedic, and Pre-hospital RN programs. EMTs provide care for the sick and injured in emergency medical settings. The EMT educational program is provided in a variety of settings on the School of Health Sciences campus, or at off-campus local fire companies and businesses who request courses. Current EMT enrollment is 27 on site students.

The Paramedic Education Program was founded in 1987 to prepare individuals for careers as pre-hospital services professionals. Emergency Medical Technicians with one or more years of field experience are eligible to apply to the Paramedic program. The Paramedic Program gives students the opportunity to combine their educational and work experience in the community and in the hospital. From this combination, students gain an understanding of continuity of care – from first contact with the

patient in the field until discharge from the Hospital. The program includes didactic, clinical, and field experiences provided by RHSHS in cooperation with advanced life support services in the Eastern Pennsylvania EMS region. Currently, 11 students are enrolled in the Paramedic Program.

Clinical Pastoral Education Program. The Clinical Pastoral Education Program at Reading Hospital offers program formats tailored to the needs of theological-degree candidates, clergy, and lay ministers seeking continuing education or wishing to train for careers in chaplaincy. The curriculum and supervised clinical pastoral experiences focus on the development and refinement of pastoral care and counseling skills that are theoretically informed and pastorally effective. Several types of programs are offered including one unit internships offered at various times throughout the year, a year-long 3 unit chaplain resident program, and a multi-year Supervisory Education Student (SES) program. There are currently six residents and four interns in the CPE Program.

Medical Imaging Program. The Medical Imaging Program is approved by the Joint Review Committee on Education in Radiologic Technology (JRCERT), and has graduated over 550 Radiologic Technologists since being organized in 1951. The Medical Imaging Program is a dual enrollment program presented in seven semesters. A new class begins each January. Class size is limited to 20 students per year. Combining classroom and clinical experiences, the RHSHS certificate program prepares graduates for entry level employment as diagnostic radiographers in a variety of radiologic healthcare settings. Graduates also earn an Associate's Degree in Medical Imaging from Alvernia University. Current enrollment in the school is 34.

Reading Hospital also provides a Critical Care training course using the American Association of Critical Care Nurses' Essentials of Critical Care Orientation (ECCO), which is comprised of 17 modules for Progressive Care Units and 18 modules for ICU/PACU. Registered nurses working in critical care, intermediate care units, and Heart Failure units (N2W, N2S, & C1) are required to take selected modules of the ECCO program to master the required knowledge to work in those areas

Reading Hospital provides clinical support for programs operated by the following institutions:

- **Physical Therapy and Physical Therapy Assistant:** Arcadia University, Drexel University, Hampton University, Ithaca College, Lebanon Valley College, Misericordia University, Neumann College, St. Francis University, Temple University, Thomas Jefferson University, University of Delaware, University of Scranton, University of the Sciences in Philadelphia, Widener University, Harcum College, Central Penn College, Lehigh Carbon Community College, Penn State (Hazelton), St. Augustine

- **Medical Records Administration/Coding:** Lehigh Carbon Community College, Temple University, University of Pittsburgh, Reading Area Community College, Berks Technical Institute and other on line health information management programs

- **Speech Pathology:** Bloomsburg University, University of Pittsburgh, Ithaca College, Marywood University, Penn State University, Temple University, West Chester University

- **Professional Nursing:** Reading Hospital provides graduate and advance practice nursing preceptorships for a wide variety of universities. Examples include Alvernia University, Penn State University, Cedar Crest College, Reading Area Community College, Chamberlain College, Walden University, Villanova University, and Wilkes University.

ACCREDITATION, MEMBERSHIP AND AWARDS

In April 2017, The Joint Commission issued a three-year accreditation to Reading Hospital. Reading Hospital is also licensed by the Pennsylvania Department of Health.

In addition, Reading Hospital is accredited or approved by the following entities:

- American Association of Blood Banks
- Accreditation Council for Graduate Medical Education
- American College of Surgeons
- American Osteopathic Association
- Association for Clinical Pastoral Education
- Commission on Accreditation of Allied Health Education Programs
- Commission on the Accreditation of Rehabilitation Facilities
- Joint Review Committee on Education in Radiologic Technology
- National Accreditation Program for Breast Centers
- National Accrediting Agency for Clinical Laboratory Science
- Pennsylvania Medical Society
- Pennsylvania State Board of Nursing
- Pennsylvania Trauma Systems Foundation
- Society of Chest Pain Centers
- Undersea and Hyperbaric Medicine Society
- Accreditation Commission for Education in Nursing
- Commission on Cancer Accreditation and Gold Rating
- Joint Commission's Gold Seal of Approval
- American College of Radiology

In addition, all of Reading Hospital's educational programs have received the appropriate accreditation. Reading Hospital's Cancer Program is approved by the American College of Surgeons.

Reading Hospital is also a member of the following organizations:

- American Hospital Association
- Hospital & Healthsystem Association of Pennsylvania
- Berks County Chamber of Commerce
- United Way of Berks County (non-funded member)
- Central Pennsylvania Health Alliance
- AllSpire Health Partners

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Reading Hospital has been the recipient of numerous awards and recognitions for quality and excellence in the delivery of health services, including:

Organization	Award/Accreditation
Healthgrades	▪ Distinguished Hospital for Clinical Excellence Award™ ▪ America's 100 Best Hospitals ▪ America's 100 Best Specialty Care for Critical Care ▪ America's 100 Best Specialty Care for Pulmonary Care ▪ America's 100 Best Specialty Care for Stroke Care
ANCC	▪ Reading Hospital Received Magnet® Designation for Excellence in Nursing and Patient Care Outcomes
US News and World Report	▪ Reading Hospital is ranked as the 7th best hospital in the Commonwealth of PA, up from 34th 5 years ago.
Verras Medical Value Index™	▪ One of 10 Best Hospitals in Pennsylvania
Becker's Hospital Review	▪ One of 50 of the Greenest Hospitals in America ▪ One of 100 Hospitals and Health Systems with Great Neurosurgery and Spine Programs
Centers for Medicare & Medicaid Services	▪ 4-Star Rating for Overall Hospital Quality
Hospitals and Health Network	▪ HealthCare's Most Wired
Blue Cross and Blue Shield Association	▪ Blue Distinction Center for Bariatric Surgery ▪ Blue Distinction Center for Cardiac Care ▪ Blue Distinction Center for Knee & Hip Replacement ▪ Blue Distinction Center for Spine Surgery
International Lactation Consultants Association	▪ Care Award
Diversified Clinical Services	▪ Center for Distinction for Wound Healing & Hyperbaric Medicine
The Joint Commission	▪ Disease-Specific Certifications for: ▪ Advanced Primary Stroke Center ▪ Chronic Obstructive Pulmonary Disease ▪ Heart Failure Program ▪ Pneumonia ▪ Total Hip Replacement ▪ Total Knee Replacement
American Heart Association	▪ Get with the Guidelines Gold Performance Achievement for Heart Failure ▪ Mission Lifeline Gold Plus Receiving Award for Heart Attack
American Heart Association/ American Stroke Association	▪ Get with the Guidelines Gold Performance Achievement for Stroke Care
ProPublica	▪ #1 in Pennsylvania for Knee and Hip Replacements

The Acquired Hospitals have also been the recipient of numerous awards and recognitions for quality and excellence in the delivery of health services, including:

Hospital	Award/Accreditation
Brandywine Hospital	▪ 2014 Joint Commission Top Performer on Key Quality Measures ▪ 2016 Joint Commission Gold Seal of Approval for: ▪ Hip and Knee Replacement ▪ Acute Myocardial Infarction (AMI) ▪ Wound Care ▪ Advanced Certification in Stroke - Primary Stroke Center ▪ 2016 Independence Blue Cross - Blue Distinction Center for Cardiac Care & Hip and Knee ▪ Designated Lung Screening Center - American College of Radiology ▪ Accredited Chest Pain Center Society of Cardiovascular Patient Care ▪ Aetna Institute of Quality
Chestnut Hill Hospital	▪ 2014 American Stroke Association Get with the Guidelines Stroke, Gold Plus ▪ 2014 Chest Pain Accreditation
Jennersville Hospital	▪ Joint Commission Accredited Hospital and Laboratory ▪ Silver American Heart Association Get with the Guidelines for Heart Failure (2012) ▪ Press Ganey Summit Award (2011) ▪ American College of Surgeons Commission on Cancer (2012) ▪ American College of Radiology Mammography Accredited Facility (2013) ▪ Joint Commission Key Quality Measures (based on 2010 data)
Phoenixville Hospital	▪ The Joint Commission, National Quality Approval Accreditation ▪ Society of Cardiovascular Patient Care, Accredited Chest Pain Center PCI ▪ Society of Cardiovascular Patient Care, Accredited Heart Failure ▪ Commission on Cancer Accreditation ▪ Accredited MRI, Breast MRI, Mammography, Breast Ultrasound, CT – American College of Radiology ▪ National Accreditation Program of Breast Centers Accredited Breast Health Center of Phoenixville ▪ Regional Rehab Center at Phoenixville Hospital Ranked in the Top 10%of all Rehab Facilities in the U.S. in 2016

Pottstown Hospital	▪ 2014 Joint Commission Gold Seal of Approval for: ▪ Hip and Knee Replacement ▪ Primary Stroke Center Designation ▪ 2014 Blue Distinction Plus Center for Orthopedics from Independence Blue Cross ▪ 2015 American Stroke Association Get with the Guidelines, Gold Plus ▪ Accreditation with Commendation/Outstanding Achievement Award, 2015 ▪ Chest Pain Center Accreditation from the Society of Chest Pain Centers (SCPC), in recognition of the hospital's commitment to the highest standards in the country for heart failure care.

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SUMMARY OF FINANCIAL INFORMATION

(dollars in thousands)

Summary of Financial Data – Tower Health and Subsidiaries

The following consolidated statements of operations and balance sheets for Tower Health and Subsidiaries as of and for the fiscal years ended June 30, 2015, 2016 and 2017 are derived from the audited financial statements of the Tower Health and Subsidiaries. This information should be read in conjunction with the consolidated financial statements, related notes and other financial information included in Appendix B to this Official Statement. This financial information and consolidated financial statements include information concerning subsidiaries of Tower Health which are not members of the Reading Health Obligated Group. **The following consolidated statements of operations and balance sheets do not include financial results of the New Hospital Entities.**

Condensed Statements of Operations
Tower Health (formerly known as Reading Health System) and Subsidiaries

	Years ended June 30		
	2015	**2016**	**2017**
Unrestricted revenues and other support:			
Net patient service revenue	893,863	975,705	1,045,331
Provision for uncollectible accounts	(46,489)	(51,468)	(47,592)
Net patient service revenue less provision for uncollectible accounts	847,374	924,237	997,739
Residential revenue	21,069	22,372	23,143
Other revenue	31,285	31,861	31,474
Total revenues and other support	899,728	978,470	1,052,356
Expenses:			
Salaries and benefits	522,074	540,385	595,442
Supplies	142,872	158,489	160,158
Utilities	12,510	12,282	12,465
Interest	13,925	10,840	12,524
Depreciation	83,637	78,385	84,039
Purchased services	82,563	86,134	90,176
Repairs and maintenance	31,105	32,046	32,131
Other	61,130	49,158	53,475
Acquisition related expenses	-	-	2,221
Total expenses	949,816	967,719	1,042,631
Income (loss) from operations	(50,088)	10,751	9,725
Nonoperating (losses) gains:			
Investment income	52,313	29,324	44,395
Change in fair value of swap contracts and net of settlement payments	(7,061)	(20,172)	9,598
Other-than-temporary impairment losses on investments	(9,432)	(9,228)	(4,111)
Other (losses) gains	3,373	1,200	(7,490)
Nonoperating (losses) gains, net	39,193	1,124	42,392
Excess (deficiency) of revenues, (losses) gains and other support over expenses	(10,895)	11,875	52,117
Operating margin	-6%	1%	1%
Operating cash flow *	47,474	99,976	108,509
Operating cash flow margin **	5%	10%	10%

* Operating cash flow = Income (loss) from operations + interest + depreciation + acquisition related expenses
** Operating cash flow margin = Operating cash flow / total revenues and other support

Consolidated Balance Sheets
Tower Health (formerly known as Reading Health System) and Subsidiaries

Assets	June 30 2015	2016	2017
Current assets:			
Cash and cash equivalents	$ 37,005	117,814	55,535
Patient accounts receivable, less allowance for uncollectible accounts of $33,770, $38,194, and $34,640, respectively	115,772	113,033	123,553
Other receivables	9,585	6,832	5,460
Receivable from affiliates	720	—	—
Inventories	14,683	14,127	15,034
Estimated third-party payor receivables	6,993	11,404	7,262
Prepaid expenses and other current assets	12,964	20,994	15,101
Assets whose use is limited – required for current liabilities:			
Self-insurance funding arrangements	12,503	10,711	7,482
Revenue bond indentures – debt service requirements	251	—	—
Total current assets	210,476	294,915	229,427
Assets whose use is limited:			
Self-insurance funding arrangements	16,914	8,408	11,804
Under regulatory requirements	3,071	2,719	2,666
By board for capital improvements	953,539	775,662	857,972
Total assets whose use is limited, net of current portion	973,524	786,789	872,442
Restricted investments	25,733	25,640	28,149
Temporarily restricted funds	705	366	302
Property, plant and equipment, net	729,610	827,264	834,146
Investments in joint ventures	11,577	10,393	12,317
Other assets	3,526	9,599	5,387
Total assets	$ 1,955,151	1,954,966	1,982,170
Liabilities and Net Assets			
Current liabilities:			
Current installments of long-term debt	$ 5,314	5,529	5,719
Accounts payable	31,016	60,399	54,756
Estimated third-party payor settlements	10,434	7,171	4,112
Current portion of estimated self-insurance costs	13,103	13,243	10,885
Accrued expenses	38,373	38,977	29,713
Accrued vacation	24,295	27,245	30,160
Other current liabilities	9,904	7,613	8,906
Total current liabilities	132,439	160,177	144,251
Long-term debt, net of current portion and unamortized discount/premium and deferred financing costs	579,824	574,368	568,800
Accrued pension liabilities	172,385	325,912	252,256
Deferred revenue	39,289	41,062	42,811
Other liabilities	2,899	2,563	2,694
Estimated self-insurance costs, net of current portion	45,242	47,955	37,499
Swap contracts	48,703	59,134	40,790
Total liabilities	$ 1,020,781	1,211,171	1,089,101
Net assets:			
Unrestricted	910,023	720,076	862,951
Temporarily restricted	705	366	1,667
Permanently restricted	23,642	23,353	28,451
Total net assets	934,370	743,795	893,069
Total liabilities and net assets	$ 1,955,151	1,954,966	1,982,170

Summary of Financial Data – Reading Health Obligated Group

The following selected condensed financial information of the Reading Health Obligated Group for the three years ended June 30, 2015, 2016 and 2017 have been prepared by Management and are derived from the audited financial statements of the Tower Health and Subsidiaries. The statements include, in the opinion of Management, all adjustments necessary to summarize fairly the results for such period. The Reading Health Obligated Group accounted for 88.7%, 88.6%, and 89.0% of consolidated total revenues and other support for the years ended June 30, 2015, 2016 and 2017, respectively. **The following selected condensed financial information does not include financial information for the New Hospital Entities.**

Condensed Consolidated Financial Information
Reading Health Obligated Group

	Years ended June 30		
	2015	**2016**	**2017**
Unrestricted revenues and other support:			
Net patient service revenue	812,441	884,795	950,498
Provision for uncollectible accounts	(42,590)	(46,958)	(43,713)
Net patient service revenue less provision for uncollectible accounts	769,851	837,837	906,785
Other revenue	28,013	29,425	30,007
Total revenues and other support	797,864	867,262	936,792
Expenses:			
Salaries and benefits	403,986	413,329	452,907
Supplies	134,813	148,821	150,830
Utilities	10,466	10,666	10,946
Interest	12,622	9,587	11,327
Depreciation	77,791	72,333	77,908
Purchased services	68,995	72,054	75,849
Repairs and maintenance	29,761	30,691	30,895
Other	50,000	38,762	38,530
Acquisition related expenses	-	-	2,221
Total expenses	788,434	796,243	851,413
Income from operations	9,430	71,019	85,379
Nonoperating (losses) gains:			
Investment income	51,062	28,723	41,435
Change in fair value of swap contracts and net of settlement payments	(7,061)	(20,172)	9,598
Other-than-temporary impairment losses on investments	(9,432)	(9,228)	(4,111)
Other (losses) gains	2,318	1,128	(6,976)
Nonoperating gains, net	36,887	451	39,946
Excess of revenues, (losses) gains and other support over expenses	46,317	71,470	125,325
Operating margin	1%	8%	9%
Operating cash flow *	99,843	152,939	176,835
Operating cash flow margin **	13%	18%	19%

* Operating cash flow = Income from operations + interest + depreciation + acquisition related expenses
** Operating cash flow margin = Operating cash flow / total revenues and other support

Unaudited Pro Forma Combined Statements of Operations

Tower Health and Subsidiaries completed the acquisition of the Acquired Hospitals on October 1, 2017. The unaudited pro forma condensed combined statements of operations for the years ended June 30, 2016 and 2017 are prepared on the basis as described in the introductory paragraph to the table below and presented as if the acquisitions occurred on July 1, 2015, combining the audited consolidated statements of operations of Tower Health and Subsidiaries with the unaudited statements of operations of the Acquired Hospitals for the years ended June 30, 2016 and 2017.

The pro forma data is based upon available information and certain assumptions that we believe are reasonable. The pro forma data is for informational purposes only and does not purport to represent what Tower Health's results of operations or financial position actually would have been if such events had occurred on the dates specified above and does not purport to project the results of operations or financial position for any future period or date. The pro forma financial information does not reflect revenue opportunities, additional investment or cost savings that Tower Health may realize after the acquisition. The pro forma financial information also does not reflect expenses related to integration activity or exit costs that may be incurred by Tower Health in connection with integrating the businesses. The Tower Obligated Group on a pro forma basis accounted for 90.3%, and 90.5% of consolidated revenues for the years ended June 30, 2016 and 2017, respectively.

Unaudited Pro Forma Combined Statements of Operations

	Year Ended June 30	
	2016	**2017**
Unrestricted revenues and other support:		
Net patient service revenue	1,674,928	1,738,722
Provision for uncollectible accounts	(112,545)	(99,414)
Net patient service revenue less provision for uncollectible accounts	1,562,383	1,639,308
Residential revenue	22,372	23,143
Other revenue	46,227	42,645
Total revenues and other support	1,630,982	1,705,096
Expenses:		
Salaries and benefits	823,637	891,931
Supplies	276,337	274,680
Utilities	20,419	20,373
Interest	34,820	36,504
Depreciation	114,349	118,019
Purchased services	204,983	207,576
Repairs and maintenance	47,153	46,063
Other	93,687	107,863
Total expenses	1,615,385	1,703,009
Income from operations	15,597	2,087
Nonoperating (losses) gains:		
Investment income	29,324	44,395
Change in fair value of swap contracts and net of settlement payments	(20,172)	9,598
Other-than-temporary impairment losses on investments	(9,228)	(4,111)
Other (losses) gains	1,200	(7,490)
Minority interest	2,049	370
Nonoperating gains, net	3,173	42,762
Excess of revenues, (losses) gains and other support over expenses	18,770	44,849
Operating cash flow*	164,766	156,610
Operating cash flow margin**	10%	9%

* Operating cash flow = Income (loss) from operations + interest + depreciation
** Operating cash flow margin = Operating cash flow / total revenues and other support

The following table presents Tower Health's combined statements of operations for the periods indicated on a pro forma basis. The "Legacy System" column is the historical statements of operations for the legacy Tower Health entities for the years ended June 30, 2016 and 2017. The "New Hospital Entities" column is based on the historical unaudited statements of operations for the Acquired Hospitals for the years ended June 30, 2016 and 2017. Such information is unaudited and is adjusted as indicated and presented as though the acquisitions of the Acquired Hospitals occurred on July 1, 2015.

Pro Forma Combining Schedules

	Year Ended June 30, 2017				
	Legacy System	New Hospital Entities	Pro-forma Adjustments		Total
Unrestricted revenues and other support:					
Net patient service revenue	1,045,331	693,391	-		1,738,722
Provision for uncollectible accounts	(47,592)	(51,822)	-		(99,414)
Net patient service revenue less provision for uncollectible accounts	997,739	641,569	-		1,639,308
Residential revenue	23,143	-	-		23,143
Other revenue	31,474	11,171	-		42,645
Total revenues and other support	1,052,356	652,740	-		1,705,096
Expenses:					
Salaries and benefits	595,442	296,489	-		891,931
Supplies	160,158	114,522	-		274,680
Utilities	12,465	7,908	-		20,373
Interest	12,524	27,129	(3,149)	(1)	36,504
Depreciation	84,039	33,980			118,019
Purchased services	90,176	117,400	-		207,576
Repairs and maintenance	32,131	13,932	-		46,063
Other	53,475	58,316	(3,928)	(2)	107,863
Acquisition related expenses	2,221	-	(2,221)	(3)	-
Total expenses	1,042,631	669,676	(9,298)		1,703,009
Income (loss) from operations	9,725	(16,936)	9,298		2,087
Nonoperating (losses) gains:					
Investment income	44,395	-	-		44,395
Change in fair value of swap contracts and net of settlement payments	9,598	-	-		9,598
Other-than-temporary impairment losses on investments	(4,111)	-	-		(4,111)
Other (losses) gains	(7,490)	-	-		(7,490)
Minority interest	-	370	-		370
Nonoperating gains, net	42,392	370	-		42,762
Excess (deficiency) of revenues, (losses) gains and other support over expenses	52,117	(16,566)	9,298		44,849
Operating cash flow*	108,509	44,173			156,610
Operating cash flow margin**	10%	7%			9%

* Operating cash flow = Income (loss) from operations + interest + depreciation + acquisition related expenses
** Operating cash flow margin = Operating cash flow / total revenues and other support

	Year Ended June 30, 2016				
	Legacy System	New Hospital Entities	Pro-forma Adjustments		Total
Unrestricted revenues and other support:					
Net patient service revenue	975,705	699,223	-		1,674,928
Provision for uncollectible accounts	(51,468)	(61,077)	-		(112,545)
Net patient service revenue less provision for uncollectible accounts	924,237	638,146	-		1,562,383
Residential revenue	22,372	-	-		22,372
Other revenue	31,861	14,366	-		46,227
Total revenues and other support	978,470	652,512	-		1,630,982
Expenses:					
Salaries and benefits	540,385	283,252	-		823,637
Supplies	158,489	117,848	-		276,337
Utilities	12,282	8,137	-		20,419
Interest	10,840	26,620	(2,640)	(1)	34,820
Depreciation	78,385	35,964			114,349
Purchased services	86,134	118,849	-		204,983
Repairs and maintenance	32,046	15,107	-		47,153
Other	49,158	48,457	(3,928)	(2)	93,687
Acquisition related expenses	-	-	-		-
Total expenses	967,719	654,234	(6,568)		1,615,385
Income (loss) from operations	10,751	(1,722)	6,568		15,597
Nonoperating (losses) gains:					
Investment income	29,324	-	-		29,324
Change in fair value of swap contracts and net of settlement payments	(20,172)	-	-		(20,172)
Other-than-temporary impairment losses on investments	(9,228)	-	-		(9,228)
Other (losses) gains	1,200	-	-		1,200
Minority interest	-	2,049	-		2,049
Nonoperating gains, net	1,124	2,049	-		3,173
Excess of revenues, (losses) gains and other support over expenses	11,875	327	6,568		18,770
Operating cash flow*	99,976	60,862			164,766
Operating cash flow margin**	10%	9%			10%

* Operating cash flow = Income (loss) from operations + interest + depreciation + acquisition related expenses
** Operating cash flow margin = Operating cash flow / total revenues and other support

1 These pro forma adjustments eliminate the historical unaudited interest expense associated with the New Hospital Entities and give effect to the new money portion of the 2017 Bonds as if they had been issued on July 1, 2015.

2 These pro forma adjustments eliminate the historical unaudited property tax expense associated with the New Hospital Entities due to the tax-exempt status of Tower Health for all periods presented.

3 This pro forma adjustment eliminates the direct acquisition related costs incurred by Tower Health.

Trends In Liquidity

The table below sets forth (i) the cash position and liquidity of Tower Health and the Subsidiaries at June 30, 2015, 2016 and 2017 and (ii) a pro-forma cash position and liquidity analysis for the year ended June 30, 2017, assuming that the 2017 Bonds were outstanding and the acquisition of the Acquired Hospitals was effective as of July 1, 2016. Liquidity includes operating cash, short-term investments and assets limited by the Board to capital improvements. Excluded are trustee-held bond funds, funds held under self-insurance funding arrangements, and funds held for workers' compensation.

Selected Liquidity Indicators
Tower Health and Subsidiaries

	As of and for the Year Ended June 30			
	2015	**2016**	**2017**	**2017 Pro Forma**
Unrestricted Cash and Investments[1]	$990,544	$893,476	$913,507	$1,080,508[5]
Average Daily Operating Expenses[2]	2,373	2,430	2,626	4,342
Days Cash on Hand[3] (Days)	417	368	348	249
Cash to Debt[4] (%)	169%	154%	159%	93%

(1) Includes all cash and cash equivalents and Board designated investments that are not restricted by donors or other third parties.
(2) Annual expenses exclusive of depreciation divided by number of days in the year
(3) Unrestricted cash and investments divided by Average Daily Operating Expenses
(4) Unrestricted cash and investments divided by long term debt, net
(5) Includes approximately $167,001 in cash reimbursement of prior capital expenditures

As of June 30, 2016 and 2017, Tower Health had total debt obligations, net of unamortized discount/premium and deferred financing costs of $579,897 and $574,519, respectively. The following Table sets forth (i) selected capitalization indicators with respect to Tower Health and Subsidiaries at June 30, 2015, 2016 and 2017 and (ii) pro-forma capitalization indicators for the year ended June 30, 2017, assuming that the 2017 Bonds were outstanding and the acquisition of the Acquired Hospitals was effective as of July 1, 2016.

Selected Capitalization Indicators
Tower Health and Subsidiaries

	As of June 30			
	2015	**2016**	**2017**	**2017 Pro Forma**
Outstanding Long-Term Debt, net	$585,138	$579,897	$574,519	$1,174,436[2]
Unrestricted Net Assets	$910,023	$720,076	$862,951	$862,951
Debt to Capitalization[1] (%)	39%	45%	40%	58%

(1) Outstanding long term debt, net divided by the sum of (a) outstanding long term debt, net and (b) unrestricted net assets
(2) Includes approximately $599,917 related to the 2017 Bonds

Debt Service Coverage

The following table sets forth (i) income available for debt service for each of the years ended June 30, 2015, 2016 and 2017 for the Reading Health Obligated Group; (ii) historical coverage of the maximum annual principal and interest requirement on debt outstanding as of June 30, 2015, 2016 and 2017 for the Reading Health Obligated Group; and (iii) pro-forma coverage of maximum annual debt service for the year ended June 30, 2017, for the Tower Health Obligated Group assuming that the 2017 Bonds were outstanding and the acquisition of the Acquired Hospitals was effective as of July 1, 2016.

Historical and Pro Forma Coverage of Maximum Annual Debt Service

	2015	2016	2017	Pro Forma 2017
Income from Operations	$9,430	$71,019	$85,379	$97,486
Adjustments:				
Depreciation and Amortization	77,791	72,333	77,908	110,493
Interest	12,622	9,587	11,327	32,841
Investment Income	51,062	28,723	41,435	41,435
Gifts and Bequests & Other Gains (Losses)	2,318	1,128	(6,976)	(6,976)
Realized and Unrealized gains (and loss) on interest rate swaps	(7,061)	(20,172)	9,598	9,598
Other-than-temporary Impairment losses on investments	(9,432)	(9,228)	(4,111)	(4,111)
Income Available for Debt Service	$136,730	$153,390	$214,560	$280,766
Maximum Annual Debt Service Requirement[(1)]	$34,443	$34,560	$34,560	n.a.
Coverage of Maximum Annual Debt Service Requirement[(2)]	3.97x	4.44x	6.21x	n.a.
Pro Forma Maximum Annual Debt Service Requirement[(2)]*	n.a.	n.a.	n.a.	$67,915
Coverage of Pro Forma Maximum Annual Debt Service	n.a.	n.a.	n.a.	4.13x

(1) As reported. 2016 reflects new bank funding obtained in May 2016.

(2) Calculated in compliance with the provisions of the Master Trust Indenture. See Appendix D – Summary of Master Trust Indenture attached hereto.

* Assumes all variable rate indebtedness pays interest at the most recent 25-Year Revenue Bond Index (3.85%) per the Master Indenture.

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Investment Policy

Cash and investments are managed pursuant to policies established by the Investment Committee, a subcommittee of the Board. The Investment Committee and Tower Health's senior management meet bimonthly, determines the allocation of Unrestricted Long Term Capital and Pension investments according to asset classes, selects Advisors for each investment allocation, and reviews Advisor performance based on a benchmark rate of return established for that Advisor portfolio. The Investment Committee also reviews and modifies, as appropriate, both Unrestricted Long Term Capital and Pension Investment Policy Statements at least annually.

The following table sets forth the operating cash and unrestricted investments (including assets held under regulatory requirements) at market value by asset class and the percentage which each asset class represents of the total as of June 30, 2016 and 2017 **(the table does not include the New Hospital Entities)**:

	As of June 30			
	2016		2017	
Asset Class	**Market Value**	**Percentage of Total**	**Market Value**	**Percentage of Total**
Cash and cash equivalents	$ 126,216	14%	76,192	8%
State, municipal government, and auction rate securities	8,216	1%	8,158	1%
Common, preferred, and foreign stock	26,482	3%	11,694	1%
Equity mutual funds	305,704	34%	375,114	41%
Fixed income funds	243,259	27%	276,961	30%
Hedge, private equity, and common collective trust funds	186,318	21%	168,054	19%
Total	$ 896,195	100%	916,173	100%

Liquidity and Leverage. The System has historically balanced the incurrence of incremental indebtedness with the maintenance of substantial balance sheet liquidity. Since the downturn in equity markets in calendar year 2008 and their continued volatility, the System has maintained a conservative investment philosophy choosing liquidity and minimizing equities risk exposure. Excluding corporate cash which is for daily liquidity needs, approximately 75% of the System's and Reading Hospital's Long Term Capital portfolio is available within T+3 and a full 81% within one month. During fiscal year 2012 the Investment Committee of the Tower Health Board developed an Investment Policy Statement (IPS) that was approved by the Tower Health Board. This IPS is reviewed and updated annually by the investment consultant and Investment Committee. The IPS is intended to provide investment guidelines for the institution, its investment consultants, advisors and managers.

Interest Rate Swaps. The System has certain interest rate and basis swap agreements in place for a portion of its outstanding debt. The fair value of these swaps was a liability of $59,134 and $40,790 as of June 30, 2016 and 2017, respectively. The System, however, would be required to pay thereon only in the event that all or a portion of such swap portfolio was terminated. The System has the right to terminate at market at any time but has no present intention of exercising such right; the respective counterparty, J.P. Morgan Chase or Royal Bank of Canada, may exercise a right to terminate only upon the occurrence of certain prescribed events. In addition, the swap documents provide for collateralization of a portion of the mark to market valuation; however, based upon the current credit ratings of the System, no such collateralization obligation exists. The New Hospital Entities currently do not have any associated interest rate swaps.

Recent Trends and Developments.

Management has adopted a performance improvement culture which has led to a $60,000 operating turnaround in fiscal 2016 and continued stable performance in fiscal 2017. Total operating revenue increased by 17.0% over the past two years, compared with a 9.8% increase in total operating expenses. Supporting revenue improvement was growth in volume, as discharges increased by 9.0% over the past two years. Drivers of increased utilization were the opening of the Reading HealthPlex for Advanced Surgical & Patient Care in January 2017 and a highly successful advertising campaign, "101 Reasons to Choose Reading Health System," which featured print, ad, radio, and billboard advertisements that were updated throughout 2015 and 2016 with different reasons, which proved effective in improving name recognition. Management achieved improved operating efficiencies through its Operational Excellence Plan, which includes revenue cycle, supply chain, and other productivity initiatives. Management saved $92,100 from these system-wide efforts over the past two years. Salaries and benefits comprised 48.4% of revenue in fiscal 2017, compared with 50.6% of revenue in fiscal 2015. Management plans on deploying these same tactics to the New Hospital Entities.

In recent years, Tower Health and Subsidiaries has focused on the ongoing implementation of its performance improvement plan. On a consolidated basis, operating cash flow was $47,474, $99,976 and $108,509 for the years ended June 30, 2015, 2016 and 2017, respectively. Operating cash flows from the Reading Health Obligated Group was $99,843, $152,939 and $176,814 for the years ended June 30, 2015, 2016 and 2017, respectively. Operating margin from the Reading Health Obligated Group has improved and was 1%, 8% and 9% for the years ended June 30, 2015, 2016 and 2017, respectively.

In January 2017, the Reading HealthPlex for Advanced Surgical & Patient Care opened and is a 476,000 square foot surgical and inpatient tower that includes seven patient-care levels and combines the hospital's many surgical services into one of the most technologically advanced and sophisticated surgical centers in the region. The new facility added surgical suites, private patient rooms, and an eco-friendly Green Roof while paving the way for the existing Emergency Department and Trauma Center to be expanded by 17,500 square feet.

On January 1, 2017, the System created a 50/50 joint venture health plan with UPMC Health Plan. Also effective January 1, 2017, UPMC Health Plan began to operate as the third party administrator and provide flexible spending account administration services for the Reading Health System 11,000 members. The joint venture health plan offers a complete line of health coverage and related services to individuals, as well as employers and their employees, exclusively in the defined nine county joint venture service area. The service area includes; Berks, Bucks, Carbon, Chester, Lancaster, Lehigh Montgomery, Northampton and Schuylkill counties. Throughout 2017, the new partnership has been strategically introducing a full spectrum of health insurance products that includes Medicare Advantage, Administrative Services Only (ASO) for self-insured employers, Individual (Exchange), and Commercial Group, Special Needs Plans (SNP), Managed Medical Assistance, Children's Health Insurance Program (CHIP) to the community. The Tower Health-UPMC Health Plan enterprise combines access to the System's high-quality clinical care, expert providers, and advanced healthcare facilities with UPMC Health Plan's experience, expertise and advanced analytics to improve the health of the community. Additional future benefits will result in enhanced cost savings, value based healthcare to residents and companies in the greater Berks County area and access to Tower Health providers as in-network providers.

Consolidated Statements of Operations

Total revenues and other support

Total revenues and other support for the Reading Health Obligated Group was $797,864, $867,262, and $936,792 for the years ended June 30, 2015, 2016 and 2017, respectively. Total revenues and other support for the Reading Health Obligated Group has increased by 8% and 7% for the years ended June 30, 2016 and 2017, respectively. These increases are attributable to increased volume and reimbursement.

From the years ended June 30, 2015 to June 30, 2017, inpatient admissions continued the trend of steady growth. Total admissions grew by 5% and 4% for the years ended June 30, 2016 and 2017, respectively, and specifically, Medical/Surgical admissions showed a 6% increase in each of the years. The average case mix index, and resulting average length of stay, increased for the year ended June 30, 2017 over the year ended June 30, 2016. The table below presents selected statistical indicators of patient activity for Reading Hospital for each of the years ended June 30, 2015, 2016 and 2017. **The following utilization statistics do not include the New Hospital Entities.**

Utilization Statistics

	Years Ended June 30		
	2015	**2016**	**2017**
Beds in Service:			
Medical/Surgical	418	418	463
Obstetrics/Gynecology	60	60	60
NICU	30	30	30
Pediatrics	19	19	19
Skilled Nursing	50	50	50
Acute Rehab	62	62	62
Psych	40	40	40
Total Acute Skilled Rehab Psych	679	679	724
Newborn	34	34	34
Total	713	713	758
Admissions:			
Medical/Surgical	21,862	23,216	24,638
Obstetrics/Gynecology	3,776	3,911	3,869
NICU	363	335	312
Pediatrics	866	1,127	1,105
Skilled Nursing	1,407	1,407	1,401
Acute Rehab	1,529	1,496	1,463
Psych	1,268	1,368	1,370
Subtotal	31,071	32,860	34,158
Newborn	3,236	3,235	3,246
Total	34,307	36,095	37,404

Patient Days:			
Medical/Surgical	100,033	100,027	110,787
Obstetrics/Gynecology	9,756	9,911	9,794
NICU	7,162	8,515	7,590
Pediatrics	2,159	2,541	2,115
Skilled Nursing	17,476	17,500	17,307
Acute Rehab	17,479	16,923	17,943
Psych	11,767	11,367	12,309
Subtotal	165,832	166,784	177,845
Newborn	6,335	6,052	6,125
Total	172,167	172,836	183,970
Acuity:			
Case Mix Index	1.42	1.40	1.43
Length of Stay:			
Medical/Surgical	4.58	4.31	4.50
Obstetrics/Gynecology	2.58	2.53	2.53
NICU	19.73	25.42	24.33
Pediatrics	2.49	2.25	1.91
Skilled Nursing	12.42	12.44	12.35
Acute Rehab	11.43	11.31	12.26
Psych	9.28	8.31	8.98
Total	5.34	5.08	5.21
Newborn	1.96	1.87	1.89
Total	5.02	4.79	4.92
Occupancy Rates:			
Medical/Surgical	66%	65%	65%
Obstetrics/Gynecology	45%	45%	45%
NICU	65%	78%	69%
Pediatrics	31%	37%	30%
Skilled Nursing	96%	96%	95%
Acute Rehab	77%	75%	79%
Psych	81%	78%	84%
Total	67%	67%	67%
Newborn	51%	49%	49%
Total	66%	66%	66%

Sources of Revenue

Reading Hospital's revenues come directly from patients, commercial insurance carriers or from governmental sources such as Medicare and Medicaid. The following is a summary of net patient service revenue by source for the years ended June 30, 2015, 2016 and 2017. **The following summary of net patient service revenue by source does not include data for the New Hospital Entities.**

	Years Ended June 30		
	2015	**2016**	**2017**
Medicare	31%	31%	32%
Medicaid	8%	10%	11%
Capital Blue Cross	15%	16%	16%
Highmark	19%	18%	15%
Other Commercial	23%	21%	22%
Self-Pay	4%	4%	4%
Total	100%	100%	100%

Medicare and Medicaid. Medicare and Medicaid are the commonly accepted names for hospital payment programs created by certain provisions of the Federal Social Security Act. Medicare is exclusively a Federal Program and Medicaid is a combined Federal and state program. Effective April 2015, the Medicaid program was expanded in the Commonwealth of Pennsylvania, which lowered the uninsured rate and increased the number of patients covered by Medicaid.

Highmark Blue Shield. Highmark Blue Shield reimburses Reading Hospital under an agreement which provides for payment based on a percentage of charges. The contract is evergreen with payment increases tied to increases in charges. The contract cycle is typically three years.

Capital Blue Cross. A fixed case rate payment for each MS DRG identified in the Medicare payment structure was established. The initial rates were determined at budget neutral levels relative to the expiring contract. An annual increase is applied at the contract anniversary based on a Bureau of Labor Statistics index. Outpatient activity continues to be reimbursed based on a percentage of charges.

Other Commercial, Non Governmental Insurers. United Healthcare, Cigna, Aetna, and Independence Blue Cross, HealthAmerica, Geisinger and EHP all have similar contracts based on a percentage of charges.

Non contracted Commercial Insurance. Other commercial insurance plans reimburse their subscribers or make direct payments to Reading Hospital for covered services at prevailing area room rates plus ancillary service charges, subject to various limitations, insurance provisions and deductibles.

Acquired Hospitals. The following is a summary of aggregate net patient service revenue for the Acquired Hospitals by source for the year ended June 30, 2016.

Name of Managed Care Payor	**Total Net Revenue**	**Percentage of Total**
Independence Blue Cross	$123,431,000	24.3%
All Other Commercial	90,127,001	17.8%
Medicaid	50,789,000	10.0%
Medicare	236,157,000	46.6%
All Other	6,441,000	1.3%
Total	$506,945,001	

On October 6, 2017, Independence Blue Cross ("Independence") and Tower Health agreed to a new three-year contract, effective October 1, 2017, that ensures that Independence customers continue to receive in-network health care coverage at Brandywine Hospital, Chestnut Hill Hospital, Jennersville Hospital, Phoenixville Hospital, and Pottstown Hospital. Reading Hospital will also remain in the Independence network.

Total Expenses

Operating margin from the Reading Health Obligated Group has improved and was 1%, 8% and 9% for the years ended June 30, 2015, 2016 and 2017, respectively, due to revenue growth and expenses decreasing as a percentage of total revenues and other support. The following are comparative summaries of consolidated expenses of the Reading Health Obligated Group for the years ended June 30, 2015, 2016 and 2017:

	Years ended June 30					
	2015		2016		2017	
	Dollars	% of Revenues	Dollars	% of Revenues	Dollars	% of Revenues
Expenses:						
Salaries and benefits	$ 403,986	50.6%	413,329	47.7%	452,907	48.4%
Supplies	134,813	16.9%	148,821	17.2%	150,830	16.1%
Utilities	10,466	1.3%	10,666	1.2%	10,946	1.2%
Interest	12,622	1.6%	9,587	1.1%	11,327	1.2%
Depreciation	77,791	9.8%	72,333	8.3%	77,908	8.3%
Purchased services	68,995	8.7%	72,054	8.3%	75,849	8.1%
Repairs and maintenance	29,761	3.7%	30,691	3.5%	30,895	3.3%
Other	50,000	6.3%	38,762	4.5%	38,530	4.1%
Acquisition related expenses	-	0.0%	-	0.0%	2,221	0.2%
Total expenses	$ 788,434	98.9%	796,243	91.8%	851,413	90.9%

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PENSION AND POST-RETIREMENT BENEFIT PLANS

(dollars in thousands)

Prior to June 30, 2016, substantially all employees of the System were covered under a qualified noncontributory defined benefit pension plan (the "Plan"). Pension costs are funded as accrued except when not permitted by regulations, such as full funding limitations. Unfunded prior service costs are amortized over an initial term of thirty years.

The System has effectively transitioned the retirement benefits for employees into a defined contribution plan as of June 30, 2016. Employees hired on or after July 1, 2013 have been enrolled in the defined contribution plan. Previous defined benefit participants hired on or before June 30, 2013, continued to accrue benefits in the existing defined benefit plan until June 30, 2016. As of July 1, 2016, all vested participant defined benefits remain accrued, but all current employees have now converted to and began to accumulate funds under the defined contribution plan. This action has effectively frozen the defined benefit plan as of June 30, 2016.

At June 30, 2016 and 2017, the Plan benefit obligations exceeded the fair value of plan assets by $325,912 and $252,256, respectively. The System also offers a supplemental employee retirement plan for certain members of upper management.

Tower Health is not assuming any outstanding pension obligations with respect to the former employees of the Acquired Hospitals.

FOUNDATION AND FUNDRAISING

(dollars in thousands)

Reading Hospital Foundation (the "Foundation"), created on January 21, 2015, is a nonprofit corporation operated for charitable purposes by supporting innovation, education and research in support of Reading Hospital and the community, and engaging in fundraising and related programs or activities benefiting Reading Hospital and its affiliated charitable organizations.

Donations to the Foundation are held in one or more investment accounts and are managed and administered by the Foundation for Reading Hospital's benefit. The Development Fund is designed to support patient care by utilizing donated funds to purchase equipment or initiate new programs focused on patients and their families. These include funds that may be restricted by donors for certain clinical areas, such as heart or oncology care, or to support ongoing education for health professionals through educational programs or scholarships. However, the majority of the Development Fund is unrestricted.

Reading Hospital also has a permanent endowment fund valued at $3,382. These endowments provide earnings that are used to offset annual scholarships and awards, continuing medical education programs, and/or medications and related support for patients with specific health conditions or needs.

The Foundation has established a Grants and Awards committee that accepts proposals twice annually from internal stakeholders for projects and programs that seek to advance innovation, education and research. To-date, over $750 has been awarded for projects that strive to advance health and transform lives in the community.

COMMUNITY BENEFIT

(dollars in thousands)

Rooted in the core values of Reading Hospital is the goal of improving the health and wellbeing of Reading Hospital's neighbors throughout the Berks County region. This is a tradition that dates back 144 years – to treat those served like family, to address issues outside our doors that impact health,

healing, and an improved quality of life for every individual regardless of background, or medical condition, or ability to pay. During the fiscal year ended June 30, 2016, Reading Hospital committed $170,600 to community benefit efforts that addressed specific community needs through a broad array of education, service, and outreach offerings. More than 200 programs and events reached approximately 56,000 individuals, and included free screenings, free immunizations, provision of information, sponsorship of support groups, and hosting educational programs.

In addition, during the fiscal year ended June 30, 2016, Reading Hospital provided $27,700 in charity care, $103,900 in unreimbursed government-sponsored care, and $9,200 to individuals unable or unwilling to pay. Another $4,900 of community benefit funding supported patient care community services, including free flu immunizations and screenings, free educational programs, and in-kind donations to agencies that support Reading Hospital in taking care of patients. The commitment for medical education and schools for providing future health professionals for the region totaled $20,300. $2,100 was committed to Cancer Clinical Research and Tumor Registry.

The Community Health Needs Assessment (CHNA), which is developed in conjunction with four other community organizations, the United Way of Berks County, the Berks County Community Foundation, the Berks Community Health Center and Penn State Health St. Joseph, is the primary driver of community initiatives and collaborations for Reading Hospital. The CHNA has identified four areas of priority that include: Addiction, Obesity/Overweight, Mental Health and Access to Care. Consistent with these priorities Reading Health has been designated as a Pennsylvania Center of Excellence (COE) to fight opioid abuse and awarded a grant to develop interventions to address the opioid crisis. In addition, Reading Hospital has also been awarded a 5-year grant from CMS to, provide core health-related social need services to 40% of high risk Berks County Medicaid and Medicare beneficiaries and reduce unnecessary emergency room utilization in the target population through more efficient provision of core and supplemental health-related social need services.

THE FRIENDS AND VOLUNTEER PROGRAM

(dollars in thousands)

The Friends of The Reading Hospital and Medical Center ("The Friends") is a voluntary group of individuals who support Reading Hospital's mission through the coordination of in service voluntarism, special event and project volunteers and group volunteers, as well as through fundraising for specific hospital projects. The Friends receive input and support through the Hospital employed Director and staff of the Volunteer Services Department. The Director has oversight of volunteer initiatives and reports to a Hospital Vice President. The Friends grew from a small group of volunteers who, in 1873, offered to make pillows, buy fruits and vegetables, and gather other donations to benefit the patients of The Reading Hospital. This early group, then called the Ladies' Advisory Committee, became The Ladies Auxiliary in 1890, later shortened to The Auxiliary of The Reading Hospital. In 2005, this name was changed to The Friends of The Reading Hospital, who continue to support the mission of Reading Hospital through fundraising, coordinating work groups, and recruiting and coordinating in service volunteers. The Friends raised $494 in FY17 through fundraising activities and events. The unrestricted funds are used for the following programs: Centering Parenting, Cold Cap Therapy for oncology patients, Patient Assistance Fund for cancer patients and HeartSAFE Berks County.

The Board of The Friends currently has 69 members.

In 2016-17, donated hours to support the Hospital mission totaled 69,416. 580 individuals volunteered their time: 345 in-service, onsite volunteers, 81 people participated in groups onsite, and 120 people volunteered offsite as knitters, sewers, or in support of The Friends events. 41 Friends reported hours, 7 of which also volunteered as an in-service volunteer.

INSURANCE AND LITIGATION

(dollars in thousands)

Medical Malpractice Considerations

Tower Health participates in the Pennsylvania Medical Care Availability and Reduction of Error Fund or Mcare Fund established under the Commonwealth of Pennsylvania. The Mcare Fund presently provides coverage excess of up to $500 to Tower Health's primary per occurrence retention (which is currently $500) with annual aggregate coverage of $1,500.

Tower Health established a self-insurance trust fund to provide protection against professional liability claims. The trust is actuarially funded on an annual basis to provide single limit professional liability coverage of $500 per occurrence and $4,500 in the annual aggregate for the Hospital and certain employees. For incidents occurring since April 30, 2009, Tower Health purchased commercial insurance to provide coverage on a claims made basis in an amount up to $25,000 in excess of a total retention of $3,000, $500 primary; $500 Mcare excess and a $2,000 self-insured buffer. Claim liabilities are presented gross of any insurance recoveries. Funding requirements of the plan are subject to increase depending on the plan's claim experience. Premium payments for the Mcare Fund are based upon each individually licensed healthcare provider's rating with the Joint Underwriters Association and the amount of the surcharge to be assessed is determined by the Mcare Fund on an annual basis.

Other Insurance Coverage

Tower Health carries liability insurance covering various risk exposures including employer's liability, automobile liability and aviation (helipad) liability, and self-insures for its general liability. These lines of coverage are part of an overall insurance program with a total annual aggregate amount of at least $25,000 through a combination of self-insurance and commercial insurance. Tower Health is self-insured for workers' compensation as part of its self-insurance program. In addition, Tower Health carries comprehensive policies of insurance to cover the facilities, equipment and other contents, and to cover potential directors and officers liability, security and privacy liability, and fiduciary liability.

Litigation

There is no litigation pending or threatened against Tower Health (other than claims for malpractice, against which Tower Health is insured) that management believes would adversely affect Tower Health's ability to meet its obligations in the event of an adverse result.

APPENDIX B

AUDITED CONSOLIDATED FINANCIAL STATEMENTS
OF TOWER HEALTH AND SUBSIDIARIES
FOR THE YEARS ENDED JUNE 30, 2017 AND 2016

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READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Consolidating Information

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

READING HEALTH SYSTEM AND SUBSIDIARIES

June 30, 2017 and 2016

Table of Contents

KPMG LLP
1601 Market Street
Philadelphia, PA 19103-2499

Independent Auditors' Report

The Board of Directors
Reading Health System:

We have audited the accompanying consolidated financial statements of Reading Health System and Subsidiaries, which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Reading Health System and Subsidiaries as of June 30, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audits were performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The Supplementary Consolidating Information is presented for the purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Philadelphia, Pennsylvania
September 27, 2017

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	55,535	117,814
Patient accounts receivable, less allowance for uncollectible accounts of $34,640 and $38,194, respectively		123,553	113,033
Other receivables		5,460	6,832
Inventories		15,034	14,127
Estimated third-party payor receivables		7,262	11,404
Prepaid expenses and other current assets		15,101	20,994
Assets whose use is limited – required for current liabilities:			
Self-insurance funding arrangements		7,482	10,711
Total current assets		229,427	294,915
Assets whose use is limited:			
Self-insurance funding arrangements		11,804	8,408
Under regulatory requirements		2,666	2,719
By board for capital improvements		857,972	775,662
Total assets whose use is limited, net of current portion		872,442	786,789
Restricted investments		28,149	25,640
Temporarily restricted funds		302	366
Property, plant and equipment, net		834,146	827,264
Investments in joint ventures		12,317	10,393
Other assets		5,387	9,599
Total assets	$	1,982,170	1,954,966

(continued)

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Liabilities and Net Assets		2017	2016
Current liabilities:			
Current installments of long-term debt	$	5,719	5,529
Accounts payable		54,756	60,399
Estimated third-party payor settlements		4,112	7,171
Current portion of estimated self-insurance costs		10,885	13,243
Accrued expenses		29,713	38,977
Accrued vacation		30,160	27,245
Other current liabilities		8,906	7,613
Total current liabilities		144,251	160,177
Long-term debt, net of current portion and unamortized discount/premium and deferred financing costs		568,800	574,368
Accrued pension liabilities		252,256	325,912
Deferred revenue		42,811	41,062
Other liabilities		2,694	2,563
Estimated self-insurance costs, net of current portion		37,499	47,955
Swap contracts		40,790	59,134
Total liabilities		1,089,101	1,211,171
Net assets:			
Unrestricted		862,951	720,076
Temporarily restricted		1,667	366
Permanently restricted		28,451	23,353
Total net assets		893,069	743,795
Total liabilities and net assets	$	1,982,170	1,954,966

See accompanying notes to consolidated financial statements.

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Unrestricted revenues and other support:		
Net patient service revenue	$ 1,045,331	975,705
Provision for uncollectible accounts	(47,592)	(51,468)
Net patient service revenue less provision for uncollectible accounts	997,739	924,237
Residential revenue	23,143	22,372
Other revenue	31,474	31,861
Total revenues and other support	1,052,356	978,470
Expenses:		
Salaries and benefits	595,442	540,385
Supplies	160,158	158,489
Utilities	12,465	12,282
Interest	12,524	10,840
Depreciation	84,039	78,385
Purchased services	90,176	86,134
Repairs and maintenance	32,131	32,046
Other	53,475	49,158
Acquisition related expenses	2,221	—
Total expenses	1,042,631	967,719
Income from operations	9,725	10,751
Nonoperating gains:		
Investment income	44,395	29,324
Change in fair value of swap contracts and net of settlement payments	9,598	(20,172)
Other-than-temporary impairment losses on investments	(4,111)	(9,228)
Other (losses) gains	(7,490)	1,200
Nonoperating gains, net	42,392	1,124
Excess of revenues, gains and other support over expenses	$ 52,117	11,875

See accompanying notes to consolidated financial statements.

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Unrestricted net assets:		
Excess of revenues, gains and other support over expenses	$ 52,117	11,875
Change in unrealized gains (losses) on investments, net	37,367	(32,136)
Change in pension liability	54,056	(169,690)
Net assets released from restriction and other	(665)	4
Increase (decrease) in unrestricted net assets	142,875	(189,947)
Temporarily restricted net assets:		
Contributions	1,549	18
Realized losses on investments	—	(13)
Net assets released from restrictions – for operations	(248)	(344)
Increase (decrease) in temporarily restricted net assets	1,301	(339)
Permanently restricted net assets:		
Contributions	2,211	853
Change in unrealized gains (losses) on investments, net	1,869	(209)
Change in beneficial interest in trusts	1,018	(933)
Increase (decrease) in permanently restricted net assets	5,098	(289)
Change in net assets	149,274	(190,575)
Net assets:		
Beginning of year	743,795	934,370
End of year	$ 893,069	743,795

See accompanying notes to consolidated financial statements.

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Cash flows from operating activities:		
Change in net assets	$ 149,274	(190,575)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Change in unrealized gains (losses) on investments and beneficial interest in trusts	(40,254)	33,278
Change in fair value of swap contracts	(18,344)	10,431
Amortization of bond discount	77	77
Amortization of bond premium	(212)	(212)
Amortization of deferred financing costs	285	193
Change in pension liability, net	(73,656)	153,527
Depreciation	84,039	78,385
Amortization of entrance fees	(4,972)	(4,849)
Proceeds from entrance fees and deposits	6,165	6,316
Provision for uncollectible accounts	47,592	51,468
Investment income	(44,048)	(22,660)
Equity in earnings of affiliates	(2,987)	(1,449)
Restricted contributions	(3,760)	(871)
Change in cash due to changes in operating assets and liabilities:		
Receivable from patients and others	(56,740)	(45,976)
Receivable from affiliates	—	720
Inventories	(907)	556
Prepaid expenses and other assets	11,470	(14,663)
Accounts payable and other liabilities	12,207	21,075
Estimated self-insurance costs	(12,814)	2,853
Deferred revenue	1,104	970
Third-party payor settlements	1,083	(7,674)
Net cash provided by operating activities	54,602	70,920
Cash flows from investing activities:		
Acquisition of property, plant and equipment	(113,696)	(166,244)
Investment in equity investees	(2,000)	—
Distribution from equity investees	3,063	2,633
Sales of investments and assets whose use is limited, net	167,460	449,680
Purchases of investments and assets whose use is limited, net	(168,027)	(271,088)
Net cash (used in) provided by investing activities	(113,200)	14,981
Cash flows from financing activities:		
Restricted contributions and investment income received	2,395	871
Repayment of refinanced long-term debt	—	(174,200)
Proceeds from long-term debt issuance	—	175,165
Increase deferred financing costs	—	(990)
Payments of long-term debt	(5,528)	(5,274)
Refunds of entrance fees and deposits	(548)	(664)
Net cash used in financing activities	(3,681)	(5,092)
Net (decrease) increase in cash and cash equivalents	(62,279)	80,809
Cash and cash equivalents:		
Beginning of year	117,814	37,005
End of year	$ 55,535	117,814
Supplemental cash flow information:		
Cash paid during the year for interest, net of capitalized interest of $5,790 and $6,851 for 2017 and 2016	$ 12,424	10,540
Fixed asset additions included in accounts payable and accrued expenses at June 30	5,515	28,290

See accompanying notes to consolidated financial statements.

(1) Organizational Structure and Nature of Operations

Reading Health System (Parent) is a tax-exempt not-for-profit corporation under Section 501(c)(3) of the Internal Revenue Code. The Parent is located in West Reading, Pennsylvania, and provides inpatient, outpatient and emergency care for residents of the greater Berks County area through its subsidiaries (collectively, the System).

(a) Subsidiaries of the Parent Include:

Reading Hospital (Hospital), a tax-exempt not-for-profit corporation providing acute and post-acute care.

Reading Health Physician Network (RHPN), a tax-exempt entity established on July 1, 2015 through consolidation of Reading Professional Services (RPS) and The Reading Hospital Medical Group (TRHMG) to assure access to high quality primary care physicians and specialty physicians in sufficient numbers to meet the community needs for charitable, educational, and scientific purposes. RHPN also recruits physicians and provides administrative services for the Hospital, including supervision and instruction for medical students completing their residency training.

The Highlands at Wyomissing (The Highlands), a not-for-profit corporation, is a fully controlled entity of the Parent. The purpose of The Highlands is to operate a continuing care retirement community including residential, recreational and health care facilities and services specially designed to meet the physical, social and psychological needs of elderly persons. The Highlands facility is located in Wyomissing, Pennsylvania, and its residents are principally from the Wyomissing and Reading, Pennsylvania, area. The facility contains 285 residential living units, an 80-bed skilled nursing unit, and 66 personal care units. Certain members of the Board of Directors from the Hospital are also members of the Board of Directors of The Highlands.

Reading Health Partners (RHP), a Pennsylvania limited liability company, was formed to develop a physician network working in conjunction with the Parent to implement a clinical integration program. Clinical integration is the implementation of an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and improve the quality and efficiency of health care in the community.

Reading Health System Foundation (RHF), a not-for-profit corporation to support research, education, innovation and fund raising in support of the Parent and its' subsidiaries, and the community. The Parent is the sole member of RHF.

(b) Other Noncontrolled Entities Include:

Berkshire Health Partners (BHP) is licensed by the Commonwealth of Pennsylvania as a fully integrated, nonrisk bearing preferred provider organization. A not-for-profit corporation in Pennsylvania, BHP was established by hospitals and physicians and offers a provider network of physicians, hospitals and ancillary providers and services. Certain members of the Hospital's Board of Directors are directors of BHP. During the year ended June 30, 2017, Berkshire Health Partners became wholly owned by Reading Hospital. Prior to consolidation, this investment was recorded under the equity method of accounting and

is included in investments in joint ventures on the accompanying consolidated balance sheet, $677 in 2016.

The Reading Hospital Surgicenter at Springridge, LLC (Springridge, LLC), a limited liability company, was established to provide ambulatory surgery services to the surrounding community. The Hospital maintains a 50% ownership under the equity method of accounting. In the years ended June 30, 2017 and 2016, the Hospital received a distribution of, $3,063 and $2,633, respectively. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $1,065 and $953 in 2017 and 2016, respectively.

The Parent, along with several other acute care service hospitals throughout the central Pennsylvania area, contributed capital to form Central Pennsylvania Alliance Laboratories (CPAL), a joint venture to combine laboratory operations. The Parent maintains a 20% ownership interest in CPAL. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $350 and $350 in 2017 and 2016, respectively.

The Parent's ownership of Central Pennsylvania Homecare, Inc. (d.b.a. Affilia Home Health, AHH) is 44.1%. AHH provides visiting home nursing services to outpatients of the Hospital and other healthcare providers in the surrounding community. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $6,163 and $6,948 in 2017 and 2016, respectively.

The Parent is a 20% owner of Quest Behavioral Health, Inc. (Quest). Quest is a not-for-profit corporation providing full service managed behavioral healthcare. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $84 and $77 in 2017 and 2016, respectively.

Horizon is a for-profit limited liability partnership of which the Parent is a 25% owner. The investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $1,204 and $861 in 2017 and 2016, respectively.

AllSpire Health Partners, LLC is an alliance of five systems in New Jersey and Pennsylvania for which the Parent is a 20% owner. The consortium will carry out joint activities in traditional areas of patient care services, research and education to enhance the value of health care that communities receive. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $596 and $527 in 2017 and 2016, respectively.

Allspire Health GPO, LLC formed May 31, 2016 is an alliance of the five system's that are part of AllSpire Health Partners, LLC for which the Parent is a 20% owner. The alliance was created to help manage the expenses by group purchasing volumes, streamline suppliers and implementations efficiencies across all partners. The goal is to identify clinical optimization and revenue opportunities to give access of quality products to providers and patients. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $854 in 2017.

UPMC (University of Pittsburgh Medical Center) Health Plan and the Parent created a joint venture on January 1, 2017, which each member is a 50% equity owner. UPMC Health Plan provides third party administration and flexible spending account administration services for the System. Additional benefits result in enhanced cost savings, value based healthcare to residents and companies in the greater Berks County area and access to the System as an in-network provider. This investment is recorded under the equity method of accounting and is included in investments in joint ventures on the accompanying consolidated balance sheets, $2,001 in 2017.

(2) Summary of Significant Accounting Policies

Basis of Accounting

These consolidated financial statements have been prepared on the accrual basis of accounting in conformity with U.S. generally accepted accounting principles (GAAP). The significant accounting policies followed by the System are as follows:

(a) Principles of Consolidation

The consolidated financial statements of the System include the accounts of the Parent, the Hospital, RHPN, The Highlands, RHP, and RHF. All entities where the Parent or Hospital exercises significant influence but for which it does not have control are accounted for under the equity method. All significant intercompany balances and transactions have been eliminated.

(b) Use of Estimates

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

(c) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less. At June 30, 2017 and 2016, the System had cash balances in financial institutions that exceeded federal depository insurance limits. Management believes that the credit risk related to these deposits is minimal.

(d) Net Service Revenue and Accounts Receivable

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

(Dollars in thousands)

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, the System recognizes revenue based on established rates, subject to certain discounts as determined by the System. An estimated provision for uncollectible accounts is recorded that results in net patient service revenue being reported at the net amount expected to be received. The System has determined that patient service revenue primarily is recorded prior to assessing the patient's ability to pay, and, as such, the entire provision for uncollectible accounts related to patient revenue is recorded as a deduction from patient service revenue in the consolidated statements of operations. Patient service revenue, net of contractual allowances and discounts (but before the provision for uncollectible accounts), for the years ended June 30, 2017 and 2016 from its major payor sources are as follows:

	2017	2016
Medicare	32%	32%
Medical assistance	11	7
Blue Cross	35	35
Commercial insurance	16	15
Self-pay	4	6
Other	2	5
	100%	100%

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectability of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for uncollectible accounts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for uncollectible accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

(Dollars in thousands)

(e) Inventories

Inventories are stated at lower of cost (determined by the first-in, first-out method) or market.

(f) Assets Whose Use is Limited

Assets whose use is limited includes designated assets set aside by the Board of Directors for future capital improvements, assets held by trustees under indenture agreements and self-insurance trust arrangements and are considered available-for-sale investments. The Board of Directors retains control over Board-designated assets and may at its discretion subsequently use these assets for other purposes.

Assets whose use is limited includes cash and cash equivalents, marketable securities (including U.S. government and government agencies, corporate, state and local government), marketable equity securities (including common, preferred, and foreign stock), exchange traded/listed mutual funds (including fixed income funds), hedge funds, private equity funds, and limited partnerships.

The Pennsylvania Continuing Care Provider Registration and Disclosure Act requires a statutory reserve equivalent to the greater of the total of debt service payments due during the next 12 months on account of any loan, or 10% of the projected annual operating expenses of the facilities exclusive of depreciation, computed only on the proportional share of financing or operating expenses that is applicable to residents under entrance agreement contracts. For the System, this statutory requirement applies only to The Highlands. This statutory reserve requirement is considered to be fulfilled from board-designated funds included within assets limited as to use under regulatory requirements.

The calculation of the 10% of the annual operating expenses for the fiscal year ended June 30, 2018 is as follows:

Budgeted operating expenses for fiscal year ended June 30, 2018	$	28,006
Less budgeted depreciation and amortization expense		4,034
Net budgeted operating expenses for fiscal year ended June 30, 2018		23,972
Required reserve as of July 1, 2017 (10%)	$	2,397

The principal and interest due in the next 12-month period for long-term financing of The Highlands, which is the greater of the two options and is calculated as follows:

Principal due	$	1,522
Interest due		1,144
Required reserve as of July 1, 2017	$	2,666

(Continued)

In addition, The Pennsylvania Continuing Care Provider Registration and Disclosure Act requires that the provider establish an interest-bearing escrow account with a bank, trust company or other escrow agent approved by the commissioner for any entrance fees or payments that are in excess of 5% of the then existing entrance fee for the unit, which are received by the provider prior to the date the resident is permitted to occupy the living unit in the facilities. As of June 30, 2017 and 2016, respectively, The Highlands maintains an escrow account of $371 and $296 and is included in prepaid expenses and other current assets on the accompanying consolidated balance sheets.

(g) Investments and Investment Income

Investment income earned on securities (interest and dividends) is reported in the nonoperating gains (losses) section of the consolidated statements of operations within investment income. Realized gains or losses related to the sale of investments, impairment losses on other than trading investments, and unrealized gains or losses on alternative investments, are included in the nonoperating gains (losses) section of the consolidated statements of operations in investment income unless the income or loss is restricted by donor or law.

Investments in equity securities with readily determinable fair values and all investments in debt securities are recorded at fair value in the consolidated balance sheets. These securities have been classified as other than trading, and changes in unrealized gains on these instruments are included in the consolidated statements of changes in net assets. Unrealized losses are included in the consolidated statements of operations within nonoperating gains (losses) as other than temporary impairment on other than trading investments.

The fair value option for financial assets and liabilities permits the System to elect to measure eligible items at fair value on an instrument by instrument basis. If elected, this option requires the System to report the unrealized gains and losses on these instruments as part of the performance indicator. Once elected, the fair value option is irrevocable for that instrument. Alternative investments include investments in managed funds, which include hedge funds, private equities, limited partnerships, and other investments that do not have readily determinable fair values and may be subject to withdrawal restrictions. Investments in hedge funds, private equities, limited partnerships, and other investments in managed funds (collectively Alternative Investments) are accounted for using the fair value option. The unrealized gains or losses from these Alternative Investments are included in the consolidated statements of operations as part of nonoperating gains (losses) within investment income.

(h) Fair Value Measurements

The System follows the provisions of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurement* (ASC 820), which defines fair value as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in an orderly transaction between market participants at the measurement date. ASC 820 also establishes a framework for measuring fair value using valuation techniques such as the market approach, cost approach, and income approach, and making disclosures about fair value measurements.

ASC 820 emphasizes that fair value is a market-based measurement, not an entity specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing an asset or liability. As a basis for considering market participant assumption in fair value measurements, ASC 820 defines a three-level fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity and the reporting entity's own assumptions about market participants. The fair value hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

Level 1 – Inputs utilized quoted market prices in active markets for identical assets or liabilities that the System has the ability to access.

Level 2 – Inputs may include quoted prices for similar assets and liabilities in active markets, as well as inputs that are observable for the asset and liability (other than quoted prices) such as interest rates, foreign exchange rates, and yield curves that are observable at commonly quoted intervals.

Level 3 – Inputs are unobservable inputs for the asset or liability, which is typically based on an entity's own assumptions, as there is little, if any, related market activity.

In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the Level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest Level input that is significant to the fair value measurement in its entirety. The System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

Where quoted prices are available in an active market, investments are classified in Level 1 of the valuation hierarchy. Investments in Level 1 include cash, exchange-traded equity securities, and mutual funds with a published daily net asset value or its equivalent (NAV). Investments in Level 2 include financial instruments valued based on quoted market prices for identical securities in markets that are not active, quoted prices for similar securities in markets that are active, broker or dealer quotations or alternative pricing sources with reasonable levels of price transparency. If quoted prices are not available, other accepted valuation methodologies, such as interest rates, observable yield curves and spreads may be used to determine fair value. Level 2 includes state and municipal government securities, corporate and foreign bonds, U.S. Government securities, and certain mutual and fixed income funds that permit daily redemptions but whose NAV is not published. Auction rate securities are estimated using the income approach. This approach uses estimation techniques to determine the estimated future cash flows of the respective asset or liability expected by a market participant and discounts those cash flows back to present value.

The fair values of Alternative Investments have been estimated by management based on all available data, including information provided by third-party pricing vendors, fund managers and general partners. Alternative Investments are recorded at fair value based on the NAV as a practical expedient, as provided by the respective general partner or fund administrator of the individual Alternative Investment funds. The System believes the fair value of Alternative Investments in the consolidated balance sheets is a reasonable estimate of its ownership interest in the Alternative Investment funds. As part of the System's

(Dollars in thousands)

overall valuation process, management evaluates these third-party methodologies to ensure that they are representative of exit prices in the security's principal markets.

These valuation methods may produce a fair value estimate that may not be reflective of future fair values. Furthermore, while the System believes that its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value could result in a materially different estimate of fair value at the reporting date.

(i) Property, Plant and Equipment

Property, plant and equipment are carried at cost, less accumulated depreciation. Expenditures that substantially increase the useful lives of existing assets are capitalized. Routine maintenance and repairs are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of each class of depreciable asset. Useful lives range as follows:

Land improvements	5–25 years
Buildings and building improvements	10–40 years
Fixed equipment	5–10 years
Movable equipment (including software and hardware)	3–10 years

Gains and losses resulting from the retirement or sale of property, plant and equipment are included in the consolidated statements of operations. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Gifts of long-lived operating assets such as land, buildings or equipment are reported as unrestricted contributions and are excluded from the performance indicator unless explicit donor stipulations specify how the donated asset must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of such assets may not be recoverable. Management has reviewed the carrying amount of these assets and has determined that they are not currently impaired.

(j) Deferred Financing Costs

Deferred financing costs are amortized over the period the debt is outstanding using the straight-line method, which approximates the effective interest method. Amortization of deferred financing costs totaled $285 and $193 for the years ended June 30, 2017 and 2016, respectively. Accumulated amortization totaled $1,154 and $869 as of June 30, 2017 and 2016, respectively.

(Continued)

(k) Estimated Self-Insurance Costs

The provision for estimated self-insured claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The System self-insures its medical malpractice, general liability, and workers' compensation risks. Reserve estimates are subject to the impact of changes in claim trends as well as prevailing social, economic, and legal conditions. The ultimate net cost of settling these liabilities may vary from the estimated amounts. Accordingly, reserve estimates are continually reviewed and updated, and any resulting adjustments are reflected in the performance indicator.

(l) Accrued Vacation

The System records a liability for amounts due to employees for future paid leave, which are attributable to services performed in the current and prior periods.

(m) Bond Premium and Discounts

Bond premiums and discounts are amortized to interest and expensed as direct additions or reductions of the carrying values of the related debt instruments from which the discounts or premiums arose. Bond premiums and discounts are amortized to interest expense over the period during which the debt is outstanding using the straight-line method, which approximates the effective interest method.

(n) Derivative Instruments

The System follows accounting guidance on derivative financial instruments that is based on whether the derivative instrument meets the criteria for designation as cash flow and for designating a derivative as a hedge includes the assessments of the instruments effectiveness in risk reduction, matching the derivative instrument to its underlying transactions and the assessment of the probability that the underlying transaction will occur. All of the System's derivative financial instruments are interest rate swap agreements without hedge accounting designation.

Entering into interest rate swap agreements involves, to varying degrees, elements of credit, default, prepayments, and market risk in excess of the amounts recognized on the consolidated balance sheets. Such risks involved the possibility that there will be no liquid market for these arrangements, the counterparty to these arrangements may default on its obligations to perform, and there may be unfavorable changes in interest rates. The System does not hold derivative instruments for the purpose of managing credit risk and enters into derivative transactions with high quality counterparties.

The interest rate swap agreements entered into by the System are adjusted to market value based upon quotations from the counterparties and a credit valuation adjustment is applied to the valuations of the swaps which takes into consideration counterparty risk of default. The change in market value is recorded in the consolidated statements of operations within excess of revenues, gains (losses), and other support over expenses.

(o) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the System have 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 System in perpetuity.

(p) Residential Revenue and Deferred Revenue

Entrance fees paid by residents of The Highlands' independent living units are recorded as deferred revenue. Entrance fees are amortized to income using the straight-line method over the estimated remaining life expectancy of the resident for amounts nonrefundable. In addition, for all contracts entered into prior to January 1, 2005, a portion equal to 30% of the entrance fee, referred to as the health fund is reserved to be accounted for individually for each resident/couple and is refundable to the extent not amortized. Amortization of the health fund occurs when a resident utilizes health services (nursing or personal care).

The Highlands' entrance fees are refundable for a period of time up to 50 months. During this time, for refund purposes only, a resident's entrance fee is amortized at the rate of 2% per month for 50 months beginning on the date of occupancy. The Highlands has deferred revenue pertaining to entrance fees of $37,568 and $36,533 at June 30, 2017 and 2016, respectively. The amount of entrance fees, which is refundable to residents at June 30, 2017 and 2016 under contractual refund provisions, was approximately $15,556 and $14,950, respectively.

(q) Other Revenue

Significant components of other revenue include rental income on leased properties, tuition revenue for The Reading Hospital School of Health Sciences, and cafeteria revenues.

(r) Donor Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital and RHF are reported at estimated fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at estimated fair value at the date the gift is received.

Contributions are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated statements of operations.

(s) Income Taxes

The System is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. On such a basis, the exempt entities do not incur liability for federal income taxes, except in the case of unrelated business income.

The System evaluates uncertain tax positions using a two-step approach for recognizing and measuring tax benefits taken or expected to be taken in an unrelated business activity tax return and disclosures regarding uncertainties in tax positions. No adjustments to the consolidated financial statements were required as a result of this evaluation.

(t) Uncompensated Care and Community Service

The System provides services to patients who meet the criteria of its charity service policy without charge or at amounts less than the established rates. Criteria for charity care consider the patient's family income, family size, and ability to pay. Individuals who qualify for charity care do not have insurance or other coverage.

The System maintains records to identify and monitor the level of charity care and community service it provides. These records include the amount of charges foregone based on established rates for services, and supplies furnished under its charity care, community service policies, and the estimated cost of those services.

Charges foregone for uncompensated care as determined in accordance with the System's policies were approximately $9,244 and $11,613 in the years ended June 30, 2017 and 2016, respectively. Direct and indirect costs to provide these services were approximately $3,005 and $4,183 for the years ended June 30, 2017 and 2016, respectively. The estimated costs were based on a calculation, which multiplied the cost to charge ratio by the gross charges associated with providing uncompensated care to patients. The cost to charge ratio was obtained from our most recently filed Medicare cost report.

Additionally, the System sponsors certain other service programs and charity services, which provide substantial benefit to the broader community. Such programs include services to needy populations requiring special services and support, community service programs and charity services, as well as health promotion and education.

The System's community service includes the Medical Assistance program, which makes payment for services provided to families with dependent children, the aged, the blind, and the permanently and totally disabled, whose income and resources are insufficient to meet the costs of necessary medical services. Payments from the Medical Assistance program are generally less than the System's cost of providing the service.

In addition, community service represents the cost to deliver services to the community, net of any payment received for those services. Included in these services are the System's subsidies of outpatient clinics, education of medical professionals who work with various health care providers in the community upon graduation and community mental health programs. The System also sponsors health fairs and other wellness programs throughout the community.

(u) Excess of Revenue, Gains and Other Support over Expenses

The consolidated statements of operations include the excess of revenues, gains and other support over expenses. Changes in unrestricted net assets that are excluded from this performance indicator, consistent with industry practice, include changes in unrealized gains (losses) on marketable securities classified as other than trading securities, adjustments for defined benefit and other postretirement benefits, and contributions of long-lived assets (including assets acquired using contributions, which by donor-restriction were to be used for the purposes of acquiring such assets).

(v) Future Service Obligations

The Highlands' annually calculates the present value of the net cost of future services using a discount rate of 5.5% and compares that amount with the balance of deferred revenue from entrance fees. If the present value of the net cost of future services and the use of facilities exceeds the deferred revenue from entrance fees, a liability would be recorded (obligation to provide future services and use of facilities) with the corresponding charge to income. As a result of the calculation, the present value of the net cost of future services did not exceed deferred revenue; accordingly, no obligation was recorded at June 30, 2017 and 2016.

(w) Recent Accounting Pronouncements

In May 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers*, (ASU 2014-09) which changes the requirements for recognizing revenue when entities enter into contracts with customers. Under ASU 2014-09, an entity will recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The adoption of ASU 2014-09 is effective for annual and interim periods beginning after December 15, 2017 and early adoption is not permitted. The System is still evaluating the effect, if any, ASU 2014-09 will have on the System's consolidated financial condition and results of operations.

In April 2015, the FASB issued ASU No. 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, (ASU 2015-03). This ASU requires an entity to present debt issuance costs as a direct deduction from the carrying amount of the related debt liability, consistent with debt discounts. The costs will continue to be amortized to interest expense using the effective interest method. The adoption of ASU 2015-03 is effective for fiscal years beginning after December 15, 2015, and interim periods within those fiscal years, with early adoption permitted. This ASU requires retrospective application to all prior periods presented in the financial statements. The adoption of ASU 2015-03 during the reporting period ended June 30, 2017 resulted in a decrease in deferred financing costs, net and long-term debt, net of current portion of $4,980 and $5,265 as of June 30, 2017 and 2016, respectively.

In January 2016, the FASB issued ASU No 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01), which changes the income statement impact of equity investments held by an entity, and the recognition of changes in fair value of financial liabilities when the fair value option is elected. The adoption of ASU 2016-01 is effective for fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. Early adoption is permitted for fiscal years beginning after December 15, 2017. The System is currently assessing the impact of the adoption of ASU 2016-01 and the impact it will have on the System's consolidated financial condition and results of operations.

In February 2016, the FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02), which will require lessees to recognize most leases on-balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information about an entity's leasing activities, and will require changes in processes and internal controls. The

adoption of ASU 2016-02 is effective for annual and interim periods beginning after December 15, 2018, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The System is currently assessing the impact of the adoption of ASU No. 2016-02, which is expected to have a material impact on the System's consolidated financial condition and results of operations.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements for Not- For-Profit Entities*, which will require not-for-profit entities to revise financial presentation to include: net asset classifications, provide quantitative and qualitative information as to available resources and management of liquidity and liquidity risk, information on investment expenses and returns, and the presentation of operating cash flows. The standard aims to help the reader of the financial statements to better understand the financial position of the organization and enhance consistency among similar organizations. ASU 2016-02 is effective for annual periods beginning after December 15, 2017. Early adoption is permitted. The System is currently assessing the impact ASU 2016-14 will have on its consolidated financial condition and results of operations.

In March 2017, the FASB issued ASU No. 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost* (ASU 2017-07). This new guidance requires the disaggregation of the service cost component from the other components of net benefit cost. The service cost component of net benefit cost is to be reported in the same line item on the consolidated statement of operations as other compensation costs arising from services rendered by the pertinent employees, while the other components of net benefit cost are to be presented in the consolidated statement of operations separately, outside a subtotal of operating income. The amendments also provide explicit guidance to allow only the service cost component of net benefit cost to be eligible for capitalization. This new guidance is effective for annual periods beginning after December 15, 2018, and interim periods within annual periods beginning after December 15, 2019, with the adoption of the change in presentation of net benefit cost in the consolidated statement of operations to be applied retrospectively, and the change in capitalization for only service cost applied prospectively. The guidance allows a practical expedient that permits the use of the amounts disclosed in the retirement benefits footnote for the prior comparative periods as the estimation basis for applying the retrospective presentation requirements. The System early adopted the provisions of ASU 2017-07 for the reporting period ended June 30, 2017 an the provisions were retrospectively applied using the practical expedient, resulting in a (decrease) increase to salaries and benefits of ($3,952) and $1,415 for the years ended June 30, 2017 and 2016, respectively.

(x) Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation due to retrospective application of ASU 2015-03 and ASU 2017-07 described in note 2(w).

(3) Pending Transactions

On May 30, 2017, the System and subsidiaries of Community Health Systems signed an Asset Purchase Agreement for the System to acquire five Pennsylvania hospitals. The five hospitals include: Brandywine Hospital in Coatesville; Phoenixville Hospital in Phoenixville; Pottstown Memorial Medical Center in Pottstown; Jennersville Regional Hospital in West Grove; and Chestnut Hill Hospital in Philadelphia. The

transaction is expected to close during the year ended June 30, 2018, subject to customary regulatory approvals and closing conditions.

On June 19, 2017, the System and The Highlands signed an Agreement of Sale and Purchase of Controlling Interest for the Highlands to spin-off and operate independently of the System. The transaction is expected to close during the year ended June 30, 2018, subject to customary regulatory approvals and closing conditions.

On September 14, 2017, the System announced that it is currently evaluating a plan to access the tax-exempt municipal securities market through the issuance of revenue bonds in a principal amount not to exceed $625,000 by the Berks County Industrial Development Authority in the quarter ended December 31, 2017.

(4) Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows.

(a) Medicare and Managed Medicare

Inpatient acute care and rehabilitation services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are reimbursed by Medicare under the Ambulatory Payment Classification System. The System is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare fiscal intermediary. The System's classification of patients under the Medicare program and the appropriateness of their admission are subject to medical necessity reviews by independent organizations under contract with the Center for Medicare and Medicaid Services (CMS). The System has received settlements on Medicare cost reports through June 30, 2014.

(b) Medicaid and Managed Medicaid

On December 29, 2010, the Pennsylvania Department of Human Services (DHS) received approval from the Centers for Medicare & Medicaid Services for the state plan amendments pursuant to Act 49 of 2010, passed by the Pennsylvania General Assembly on July 3, 2010, which established a new inpatient hospital fee for service payment system, new supplemental payments and the waiver to establish the statewide Quality Care Assessment. DHS also received approval on final language for the DHS contracts with managed care organizations. The estimated net impact on the System for the years ended June 30, 2017 and 2016, was $9,479 and $7,506, respectively, (based on total payment increases of $25,117 and $23,156, offset by assessments of $15,638 and $15,650), respectively.

(c) Nongovernmental Payors

Inpatient services rendered by nongovernmental payors are reimbursed at negotiated rates. The System continues to be reimbursed for outpatient services at a negotiated percentage of covered charges.

(d) Workers' Compensation

The payment method by which all employers and/or insurers of workers' compensation policies will pay for the services provided by health care providers to employees covered by workers' compensation is a percentage of the Medicare payment for these services.

(e) Other Contractual Arrangements

The System has various payment agreements with preferred provider organizations and health maintenance organizations. The basis for payment under these agreements includes discounts from established charges.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at the time. Recently, government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed.

(Continued)

(Dollars in thousands)

(5) Assets Whose Use is Limited and Investments

Assets whose uses are limited and that are required for obligations classified as current liabilities are reported as current assets. The composition of assets whose uses are limited at June 30, is set forth in the following tables.

	2017	2016
Self-insurance funding arrangements:		
Cash and cash equivalents	$ 142	26
U.S. government securities	8,980	9,088
Corporate bonds	9,713	9,622
Equity mutual funds	451	383
Total assets whose use is limited under self-insurance funding arrangements	$ 19,286	19,119
By board for capital improvements and under regulatory requirements:		
Cash and cash equivalents	$ 20,657	8,402
State, municipal government, and auction rate securities	8,158	8,216
Common, foreign, and preferred stock	11,694	26,482
Equity mutual funds	375,114	305,704
Fixed income mutual funds	276,961	243,259
Hedge, private equity, common collective trust funds	168,054	186,318
Total assets whose use is limited by the board for capital improvements and under regulatory requirements	$ 860,638	778,381

(Continued)

(Dollars in thousands)

	2017	2016
Temporarily restricted investments:		
Cash and cash equivalents	$ 302	366
Total temporarily restricted funds	$ 302	366
Restricted investments		
Cash and cash equivalents	$ 27	526
U.S. government securities	2,492	1,951
Corporate and foreign bonds	1,220	989
Common, foreign, and preferred stock	6,544	6,090
Equity mutual funds	2,257	1,493
Beneficial interest in trusts	15,609	14,591
Total restricted investments	$ 28,149	25,640

A summary of the System's total investment return for the years ended June 30 as reflected in the consolidated statements of operations and consolidated statements of changes in net assets is as follows:

	2017	2016
Interest, dividends, and realized gains on investments, net	$ 32,054	18,943
Change in unrealized losses on nonalternative investments, net	39,236	(32,345)
Change in unrealized gains on Alternative Investments, net	12,341	10,368
Other-than-temporary impairment losses	(4,111)	(9,228)

The System's investments include a variety of financial instruments; the related values as presented in the consolidated financial statements are subject to various market fluctuations, which include changes in the equity markets, interest rate environment and general economic conditions.

The System performs an annual impairment analysis of its investments. On June 30 2017 and 2016, nonalternative investments with a fair value of $186,326 and $133,097, respectively, were in an unrealized loss position totaling $4,111 and $9,228, respectively. The unrealized losses on these investments were caused by general market conditions particularly in the commodities and emerging markets sectors. These investments were written down and shown as other-than-temporary impairment losses on investments in the consolidated statements of operations.

(Continued)

(Dollars in thousands)

The following table presents cost and fair value of assets whose use is limited and investments for June 30, 2017:

		Fair value	Cost
Cash and cash equivalents	$	21,128	21,128
State, municipal government, and auction rate securities		8,158	8,588
Corporate and foreign bonds		10,933	10,957
Common, preferred, and foreign stock		18,238	14,556
U.S. government securities		11,472	11,481
Equity mutual funds		377,822	307,235
Fixed income mutual funds		276,961	272,667
Hedge, private equity, and common collective trust funds		168,054	139,548
Beneficial interest in trusts		15,609	13,370
Total	$	908,375	799,530

The following table presents cost and fair value of assets whose use is limited and investments for June 30, 2016:

		Fair value	Cost
Cash and cash equivalents	$	9,320	9,320
State, municipal government, and auction rate securities		8,216	8,542
Corporate and foreign bonds		10,611	10,556
Common, preferred, and foreign stock		32,572	28,759
U.S. government securities		11,039	10,917
Equity mutual funds		307,580	278,045
Fixed income mutual funds		243,259	240,193
Hedge, private equity, and common collective trust funds		186,318	168,189
Beneficial interest in trusts		14,591	13,370
Total	$	823,506	767,891

(Continued)

(Dollars in thousands)

The following table represents the fair value measurement levels for all assets and liabilities, which the System has recorded at fair value on a recurring basis:

		2017		
	Fair value June 30, 2017	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant other unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 21,128	21,128	—	—
State, municipal government, and auction rate securities	8,158	—	8,158	—
Corporate and foreign bonds	10,933	—	10,933	—
Common, preferred, and foreign stock	18,238	18,238	—	—
U.S. government securities	11,472	—	11,472	—
Equity mutual funds	377,822	369,600	8,222	—
Fixed income funds	276,961	269,196	7,765	—
Hedge, private equity, and common collective trust funds (1)	168,054	—	—	—
Beneficial interest in trusts	15,609	—	—	15,609
Total investments	$ 908,375	678,162	46,550	15,609
Liabilities:				
Swap contracts	$ 40,790	—	40,790	—

(Continued)

(Dollars in thousands)

The following table represents the fair value measurement levels for all assets and liabilities, which the System has recorded at fair value on a recurring basis:

		2016		
	Fair value June 30, 2016	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant other unobservable inputs (Level 3)
Assets:				
Cash and cash equivalents	$ 9,320	9,320	—	—
State, municipal government, and auction rate securities	8,216	—	8,216	—
Corporate and foreign bonds	10,611	—	10,611	—
Common, preferred, and foreign stock	32,572	32,572	—	—
U.S. government securities	11,039	—	11,039	—
Equity mutual funds	307,580	302,511	5,069	—
Fixed income funds	243,259	230,463	12,796	—
Hedge, private equity, and common collective trust funds (1)	186,318	—	—	—
Beneficial interest in trusts	14,591	—	—	14,591
Total investments	$ 823,506	574,866	47,731	14,591
Liabilities:				
Swap contracts	$ 59,134	—	59,134	—

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

(Continued)

(Dollars in thousands)

Following is the summary of the inputs and valuation techniques as of and for the years ended 2017 and 2016 for valuing Level 2 financial instruments:

Financial instrument	Input	Valuation technique
State, municipal government, and auction rate securities	Broker/dealer	Income
Corporate and foreign bonds	Broker/dealer	Market
U.S. government securities	Broker/dealer	Market
Equity mutual funds and fixed income funds	NAV	Market/income
Swap contracts	Broker/dealer	Market

The following table represents the change in fair value for which fair value was measured under Level 3:

	Beneficial interests in trust
Fair value at June 30, 2015	$ 15,524
Net change in unrealized losses	(933)
Fair value at June 30, 2016	14,591
Net change in unrealized gains	1,018
Fair value at June 30, 2017	$ 15,609

Transfers between levels occur when there is a change in the observability of significant inputs. A transfer between Level 1 and Level 2 generally occurs when the availability of quoted prices changes or when market activity of an investment significantly changes to active or inactive. A transfer between Level 2 and Level 3 generally occurs when the underlying inputs become, or can no longer be, corroborated with market observable data. Transfers between levels are recognized on the date they occur. For the years ended June 30, 2017 and 2016, no transfers were made between any Levels.

(Continued)

The System holds instruments that calculate net asset value per share (or its equivalent) and do not have a readily determinable value are as follows as of June 30:

2017	Fair value	Unfunded commitments	Redemption frequency (if eligible)	Redemption notice period
	(In millions)			
a – Equity long/short hedge funds	$ 11.3	—	Monthly, quarterly, annually	45–65 days
b – Event driven hedge funds	8.7	—	Quarterly, annual rolling	60–65 days
c – Global opportunities hedge fund	7.8	—	Monthly	5–45 days
d – Multi-strategy hedge funds	47.2	—	Quarterly, semi-annually, annually, on anniversary, biannually	45–70 days
e – Real assets	12.4	0.8	Annually	90 days
f – Real estate funds	38.8	22.4	N/A	N/A
g – Private equity funds	41.9	13.3	N/A	N/A
Total	$ 168.1	36.5		

(Continued)

2016	Fair value	Unfunded commitments	Redemption frequency (if eligible)	Redemption notice period
	(In millions)			
a – Equity long/short hedge funds	$ 9.7	—	Monthly, quarterly, annually	45–65 days
b – Event driven hedge funds	9.2	—	Quarterly, annual rolling	60–65 days
c – Global opportunities hedge fund	5.7	—	Monthly	5–45 days
d – Multi-strategy hedge funds	64.4	—	Quarterly, semi-annually, annually, on anniversary, biannually	45–70 days
e – Real assets	12.9	1.7	Annually	90 days
f – Real estate funds	45.6	11.4	N/A	N/A
g – Private equity funds	38.8	25.7	N/A	N/A
Total	$ 186.3	38.8		

a. This class includes investments in hedge funds that invest both long and short in U.S. and foreign common stocks. Management of the hedge funds has the ability to shift investments from value to growth strategies, from small to large capitalization stocks and from a net long position to a net short position. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

b. This class includes investments in hedge funds that invest in equities and bonds to profit from economic, political and government driven events. A majority of the investments are targeted at economic policy decisions. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

c. This class includes investments in hedge funds that hold investments in U.S. and non-U.S. common stocks in the health care, energy, information technology, utilities and telecommunications sectors. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

d. This class invests in hedge funds that pursue multiple strategies to diversify risks and reduce volatility. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient. The remaining restriction period for these investments ranges from quarterly to biannually.

(Continued)

(Dollars in thousands)

e. This class includes funds with direct investments in global and energy infrastructure as well as in base and precious metals and investment securities of miners and associated mining equipment. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

f. This class includes real estate funds that invest in U.S. and non-U.S. residential and commercial properties as well as distressed real estate. The fair values of the investments in this class have been estimated using the net asset value of the System's ownership interest in partners' capital as a practical expedient. As of June 30, 2017 and 2016, certain investments in these funds have a 90-day redemption notice, but the fund manager can only accommodate redemption requests as liquid assets allow, approximately $8,500 and $16,600, respectively. The remaining funds will receive distributions from each fund as the underlying investments of the funds are liquidated. It is estimated that the underlying assets of these funds will be liquidated over the next 7 to 10 years, although these funds may liquidate early in the event of purchase by a third party or initial public offering.

g. This class includes private equity funds. These investments cannot be redeemed with the funds. Instead, the nature of the investments in this class is that distributions are received through the liquidation of the underlying assets of the fund. These funds are managed by two of the System's advisors with particular private equity experience in secondary market dealing. These funds could be subject to redemption to a third party buyer, but at June 30, 2017 and 2016, no funds were currently being evaluated this way. The fair values of the investments in this class have been estimated using the net asset value of the System's ownership interest in partners' capital as a practical expedient.

(6) Property, Plant and Equipment

Property, plant and equipment and related accumulated depreciation at June 30 consists of the following:

	2017	2016
Land and land improvements	$ 75,226	69,581
Buildings and improvements	771,378	603,609
Fixed equipment	405,037	275,846
Movable equipment (includes software and hardware)	531,043	478,587
Construction in progress	24,978	294,359
Property, plant and equipment before depreciation	1,807,662	1,721,982
Less accumulated depreciation	(973,516)	(894,718)
Property, plant and equipment, net	$ 834,146	827,264

Depreciation expense was $84,039 and $78,385 for the years ended June 30, 2017 and 2016, respectively.

(Continued)

(Dollars in thousands)

In August 2013, the Board of Directors of the System approved construction of a clinical building. The building sets forth plans for capital expenditures of more than $343,000 over a three year period, and includes significant capital improvements to the Reading Hospital's West Reading campus, 24 surgical suites, including six hybrid operating rooms; eight minor procedure rooms; and reception and recovery areas for individuals. At June 30, 2017 and 2016, the remaining commitments on construction contracts are approximately $15,000 and $100,000, respectively.

(7) Long-term Debt

Long-term debt at June 30, 2017 consists of the following:

	Carrying value	Fair value (Level 2)
Berks County Municipal Authority Hospital Revenue Bond Series of 2012, net of unamortized discount and premium	$ 300,998	308,544
Berks County Municipal Authority Hospital Revenue Bond Series of 2009, net of unamortized discount	102,280	112,054
Term loans	176,221	176,221
Total long-term debt	579,499	$ 596,819
Less: amounts due within one year	(5,719)	
Less: deferred financing costs, net	(4,980)	
Long-term debt, net of current portion	$ 568,800	

(Continued)

(Dollars in thousands)

Long-term debt at June 30, 2016 consists of the following:

	Carrying value	Fair value (Level 2)
Berks County Municipal Authority Hospital Revenue Bond Series of 2012, net of unamortized discount and premium	$ 302,126	317,846
Berks County Municipal Authority Hospital Revenue Bond Series of 2009, net of unamortized discount	106,477	121,386
Term loans	176,559	176,559
Total long-term debt	585,162	$ 615,791
Less: amounts due within one year	(5,529)	
Less: deferred financing costs, net	(5,265)	
Long-term debt, net of current portion	$ 574,368	

Under the terms of the various debt agreements, the System is required to maintain certain deposits with a trustee. Such deposits are included with assets whose use is limited in the consolidated balance sheets.

Scheduled principal repayments on long-term debt are as follows for the year ending June 30:

2018	$ 5,719
2019	6,472
2020	6,588
2021	6,577
2022	6,202
Thereafter	543,861
Total long-term debt	575,419
Plus: unamortized net premium/discounts	4,080
Less: deferred financing costs, net	(4,980)
Long term-debt, net of unamortized premiums/discount and deferred financing costs	$ 574,519

(Continued)

The Parent and the Hospital (the Obligated Group) have borrowed funds through revenue bonds issued by the Berks County Municipal Authority (Authority). The proceeds originally were used in part to finance certain facilities of the Obligated Group. The revenue bonds are secured by a pledge of revenue of the Obligated Group. For accounting purposes, the revenue bonds are treated as though they are the debt of the entity which received the proceeds.

(a) Berks County Municipal Authority Hospital Revenue Bond Series of 2012

On June 28, 2012, the Authority issued $473,275 of Revenue Bonds in four series, 2012 A, B, C, and D.

The Authority issued $160,065 of Fixed Rate Serial Revenue Bonds (2012 A) for the purpose of refunding the Dauphin Country General Authority Hospital Revenue Bond Series 1994A, Berks County Bond Series 1998 and 2008. Mandatory annual principal redemptions by the System for the 2012 A bonds due November 1, 2039 through November 1, 2044, range from $7,590 to $33,555 with final maturity on November 1, 2044. Effective interest rate of the bonds range from 4.23% to 4.50%.

The Authority issued $91,775 of Variable Rate Serial Revenue bonds (2012 B) for the purpose of refunding the Authority Series 2009 A-5. Mandatory annual principal redemptions by the System for the 2012 B bonds due November 1, 2035 through November 1, 2039, range from $3,225 to $24,955 with final maturity on November 1, 2039. Interest on these bonds is calculated on a SIFMA Municipal Index rate plus a fixed spread of 1.50%. The SIFMA Municipal Index rate at June 30, 2017 and 2016, was 0.91% and 0.41%, respectively.

The Authority issued a $47,235 Floating Rate Bond (2012 C) used to refund the Series 2009 A-4 and a $174,000 Floating Rate Bond (2012 D) used to Refund the Series 2009 A-1 and A-2. Both Series 2012 C and 2012 D were privately placed with commercial banks. Mandatory monthly principal redemptions by the System for the 2012 C bonds commenced on August 1, 2012 through July 1, 2022, and range from $39 to $129 with final maturity date on July 1, 2022. Interest on these bonds is calculated using a one-month London Interbank Offered Rate Index rate (LIBOR) plus a fixed spread of 1.20% with the sum multiplied by a factor of 70.0%. The one-month LIBOR rate at June 30, 2017 and 2016, was 1.23% and 0.45%, respectively.

(b) Berks County Municipal Authority Hospital Revenue Bond Series of 2009

The 2009 A-3 bonds were issued on July 15, 2009. The Authority issued $133,665 of Fixed Rate Revenue Bonds, Series 2009 A-3 for the primary purpose of redeeming $115,520 of 2001 Bonds and $14,965 for major renovation projects.

The 2009 A-3 bonds are comprised of $44,285 of serial bonds and $89,380 of term bonds. The serial bonds are due in installments payable November 1, 2009, through 2019, with payments ranging from $120 to $4,895. The term bonds are due on November 1 of 2024, 2031, and 2039, with payments ranging from $820 to $9,380. The effective interest rate on the serial bonds ranges from 3% to 5% and 5.25% to 5.75% for the term bonds.

(Continued)

(c) Term Loans

Effective May 16, 2016, the System refinanced 2012 D bonds by the securing term bank loans in four series, 2016 A, B, C, and D with a notional amount of $175,165. All 2016 series nonsyndicate bank loans are direct bank loans with a maturity of seven years.

Series 2016A with a notional amount of $50,165 has an interest rate calculated at 67% of 1-month LIBOR plus a fixed spread of 0.58%. Principal installments of $2,485 begin in November 1, 2022 followed by a full redemption of the balances in May 2023.

Series 2016B with a notional amount of $50,000 has an interest rate calculated at 70% of 1-month LIBOR plus a fixed spread of 0.65%. Principal installments of $2,475 begin November 1, 2022 followed by a full redemption of the balance in May 2023.

Series 2016C with a notional amount of $25,000 has an interest rate calculated at 70% of 1-month LIBOR plus a fixed spread of 0.84%. Principal installments of $1,240 begin November 1, 2022 followed by a full redemption of the balance in May 2023.

Series 2016D with a notional amount of $50,000 has an interest rate calculated at 67% of 1-month LIBOR plus a fixed spread of 0.675%. Principal installments of $2,475 begin in November 1, 2022 followed by a full redemption of the balance in May 2023.

The one-month LIBOR rate at June 30, 2017 and 2016, was 1.23% and 0.45%, respectively.

Effective retroactive to January 1, 2004, the Hospital replaced NMG Limited Partnership as the borrower on three promissory notes (NMG Loans). The Hospital was previously the guarantor for the notes. Mandatory annual principal redemptions by the Hospital for the notes for the 2016-2020 period range from $309 to $276 in 2020. The interest rate is calculated based upon the one-month LIBOR plus a spread of 1.70%.

(d) Line of Credit

At June 30, 2017 and 2016, the Hospital has an unused line of credit in the amount of $10,000. Letter of credit draws or direct borrowings from this facility are charged an interest rate of 1-month LIBOR plus 1.50%. Total combined open and undrawn letters of credit at June 30, 2017 and 2016 amounted to $3,095 and $3,095, respectively. During 2017, no new letters of credit were opened.

(e) Covenants

The various agreements also place limits on the incurrence of additional borrowings and require that the System satisfy certain measures of financial performance as long as the debt is outstanding. These covenants apply to the Obligated Group and include, but not limited to: a long-term debt service coverage ratio of 1.1 (measured quarterly) and 80 days cash on hand (measured annually at June 30).

(Continued)

(Dollars in thousands)

(8) Interest Rate Swaps

The System utilizes derivative instruments, such as interest rate swaps, to manage certain interest rate exposures. Derivative instruments are viewed as risk management tools by the System and are not used for trading and speculative purposes.

When quoted market prices are not available, the valuation of derivative instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each leg of the derivative. This analysis reflects the contractual terms of the derivatives, including interest rate curves and implied volatilities. The estimates of fair value valuation are made by swap counterparties using a standardized methodology based on observable market inputs. As part of the System's overall valuation process, management evaluates this counterparty valuation methodology to ensure that it is representative of exit prices in the principal markets. These future net cash flows, however, are susceptible to change primarily due to fluctuations in interest rates. As a result, the estimated values of these derivatives will change over time as cash is received and paid and as interest rates change. As these changes occur, they may have a positive or negative impact on estimated valuations.

The System has classified its interest rate swaps in Level 2 of the fair value hierarchy, as the significant inputs to the overall valuations are based on market-observable data or information derived from or corroborated by market-observable data. For over-the-counter derivatives that trade in liquid markets such as interest rate swaps, model inputs (i.e., contractual terms, market prices, yield curves, credit curves, and measures of volatility) can generally be verified, and model selection does not involve significant management judgment.

The fair market value of the swap contracts were as follows as of June 30:

Classification of derivatives included in liabilities on the consolidated balance sheets		Fair market value 2017	2016
Derivatives not designated as hedging instrument:			
2008 bond issuance	$	(1,787)	(755)
2005 bond issuance		2,685	4,229
2002 bond issuance		17,665	24,039
2001 bond issuance		21,331	30,139
1997 bond issuance		17	74
1992 bond issuance		791	1,221
Term loans		88	187
Total swap contracts	$	40,790	59,134

Changes in fair value of swap contracts on the consolidated balance sheets totaled a gain of $18,344 and a loss of $10,431 as of June 30, 2017 and 2016, respectively. The net amount paid or received under the swap contracts is recorded in the consolidated statements of operations as net cash settlement payments. Net payments totaled $8,746 and $9,741 for the years ended June 30, 2017 and 2016, respectively.

(Continued)

No new swaps were initiated in or closed the fiscal years ending June 30, 2017 and 2016.

In connection with the 2008 bond issuance, the System entered into two interest rate basis swap agreements with a third party by which the System pays SIFMA and receives an average of 0.85% of three-month LIBOR with a third party. Notional amounts of these basis swaps are $157,320 and $162,180, respectively, and the three-month LIBOR rate at June 30, 2017 and 2016, was 1.298% and 0.65%, respectively.

In connection with the 2005 bond issuance, the System entered into an interest rate swap agreement with a third party. The swap economically converts the variable rate obligation of the 2005 bonds to a fixed rate of 3.584%. Notional amount of the swap is $27,000.

In connection with the 2001 and 2002 bonds issuances, the System entered into two interest rate swap agreements with a third party. The swaps economically convert the variable rate obligations of the 2001 and 2002 bonds to a fixed rate of 4.30% and 4.69%, respectively. Notional amounts of the swaps are $115,845 and $65,225.

On June 26, 2006, the System entered into an interest rate swap agreement with a third party on the 2001, 2002, and 2005 bond issuances, which were effective as of August 4, 2006. The swap has a variable effective interest rate at 68% of the LIBOR.

In connection with the 2002 bond issuance, the System entered into two interest rate swap agreements with a third party. The swaps effectively convert the variable rate obligation of the Series A and B bonds to fixed rates of 4.69% and 6.28%, respectively. Notional amounts of the swaps are $1,855 and 3,985.

In connection with the 1997 bond issuance, the System entered into an interest rate swap agreement with a third party that was effective as of May 26, 2005. The swap effectively converts the variable rate obligation of the bonds to a fixed rate of 3.397%. Notional amount of the swap is $1,200.

In connection with the 1992 bond issuance, the System entered into an interest rate swap agreement with a third party, which was effective as of May 26, 2005. The swap effectively converts the variable rate obligation of the bonds to a fixed rate of 3.607%. Notional amount of the swap is $6,300.

In connection with the NMG Loans, the System assumed two interest rate swap agreements with a third party. The swaps effectively convert the variable obligations to fixed rates of 9.13% for the $2,100 note and 9.06% for the $2,000 note. The fair value of the interest rate swap agreements is the amount at which they would be settled based on estimates of market rates, which was a liability of $88 and $187 at June 30, 2017 and 2016, respectively.

The change in the fair value of the interest rate swap agreements and the net settlement payments associated with these swaps are recorded in nonoperating gains (losses) on the consolidated statements of operations.

(9) Retirement Plans

Prior to June 30, 2016, substantially all employees of the System were covered under a qualified noncontributory defined benefit pension plan (the Plan). Pension costs are funded as accrued except when not permitted by regulations, such as full funding limitations. Unfunded prior service costs are amortized over an initial term of thirty years.

(Dollars in thousands)

The System has effectively transitioned the Plan into a defined contribution plan as of June 30, 2016. Employees hired on or after July 1, 2013 have been enrolled in the defined contribution plan. Previous defined benefit participants hired on or before June 30, 2013, continued to accrue benefits in the existing defined benefit plan until June 30, 2016. As of July 1, 2016, all vested participant defined benefits remain accrued, but all current employees have now converted to and began to accumulate funds under the defined contribution plan. This action has effectively frozen the defined benefit plan as of June 30, 2016.

Obligations and funded status at June 30 for the Plan:

		2017	2016
Change in projected benefit obligation:			
Benefit obligation at beginning of year	$	692,973	557,349
Service cost		—	16,167
Interest cost		26,026	27,587
Actuarial gain		(27,526)	131,604
Benefits paid		(19,065)	(39,734)
Benefit obligation at end of year	$	672,408	692,973
Change in plan assets:			
Fair value of plan assets at beginning of year	$	367,061	384,964
Actual return on assets		48,604	(9,084)
Employer contributions		23,552	30,915
Benefits paid		(19,065)	(39,734)
Fair value of plan assets at end of year	$	420,152	367,061

Amounts recognized in the consolidated balance sheets at June 30 consist of:

		2017	2016
Accrued pension	$	252,256	325,912
Total accrued liability	$	252,256	325,912
Amounts recognized in net assets consist of:			
Net actuarial loss	$	264,340	318,396
Pension cost charged to net assets	$	264,340	318,396

(Continued)

(Dollars in thousands)

Net periodic benefit cost components at June 30 include the following:

		2017	2016
Service cost – benefits earned during the period	$	—	16,167
Interest cost on projected benefit obligation		26,026	27,587
Expected return on plan assets		(29,533)	(31,851)
Amortization of net loss		7,459	2,849
Net periodic pension cost	$	3,952	14,752

In connection with the System's adoption of ASU 2017-07, the service cost component of the net periodic pension cost are included in salaries and benefits in the accompanying statement of operations and the remaining components are included in nonoperating gains (losses) for the years ended June 30, 2017 and June 30, 2016.

Other changes in plan assets and benefit obligations recognized in unrestricted net assets as of June 30:

		2017	2016
Net loss	$	(46,597)	175,995
Amortization of net loss		(7,459)	(2,849)
Total recognized in unrestricted net assets	$	(54,056)	173,146
Total recognized in net periodic benefit cost and unrestricted net assets	$	(43,090)	187,898

The amount expected to be amortized from unrestricted net asset to net periodic pension cost in nonoperating gains (losses) during fiscal year 2018 is $6,049.

Weighted average assumptions used to determine benefit obligations at June 30:

	2017	2016
Discount rate	3.94 %	3.80 %
Rate of compensation increase	N/A	N/A
Measurement date	6/30/2017	6/30/2016

(Continued)

(Dollars in thousands)

Weighted average assumptions used to determine net periodic benefit cost for years ended June 30:

	2017	2016
Discount rate	3.80 %	4.93 %
Expected long-term return on plan assets	8.00 %	8.00 %
Rate of compensation increase	N/A	N/A

To develop the expected long-term rate of return on assets assumption, the System considered the historical returns and the future expectations for returns for each asset class, as well as the target asset allocation of the pension portfolio.

(a) Plan Assets

The Plan's weighted average actual asset allocations and target allocations as of June 30 by asset category are as follows:

	2017	
	Target	**Actual**
Asset category:		
Cash and cash equivalents	— %	1.3 %
Equity mutual funds	45.0	19.4
Fixed income, including mutual funds, state, municipal government, and auction rate securities	32.5	21.0
Equities	—	2.4
Alternative investments 1)	22.5	55.9
	100.0 %	100.0 %

	2016	
	Target	**Actual**
Asset category:		
Cash and cash equivalents	— %	1.7 %
Equity mutual funds	40.0	17.4
Fixed income, including mutual funds, state, municipal government, and auction rate securities	32.5	24.6
Equities	—	1.6
Alternative investments 1)	27.5	54.7
	100.0 %	100.0 %

1) Note: Long/Short Equity and Private Equity are classified as Alternative Investments.

(Continued)

(Dollars in thousands)

The overall investment objective of the Plan is to provide a return on investment consistent with the Plan's spending needs and to prevent erosion of purchasing power by inflation. Achievement of the return will be sought from an investment strategy that provides an opportunity for superior returns within acceptable levels of risk and volatility of returns. The following tables represent the fair value measurement levels for all assets and liabilities, which the System has recorded at fair value:

		2017		
	Fair value June 30, 2017	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant other unobservable inputs (Level 3)
Cash and cash equivalents	$ 5,366	5,366	—	—
State, municipal government, and auction rate securities	5,880	—	5,880	—
Equity mutual funds	81,645	81,645	—	—
Equities	10,280	10,280	—	—
Fixed income mutual funds	82,154	82,154	—	—
Hedge, private equity, and common collective trust funds (1)	234,827	—	—	—
Total investments	$ 420,152	179,445	5,880	—

(Continued)

(Dollars in thousands)

		2016		
	Fair value June 30, 2016	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant other unobservable inputs (Level 3)
Cash and cash equivalents	$ 6,307	6,307	—	—
State, municipal government, and auction rate securities	6,020	—	6,020	—
Equity mutual funds	64,016	64,016	—	—
Equities	5,993	5,993	—	—
Fixed income mutual funds	83,835	83,835	—	—
Hedge, private equity, and common collective trust funds (1)	200,890	—	—	—
Total investments	$ 367,061	160,151	6,020	—

(1) Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

Transfers between levels occur when there is a change in the observability of significant inputs. A transfer between Level 1 and Level 2 generally occurs when the availability of quoted prices changes or when market activity of an investment significantly changes to active or inactive. A transfer between Level 2 and Level 3 generally occurs when the underlying inputs become, or can no longer be, corroborated with market observable data. Transfers between levels are recognized on the date they occur. For the years ended June 30, 2017 and 2016, no transfers were made between Levels.

(Continued)

The Plan holds investments that calculate net asset value per share (or its equivalent) and do not have a readily determinable value are as follows as of June 30:

2017	Fair value	Unfunded commitments	Redemption frequency (if eligible)	Redemption notice period
	(In millions)			
a - Equity long/short hedge funds	$ 49.5	—	Quarterly, annually	45–90 days
b - Global opportunities hedge fund	13.2	—	Quarterly, annually	60–120 days
c - Multi-strategy hedge funds	33.9	—	Annually, biannually	30–90 days
d - Real assets	25.8	3.8	Weekly, Monthly	5–30 days
e - Long Only funds	83.4	—	Monthly	15–30 days
f - Real estate funds	9.7	6.7	N/A	N/A
g - Private equity funds	19.3	12.8	N/A	N/A
Total	$ 234.8	23.3		

2016	Fair value	Unfunded commitments	Redemption frequency (if eligible)	Redemption notice period
	(In millions)			
a - Equity long/short hedge funds	$ 36.8	—	Quarterly, annually	45–90 days
b - Global opportunities hedge fund	26.3	5.8	Quarterly, annually	60–120 days
c - Multi-strategy hedge funds	29.6	—	Annually, biannually	30–90 days
d - Real assets	23.3	—	Weekly, Monthly	5–30 days
e - Long Only funds	64.3	—	Monthly	15–30 days
f - Real estate funds	10.3	6.4	N/A	N/A
g - Private equity funds	10.3	9.8	N/A	N/A
Total	$ 200.9	22.0		

a. This class includes investments in hedge funds that invest both long and short in U.S. and foreign common stocks. Management of the hedge funds has the ability to shift investments from value to growth strategies, from small to large capitalization stocks and from a net long position to a net short position. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

b. This class includes investments in hedge funds that hold investments in U.S. and non-U.S. common stocks in the health care, energy, information technology, utilities and telecommunications sectors. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

(Continued)

c. This class invests in hedge funds that pursue multiple strategies to diversify risks and reduce volatility. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient. The remaining restriction period for these investments ranges from quarterly to biennially.

d. This class includes funds with direct investments in commodities and energy master limited partnerships. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient

e. This class invests in domestic and international hedge funds that pursue a long only equity bias. The fair values of the investments in this class have been estimated using the net asset value per share of the investments as a practical expedient.

f. This class includes real estate funds that invest in U.S. and non-U.S. residential and commercial properties as well as distressed real estate. The fair values of the investments in this class have been estimated using the net asset value of the System's ownership interest in partners' capital as a practical expedient. It is estimated that the underlying assets of these funds will be liquidated over the next 7 to 10 years, although these funds may liquidate early in the event of purchase by a third party or initial public offering.

g. This class includes private equity funds. These investments cannot be redeemed with the funds. Instead, the nature of the investments in this class is that distributions are received through the liquidation of the underlying assets of the fund. These funds could be subject to redemption to a third party buyer, but at June 30, 2017 and 2016, no funds were currently being evaluated this way. The fair values of the investments in this class have been estimated using the net asset value of the System's ownership interest in partners' capital as a practical expedient.

(b) Contributions

The System expects to contribute the minimum required contribution during the fiscal year 2018 to the Plan, which is estimated to be $14,330. For the years ended June 30, 2017 and 2016, the System contributed $23,552 and $30,915, respectively to the Plan. For the years ended June 30 2017 and 2016, the System contributed $10,866 and $4,659, respectively to the defined contribution plan and $1,504 and $1,408, respectively to the nonqualified deferred compensation plan.

(Dollars in thousands)

(c) Estimated Future Benefit Payments

The following benefit payments are expected to be paid:

Years ending June 30:	
2018	21,640
2019	22,967
2020	24,797
2021	26,493
2022	27,842
Thereafter	160,265

(10) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30:

		2017	2016
Various health care services	$	1,667	366

Permanently restricted net assets at June 30 are restricted to:

		2017	2016
Permanent endowment funds, the interest and dividend income from which is expendable to support health care services	$	12,842	8,762
Funds held in trust by others		15,609	14,591
Total permanently restricted net assets	$	28,451	23,353

(11) Insurance Arrangements

The System participates in the Pennsylvania Medical Care Availability and Reduction of Error Fund or Mcare Fund established under the Commonwealth of Pennsylvania. The Mcare Fund presently provides coverage excess of up to $500 to the System's primary per occurrence retention (which is currently $500) with annual aggregate coverage of $1,500.

The System established a self-insurance trust fund to provide protection against professional liability claims. The trust is actuarially funded on an annual basis to provide single limit professional liability coverage of $500 per occurrence and $4,500 in the annual aggregate for the Hospital and certain employees. For incidents occurring since April 30, 2009, the System purchased commercial insurance to provide coverage on a claims-made basis in an amount up to $25,000 in excess of a total retention of $3,000, $500 primary; $500 Mcare excess and a $2,000 self-insured buffer. Claim liabilities are presented gross of any insurance recoveries. Claim liabilities are discounted at an interest rate of 3% for years ended June 30, 2017 and 2016,

(Dollars in thousands)

and decreased the undiscounted liability as of June 30, 2017 and 2016 by $2,885 and $3,236, respectively. For the years ended June 30, 2017 and 2016, the insurance recoverable amount was $3,500 and $8,393, respectively, which is included in other receivables and other assets on the consolidated balance sheets. Funding requirements of the plan are subject to increase depending on the plan's claim experience. Premium payments for the Mcare Fund are based upon each individually licensed healthcare provider's rating with the Joint Underwriters Association and the amount of the surcharge to be assessed is determined by the Mcare Fund on an annual basis. The System's annual surcharge premium for participation in the Mcare Fund was $1,729 and $1,077 for the years ended June 30, 2017 and 2016, respectively.

Additionally, the System self-insures its workers' compensation and minor general liability risks. The System's self-insurance plan has been reviewed and approved by the Commissioner of Insurance of Pennsylvania. The System purchases excess workers' compensation insurance for all controlled entities of the hospital with statutory limits over a self-retention of $1,000 per occurrence subject to a policy maximum of $1,000 for the policy period. Workers' compensation liabilities are discounted at an interest rate of 3% for years ended June 30, 2017 and 2016, and decreased the undiscounted liability as of June 30, 2017 and 2016 by $2,421 and $2,624, respectively. The System had established a trust fund for the payment of workers' compensation benefits and in the year ended June 30, 2016 the assets in this trust fund were replaced with a surety bond providing liability coverage and all fund assets previously held by the trust were returned to the System.

Reserves for self-insurance claims at June 30 are summarized as follows:

		2017	2016
Professional liability claims payable	$	36,400	49,101
Workers' compensation		11,984	12,097
Total self-insurance claims reserve		48,384	61,198
Less: current portion		(10,885)	(13,243)
Self-insurance claims reserve, net of current portion	$	37,499	47,955

(12) Commitment and Contingencies

(a) Operating Leases

The System leases equipment and facilities under operating leases expiring at various dates. Total rental expense under all operating leases was $13,716 and $7,492 for the years ended June 30, 2017 and 2016, respectively.

(Dollars in thousands)

The following table summarizes future minimum rental commitments under noncancelable operating leases with initial or remaining terms of more than one year for the fiscal year:

Years ending June 30:		
2018	$	8,701
2019		6,099
2020		5,729
2021		3,657
2022		2,106
Thereafter		11,277

(b) Litigation

The System and its controlled entities are involved in certain litigation, which involves professional and general liability. In the opinion of management and legal counsel, the ultimate liability, if any, will not have a material effect on the consolidated financial condition of the Parent and its subsidiaries.

(c) Regulatory Compliance

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The System believes that it is in compliance with all applicable laws and regulations through the years ended June 30, 2017 and 2016. Compliance with such laws and regulations can be subject to government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs.

(13) Concentrations of Credit Risk

Financial instruments, which potentially subject the System to concentrations of credit risk, consist primarily of cash, cash equivalents, investments, and accounts receivable.

Management periodically evaluates the credit standing of the financial institutions with which they maintain their cash, cash equivalents, and investments. Amounts held in its accounts often exceed the federally insured levels.

The fair value of the System's investments is subject to various market fluctuations, which include changes in the interest rate environment and general economic conditions.

(Dollars in thousands)

The System grants credit to its patients and other third-party payors, primarily Medicare, Medical Assistance, Blue Cross, and various commercial insurance companies. The System maintains reserves for potential credit losses and such losses have historically been within management's expectations. The mix of receivables from patients and third-party payors as of June 30, 2017 and 2016 was as follows:

	2017	2016
Medicare	25 %	24 %
Medical assistance	18	16
Blue Cross	24	24
Commercial insurance	19	22
Self-pay	12	10
Other	2	4
	100 %	100 %

The activity in the allowance for uncollectible accounts is summarized as follows for the years ended June 30:

		2017	2016
Beginning balance	$	38,194	33,770
Provision for uncollectible accounts, net of recoveries		47,592	51,468
Write offs		(51,146)	(47,044)
Ending balance	$	34,640	38,194

(14) Functional Expenses

The System considers health program services and general/administrative to be its primary functional categories for purposes of expense classification. General/administrative includes information systems, general corporate management, advertising and marketing. Functional categories of expenses for the years ended June 30 are as follows:

		2017	2016
Health program services	$	977,133	907,019
General/administrative		65,498	60,700
Total functional expenses	$	1,042,631	967,719

(Continued)

(15) Certain Significant Risks and Uncertainties

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, Health Care Reform), enacted in March 2010, has changed and will continue to make broad-based changes to the U.S. health care system which could significantly affect the U.S. economy and which the System expects will continue to impact the System's business operations and financial results. Since its enactment in 2010, key components of Health Care Reform have been phased in, including health insurance exchanged (Public Exchanges), new Medicare products, and the individual coverage mandate. Although Health Care Reform is to be phased in through 2018, many significant changes occurred in 2014. The System is dedicating material resources to monitor the potential impacts of Health Care Reform as well as state level health care reform. While the federal government has issued a number of regulations implementing Health Care Reform, certain significant parts of Health Care Reform, including aspects of Public Exchanges, Medicaid expansion, enforcement related reporting for the individual and employer mandates, and the implementation of Medicare Advantage, require further guidance and clarification at the federal level and/or in the form of regulations and actions by state legislatures to implement the law. The federal government also has announced significant changes to and/or delays in effective dates of various aspects of Health Care Reform, and it is likely that further changes will be made at the federal and/or state level based on implementation experience. As a result, key aspects and impacts of Health Care Reform will not be known for several years, and given the inherent difficulty of foreseeing how individuals and businesses will respond to the choices afforded them by Health Care Reform, the System cannot predict the full effect Health Care Reform will have on the System. It is reasonably possible that Health Care Reform, in the aggregate, could have an adverse effect on the System's business operations and financial results.

Federal budget negotiations, ongoing regulatory changes to Health Care Reform, pending efforts in the U.S. Congress to amend or restrict funding for various aspects of Health Care Reform and litigation challenging aspects of the law continue to create uncertainty about the ultimate impact of Health Care Reform.

In addition, the federal and state governments continue to enact or seriously consider many other broad-based legislative and regulatory proposals that have impacted or could materially impact various aspects of the health care system. The System cannot predict whether pending or future federal or state legislation, will change various aspects of the health care system or Health Care Reform or the impact those changes will have on the System's business operations or financials results, but the effects could be adverse.

(16) Subsequent Events

The System has evaluated subsequent events from the consolidated balance sheet date through September 27, 2017, the date at which the consolidated financial statements were available to be issued, and determined there are no other items to disclose.

Schedule I

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading Health System consolidated
Current assets:								
Cash and cash equivalents	$ —	54,055	—	8	—	1,472	—	55,535
Patient accounts receivable, less allowance for uncollectible accounts of $34,640	—	107,932	—	12,024	—	3,597	—	123,553
Other receivables	20	1,796	—	3,644	—	—	—	5,460
Receivable from affiliates	153,113	(144,788)	—	(2)	(1,043)	(378)	(6,902)	—
Inventories	—	14,859	—	—	—	175	—	15,034
Estimated third-party payor receivables	—	7,262	—	—	—	—	—	7,262
Prepaid expenses and other current assets	—	14,301	—	560	—	240	—	15,101
Assets whose use is limited – required for current liabilities:								
Self-insurance funding arrangements	—	7,482	—		—	—	—	7,482
Total current assets	153,133	62,899	—	16,234	(1,043)	5,106	(6,902)	229,427
Assets whose use is limited:								
Self-insurance funding arrangements	—	11,804	—	—	—	—	—	11,804
Under regulatory requirements	—	—	—	—	—	2,666	—	2,666
By board for capital improvements	802,460	54	—	—	—	55,458	—	857,972
Total assets whose use is limited, net of current portion	802,460	11,858	—	—	—	58,124	—	872,442
Restricted investments	—	28,149	—	—	—	—	—	28,149
Temporarily restricted investments	—	249	—	—	—	53	—	302
Long-term receivables from affiliates	499,111	—	—	—	—	—	(499,111)	—
Property, plant and equipment, net	38,654	736,730	1,659	6,147	—	50,956	—	834,146
Investments in joint ventures	11,252	1,065	—	—	—	—	—	12,317
Other assets	—	5,329	—	111	—	(53)	—	5,387
Total assets	$ 1,504,610	846,279	1,659	22,492	(1,043)	114,186	(506,013)	1,982,170

(continued)

Schedule I

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading Health System consolidated
Current liabilities:								
Current installments of long-term debt	$ 5,380	339	—	—	—	—	—	5,719
Accounts payable	(3)	51,907	95	1,509	—	1,248	—	54,756
Estimated third-party settlements	—	4,112	—	—	—	—	—	4,112
Current portion of estimated self-insurance costs	—	10,845	—	—	—	40	—	10,885
Accrued expenses	3,701	12,296	96	13,153	—	467	—	29,713
Accrued vacation	—	19,088	81	10,447	—	544	—	30,160
Current installments of long-term affiliated payables	—	5,380	—	—	—	1,522	(6,902)	—
Other current liabilities	—	8,567	262	44	—	33		8,906
Total current liabilities	9,078	112,534	534	25,153	—	3,854	(6,902)	144,251
Long-term debt, net of current portion and unamortized discount/premium	568,125	675	—	—	—	—	—	568,800
Accrued pension liabilities	—	252,256	—	—	—	—	—	252,256
Deferred revenue	—	4,494	—	—	—	38,317	—	42,811
Other liabilities	—	2,173	20	114	11	376	—	2,694
Estimated self-insurance costs, net of current portion	—	37,499	—	—	—	—		37,499
Swap contracts	40,702	88	—	—	—	—	—	40,790
Long-term affiliates payables, net of current portion	—	467,140	—	—	—	31,971	(499,111)	—
Total liabilities	617,905	876,859	554	25,267	11	74,518	(506,013)	1,089,101
Net assets (deficit):								
Unrestricted	886,705	(60,645)	1,105	(2,775)	(1,054)	39,615	—	862,951
Temporarily restricted	—	1,614	—	—	—	53	—	1,667
Permanently restricted	—	28,451	—	—	—	—	—	28,451
Total net assets (deficit)	886,705	(30,580)	1,105	(2,775)	(1,054)	39,668	—	893,069
Total liabilities and net assets (deficit)	$ 1,504,610	846,279	1,659	22,492	(1,043)	114,186	(506,013)	1,982,170

See accompanying independent auditors' report.

Schedule II

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2017

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading Health System consolidated
Unrestricted revenues and other support:								
Net patient service revenue	$ —	950,498	—	121,074	—	4,009	(30,250)	1,045,331
Provision for uncollectible accounts	—	(43,713)	—	(3,879)	—	—		(47,592)
Net patient service revenue less provision for uncollectible accounts	—	906,785	—	117,195	—	4,009	(30,250)	997,739
Residential revenue	—	—	—	—	—	23,143	—	23,143
Other revenue	(11)	30,018	3,568	3,515	—	1,542	(7,158)	31,474
Total revenues and other support	(11)	936,803	3,568	120,710	—	28,694	(37,408)	1,052,356
Expenses:								
Salaries and benefits	—	452,907	2,514	160,786	469	13,199	(34,433)	595,442
Supplies	—	150,830	9	6,993	2	2,324	—	160,158
Utilities	—	10,946	—	554	—	965	—	12,465
Interest	—	11,327	—	—	—	1,197	—	12,524
Depreciation	—	77,908	830	1,569	—	3,732	—	84,039
Purchased services	—	75,849	611	11,391	2	2,383	(60)	90,176
Repairs and maintenance	—	30,895	100	587	58	491	—	32,131
Other	—	38,530	131	15,336	29	2,364	(2,915)	53,475
Acquisition related expenses	—	2,221	—	—	—	—	—	2,221
Total expenses	—	851,413	4,195	197,216	560	26,655	(37,408)	1,042,631
Income (loss) from operations	(11)	85,390	(627)	(76,506)	(560)	2,039	—	9,725
Nonoperating (losses) gains:								
Investment income	44,020	(2,585)	—	—	—	2,960	—	44,395
Change in fair value of swap contracts and net of settlement payments	9,584	14	—	—	—	—	—	9,598
Other-than-temporary impairment losses on investments	(4,111)	—	—	—	—	—	—	(4,111)
Other (losses) gains	—	(6,976)	—	(403)	(2)	(109)	—	(7,490)
Nonoperating (losses) gains, net	49,493	(9,547)	—	(403)	(2)	2,851	—	42,392
Excess (deficiency) of revenues, (losses) gains, and other support over expenses	$ 49,482	75,843	(627)	(76,909)	(562)	4,890	—	52,117

See accompanying independent auditors' report.

Schedule III

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading health system consolidated
Current assets:								
Cash and cash equivalents	$ —	115,960	—	8	—	1,846	—	117,814
Patient accounts receivable, less allowance for uncollectible accounts of $38,194	—	101,342	—	8,581	—	3,110	—	113,033
Other receivables	25	3,237	—	3,570	—	—	—	6,832
Receivable from affiliates	108,710	(99,503)	(930)	—	(456)	(1,109)	(6,712)	—
Inventories	—	13,958	—	—	—	169	—	14,127
Estimated third-party payor receivables	—	11,404	—	—	—	—	—	11,404
Prepaid expenses and other current assets	1	20,084	6	500	—	403	—	20,994
Assets whose use is limited – required for current liabilities:								
Self-insurance funding arrangements	—	10,711	—	—	—	—	—	10,711
Total current assets	108,736	177,193	(924)	12,659	(456)	4,419	(6,712)	294,915
Assets whose use is limited:								
Self-insurance funding arrangements	—	8,408	—	—	—	—	—	8,408
Under regulatory requirements	—	—	—	—	—	2,719	—	2,719
By board for capital improvements	725,821	53	—	—	—	49,788	—	775,662
Total assets whose use is limited, net of current portion	725,821	8,461	—	—	—	52,507	—	786,789
Restricted investments	—	25,640	—	—	—	—	—	25,640
Temporarily restricted investments	—	314	—	—	—	52	—	366
Long-term receivables from affiliates	506,109	—	—	—	—	.	(506,109)	—
Property, plant and equipment, net	38,654	728,095	2,489	7,529	—	50,497	—	827,264
Investments in joint ventures	9,440	953	—	—	—	—	—	10,393
Other assets	—	9,558	—	93	—	(52)	—	9,599
Total assets	$ 1,388,760	950,214	1,565	20,281	(456)	107,423	(512,821)	1,954,966

(continued)

Schedule III

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading health system consolidated
Current liabilities:								
Current installments of long-term debt	$ 5,190	339	—	—	—	—	—	5,529
Accounts payable	—	57,617	39	1,427	36	1,280	—	60,399
Estimated third-party settlements	—	7,171	—	—	—	—	—	7,171
Current portion of estimated self-insurance costs	—	13,243	—	—	—	—	—	13,243
Accrued expenses	3,538	17,156	69	17,482	—	732	—	38,977
Accrued vacation	—	17,610	98	9,025	—	512	—	27,245
Current installments of long-term affiliated payables	—	5,190	—	—	—	1,522	(6,712)	—
Other current liabilities	—	7,566	—	2	—	45	—	7,613
Total current liabilities	8,728	125,892	206	27,936	36	4,091	(6,712)	160,177
Long-term debt, net of current portion and unamortized discount/premium	573,313	1,055	—	—	—	—	—	574,368
Accrued pension liabilities	—	325,912	—	—	—	—	—	325,912
Deferred revenue	—	3,673	—	—	—	37,389	—	41,062
Other liabilities	—	2,168	—	—	—	395	—	2,563
Estimated self-insurance costs, net of current portion	—	47,955	—	—	—	—	—	47,955
Swap contracts	58,947	187	—	—	—	—	—	59,134
Long-term affiliates payables, net of current portion	—	472,615	—	—	—	33,494	(506,109)	—
Total liabilities	640,988	979,457	206	27,936	36	75,369	(512,821)	1,211,171
Net assets (deficit):								
Unrestricted	747,772	(52,910)	1,359	(7,655)	(492)	32,002	—	720,076
Temporarily restricted	—	314	—	—	—	52	—	366
Permanently restricted	—	23,353	—	—	—	—	—	23,353
Total net assets (deficit)	747,772	(29,243)	1,359	(7,655)	(492)	32,054	—	743,795
Total liabilities and net assets (deficit)	$ 1,388,760	950,214	1,565	20,281	(456)	107,423	(512,821)	1,954,966

See accompanying independent auditors' report.

Schedule IV

READING HEALTH SYSTEM AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2016

(Dollars in thousands)

	Parent	Hospital	RHP	RHPN	RHF	Highlands	Consolidating and eliminating entries	Reading Health System consolidated
Unrestricted revenues and other support:								
Net patient service revenue	$ —	884,795	—	110,813	—	3,605	(23,508)	975,705
Provision for uncollectible accounts	—	(46,958)	—	(4,510)	—	—	—	(51,468)
Net patient service revenue less provision for uncollectible accounts	—	837,837	—	106,303	—	3,605	(23,508)	924,237
Residential revenue	—	—	—	—	—	22,372	—	22,372
Other revenue	(1,183)	30,608	2,524	4,038	—	953	(5,079)	31,861
Total revenues and other support	(1,183)	868,445	2,524	110,341	—	26,930	(28,587)	978,470
Expenses:								
Salaries and benefits	—	413,329	2,339	138,510	320	11,881	(25,994)	540,385
Supplies	—	148,821	9	7,352	53	2,254	—	158,489
Utilities	—	10,666	—	611	—	1,005	—	12,282
Interest	—	9,587	—	—	—	1,253	—	10,840
Depreciation	—	72,333	830	1,569	—	3,653	—	78,385
Purchased services	—	72,054	423	11,348	75	2,274	(40)	86,134
Repairs and maintenance	—	30,691	448	297	—	610	—	32,046
Other	—	38,762	124	10,446	—	2,379	(2,553)	49,158
Total expenses	—	796,243	4,173	170,133	448	25,309	(28,587)	967,719
Income (loss) from operations	(1,183)	72,202	(1,649)	(59,792)	(448)	1,621	—	10,751
Nonoperating gains (losses):								
Investment income	27,775	948	—	—	—	601	—	29,324
Change in fair value of swap contracts and net of settlement payments	(20,142)	(30)	—	—	—	—	—	(20,172)
Other-than-temporary impairment losses on investments	(9,228)	—	—	—	—	—	—	(9,228)
Other gains (losses)	—	1,128	—	—	(2)	74	—	1,200
Nonoperating (losses) gains, net	(1,595)	2,046	—	—	(2)	675	—	1,124
Excess (deficiency) of revenues, (losses) gains, and other support over expenses	$ (2,778)	74,248	(1,649)	(59,792)	(450)	2,296	—	11,875

See accompanying independent auditors' report.

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APPENDIX C

SUMMARY OF THE BOND INDENTURE AND THE LOAN AGREEMENT

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SUMMARY OF THE BOND INDENTURE AND THE LOAN AGREEMENT

DEFINITIONS OF CERTAIN TERMS

In addition to the terms defined elsewhere in this Official Statement, the following are definitions of certain terms used in the Bond Indenture and the Loan Agreement and this Official Statement unless the context clearly otherwise requires. Reference is hereby made to the Bond Indenture and the Loan Agreement for complete definitions of all terms.

"Act" shall mean the Economic Development Financing Law, Act of August 23, 1967, P.L. 251, as amended.

"Authorized Investments" means any of the following that at the time are legal investments under the laws of the Commonwealth for moneys held hereunder and then proposed to be invested therein, provided that each obligation shall mature, or shall be subject to redemption by the holder thereof at the option of such holder, not later than the respective dates when the moneys will be required for the purposes intended:

(a) Government Obligations.

(b) Bonds, debentures, notes, participation certificates or other evidences of indebtedness issued, or the principal of and interest on which are unconditionally guaranteed, by the Federal National Mortgage Association, the Bank for Cooperatives, or the Federal Intermediate Credit Bank, the Federal Home Loan Bank System, the Federal Land Banks, the Government National Mortgage Association or any other agency or instrumentality of or corporation wholly owned by the United States of America when such obligations are backed by the full faith and credit of the United States.

(c) Obligations of any state of the United States or any political subdivision thereof, which is rated at the time of purchase "Aaa/AAA" by Moody's or general obligations of any state of the United States with a rating at the time of purchase of at least "A2/A" or higher by Moody's.

(d) "Pre-refunded Municipal Obligations" which means any obligations of any state of the United States or of any agency, instrumentality or local governmental unit of any such state which are not callable at the option of the obligor prior to maturity or as to which irrevocable instructions have been given by the obligor to call on the date specified in such irrevocable instructions; and which are rated at the time of purchase, based on an irrevocable escrow account or fund (the "escrow"), in the highest rating category of Moody's or any successors thereto; or which are fully secured as to principal and interest and redemption premium, if any, by an escrow consisting only of cash or obligations described in paragraph (a) above, which escrow may be applied only to the payment of such principal of and interest and redemption premium, if any, on such obligations on the maturity date or dates thereof or the specified redemption date or dates pursuant to such irrevocable instructions, as appropriate, and (ii) which escrow is sufficient, as verified by a firm of nationally recognized independent public accountants or other experts in escrow fund cash flow verification, to pay principal of and interest and redemption premium, if any, on the obligations described in this paragraph on the maturity date or dates or redemption date or dates specified in the irrevocable instructions referred to above, as appropriate.

(e) Direct obligations of any of the following federal agencies which obligations are not fully guaranteed by the full faith and credit of the United States of America: Senior debt obligations rated at the time of purchase "Aaa" by Moody's issued by the Federal National Mortgage Association

(FNMA) or Federal Home Loan Mortgage Corporation (FHLMC); obligations of the Resolution Funding Corporation (REFCORP); or senior debt obligations of the Federal Home Loan Bank System.

(f) Commercial paper which is rated at the time of purchase in the single highest classification, "P-1" by Moody's and which matures not more than 270 calendar days after the date of purchase.

(g) Shares or interests in money market mutual funds, including without limitation, any mutual fund for which the Bond Trustee or an affiliate of the Bond Trustee serves as investment manager, administrator, shareholder servicing agent, and/or custodian or subcustodian, notwithstanding that (i) the Bond Trustee or an affiliate of the Bond Trustee receives fees from such funds for services rendered, (ii) the Bond Trustee charges and collects fees for services rendered pursuant to the Bond Indenture, which fees are separate from the fees received from such funds, and (iii) services performed for such funds and pursuant to the Bond Indenture may at times duplicate those provided to such funds by the Bond Trustee or its affiliates, and which are rated in the highest rating category by Moody's or S&P, at the time of investment.

(h) Guaranteed investment contracts, repurchase agreements and/or investment agreements.

(i) U.S. dollar denominated time and demand deposit accounts, federal funds, trust funds, trust accounts, certificates of deposit and banker's acceptances with domestic commercial banks, including the Bond Trustee and any of its affiliates which have a rating on their short term certificates of deposit on the date of purchase of "A-1" or "A-1+" by S&P or "P-1" by Moody's and maturing no more than 360 days after the date of purchase (ratings on holding companies are not considered as the rating of the bank).

(j) trust funds, trust accounts, certificates of deposit, time deposit agreements, demand deposits or other comparable banking arrangements, whether negotiable or nonnegotiable, issued by any bank, trust company or national banking association (including the Bond Trustee and any of its affiliates), provided that such investments must be (i) fully insured by the Federal Deposit Insurance Corporation, or (ii) secured, to the extent not insured by the Federal Deposit Insurance Corporation, as required by applicable law or (iii) issued by an institution whose unsecured, long term senior debt obligations are, at the time of such issuance, rated by S&P and Moody's in either of their respective two highest rating categories (disregarding qualifications of such categories by symbols as "+" or "-").

"Board" shall mean the governing body of the Authority or the System, as applicable.

"Bond" or "Bonds" shall mean any 2017 Bond, or all the 2017 Bonds, as the case may be, authenticated and delivered under the Bond Indenture.

"Bondholder" or "bondholder" or "Bondowner" or "Holder of the Bonds" or "holder of the bonds" or "Holder" or "Owner" or any similar term shall mean any registered owner of any Bond or legal representative thereof.

"Bond Redemption Fund" shall mean the Bond Redemption Fund created under the Bond Indenture.

"Cede & Co." means Cede & Co., as nominee name of The Depository Trust Company, New York, New York.

"Certified Authority Resolution" shall mean a copy of a resolution certified by the Secretary or Assistant Secretary of the Authority, under its corporate seal, to have been duly adopted by the Board and to be in full force and effect on the date of such certification.

"Certified System Resolution" shall mean a copy of a resolution certified by the Secretary or Assistant Secretary of the System, under its corporate seal, to have been duly adopted by the Board of Directors of the System or a committee of the Board of Directors or officers of the System, in each case duly authorized to act on behalf of the System, and to be in full force and effect on the date of such certification.

"Code" shall mean the Federal Internal Revenue Code of 1986, as amended, and regulations promulgated thereunder.

"Commonwealth" shall mean the Commonwealth of Pennsylvania.

"Debt Service Fund" shall mean the Debt Service Fund created under the Bond Indenture.

"Defeasance Obligations" shall mean cash or Government Obligations.

"Event of Default" shall mean any one or more of those events set forth under the caption "SUMMARY OF THE BOND INDENTURE--Defaults and Remedies" and "SUMMARY OF THE LOAN AGREEMENT—Events of Default" below.

"Fiscal Year" shall mean each period of twelve consecutive calendar months ending June 30.

"Fitch" means Fitch, Inc., a corporation organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the System by notice in writing to the Issuer and the Bond Trustee.

"Government Obligations" means any of the following securities, if and to the extent the same are non-callable and not subject to redemption other than at the option of the owners, at the time legal for investment of funds held under the Bond Indenture: direct obligations of, or obligations the full and timely payment of the principal of and interest on which is unconditionally guaranteed by, the United States of America, including obligations issued or held in book-entry form on the books of the Department of the Treasury of the United States of America and including a receipt, certificate or any other evidence of an ownership interest in an aforementioned obligation, or in specified portions thereof (which may consist of specified portions of interest thereon).

"Master Notes" or "Notes" means any notes issued, authenticated and delivered under the Master Indenture.

"Moody's" means Moody's Investors Service, Inc., a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the System, by notice in writing to the Authority and the Bond Trustee.

"Officers' Certificate" shall mean a statement signed by a Responsible Officer of the System or of the Authority, as the case may be. If such Officers' Certificate shall include a statement with respect to the existence or non-existence of an event of default or any condition, event, act or omission which, with the giving of notice or lapse of time or both, would constitute an event of default, such Officers' Certificate may state that such statement is based upon the best knowledge, information and belief of the signer of such certificate, provided that such certificate also states that, in the opinion of the signer of such certificate, he has made such examination or investigation as he deemed reasonably appropriate to enable him to make such statement.

"Outstanding", "outstanding", "outstanding under the Bond Indenture" or "outstanding hereunder", when used in reference to the Bond Indenture, shall mean, with reference to 2017 Bonds, as of any particular time, all 2017 Bonds executed, authenticated, issued and delivered under the Bond Indenture; provided, however, that such terms shall not include, in any case:

(a) 2017 Bonds canceled or delivered to the Bond Trustee for cancellation at or prior to such time;

(b) 2017 Bonds in substitution for which other 2017 Bonds shall have been authenticated and delivered pursuant to provisions of the Bond Indenture; and

(c) 2017 Bonds for payment or redemption of which provision has been made in accordance with the Bond Indenture; provided, however, that if such 2017 Bonds are being redeemed, notice of any such redemption shall have been mailed or provision satisfactory to the Bond Trustee shall have been made for such notice or written waivers of such notice shall have been received as provided in the Bond Indenture.

The foregoing, however, is subject to the condition that, for purpose of reference in the Bond Indenture or in the Loan Agreement to Holders of a particular percentage of 2017 Bonds, there shall be excluded 2017 Bonds, if any, held by the Authority or the System.

"Person" shall mean an individual, a corporation, a partnership, an association, a joint stock company, a joint venture, a trust, an unincorporated organization, an authority or similar body or a government or a political subdivision or agency thereof, or any other entity.

"Project" shall mean, among other things, the application of proceeds of the 2017 Bonds for and toward: (a) the advance refunding of a portion of The Berks County Municipal Authority's Fixed Rate Revenue Bonds (The Reading Hospital and Medical Center Project) Series 2009A-3; (b) the refunding of certain outstanding taxable indebtedness of the System; (c) the design, construction, installation and furnishing of the Reading HealthPlex for Advanced Surgical & Patient Care; (d) the acquisition of Brandywine Hospital, a 234-bed acute care hospital located in Coatesville, Pennsylvania, including related office buildings, parking facilities and related facilities; (e) the acquisition of Chestnut Hill Hospital, a 135-bed acute care hospital located in Philadelphia, Pennsylvania, including related medical office buildings, surgery centers and parking facilities; (f) the acquisition of Jennersville Regional Hospital, a 63-bed acute care hospital located in West Grove, Pennsylvania, including related medical office buildings and related facilities; (g) the acquisition of Phoenixville Hospital, a 151-bed acute care hospital located in Phoenixville, Pennsylvania, including related medical office buildings and related facilities; (h) the acquisition of Pottstown Memorial Medical Center, a 232-bed acute care hospital located in Pottstown, Pennsylvania, including related medical office buildings and surgery centers; and (i) the payment of costs and expenses associated with issuance of the 2017 Bonds.

"Project Fund" means the Project Fund created under the Bond Indenture.

"Registered Owner" shall mean a Person in whose name any 2017 Bond shall be registered on books of the Authority to be kept for that purpose in accordance with provisions of the Bond Indenture and of such 2017 Bond.

"Responsible Officer" means (a) when used with respect to the Authority its Chairman, Vice Chairman, Executive Director, any Assistant Executive Director, any Treasurer, Assistant Treasurer, Secretary, Assistant Secretary, or an incumbent of such other office or such other officers specifically named as shall be designated by a currently effective Certified Authority Resolution and (b) when used with respect to the System, its president, any vice president, its secretary or assistant secretary, its treasurer or any other person designated as a Responsible Officer of the System in a Certified System Resolution.

"Revenue Fund" shall mean the Revenue Fund created under the Bond Indenture.

"S&P" means Standard & Poor's, a division of The McGraw-Hill Companies, a corporation organized and existing under the laws of the State of New York, its successors and assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the System by notice in writing to the Issuer and the Bond Trustee.

"2017 Bonds" or "Bonds" shall mean the $590,500,000 aggregate principal amount of the Berks County Industrial Development Authority Health System Revenue Bonds (Tower Health Project), Series of 2017, issued and outstanding under the Bond Indenture.

"Settlement Fund" shall mean the Settlement Fund created under the Bond Indenture.

"Tax Certificate and Compliance Agreement" means, as the context may require, the Non-Arbitrage Certificate and Compliance Agreement dated the date of issuance of the 2017 Bonds delivered by the Authority and the Confirmation Certificate and Agreement dated the date of issuance of the 2017 Bonds delivered by the System, as the same may be amended or supplemented in accordance with its terms.

SUMMARY OF THE BOND INDENTURE

The following summarizes certain provisions of the Bond Indenture; however, it is not a comprehensive description, and reference is made to the full text of the Bond Indenture for a complete recital of its terms.

Pledge and Assignment

The Authority pledges to the Bond Trustee, as trustee under the Bond Indenture, its successors in the trust and its and their assigns forever, to the extent provided in the Bond Indenture, all of the right, title and interest of the Authority in and to the Loan Agreement (excepting its right to administrative fees and expenses and indemnification), in and to the Series B of 2017 Master Note and in and to all security therefor under the Master Indenture, together with all sums of money due and payable or to become due and payable thereunder to the Authority (except sums payable in respect of the Authority's administrative fees and expenses and indemnification) or to the Bond Trustee by the System and all money, securities and funds at any time held or set aside by the Bond Trustee pursuant to the provisions of the Bond Indenture.

Funds Created by the Bond Indenture

1. Settlement Fund
2. Project Fund
3. Revenue Fund
4. Debt Service Fund
5. Bond Redemption Fund

Money, from time to time, in the various funds created under the Bond Indenture shall be held by the Bond Trustee, in trust, for the benefit of holders of 2017 Bonds and shall be secured, invested and applied as provided in the Bond Indenture; subject, however, to provisions of the Bond Indenture relating to transfer of certain investment income to or for the benefit of the System.

Settlement Fund

All money representing proceeds of sale of the 2017 Bonds shall be deposited initially into the Settlement Fund and disbursed by the Bond Trustee to pay costs of the Project and to provide for the payment of costs and expenses of issuance of the 2017 Bonds.

Project Fund

Moneys deposited to the credit of the Project Fund pursuant to the provisions of the Bond Indenture or the Loan Agreement shall be deposited therein with, and held in trust by, the Bond Trustee until withdrawn and disbursed by the Bond Trustee in payment of the Costs of the Project. The Project Fund has been established for the benefit of the System and payments therefrom shall be made solely at the direction of the System.

Revenue Fund

All money payable by the System to the Authority under the Loan Agreement and the Series B of 2017 Master Note shall be paid directly to the Bond Trustee by the System and shall be deposited by the Bond Trustee into the Revenue Fund.

Debt Service Fund

The Bond Trustee shall, on or before each date on which principal of or interest on 2017 Bonds comes due, withdraw from the Revenue Fund and deposit to the Debt Service Fund (subject to deposits from other funds made directly to the Debt Service Fund and other available funds on deposit therein) the amounts required to pay the principal or interest, or both, coming due with respect to the 2017 Bonds. Any interest or profit from investments or deposits of money in other funds created by the Bond Indenture which have been transferred to the Debt Service Fund shall first reduce the amount required to be transferred from the Revenue Fund, as more fully provided in the Bond Indenture.

Bond Redemption Fund

Any amounts that the System elects to provide, or is required by the Master Indenture to provide, for optional or extraordinary redemption of the 2017 Bonds shall be deposited in the Bond Redemption Fund.

The Bond Trustee shall be authorized, without any direction from the Authority, to transfer money from the Bond Redemption Fund to the Debt Service Fund to the extent that the money in the Debt Service Fund may be insufficient at any time to pay the 2017 Bonds and the interest thereon as the same shall become due or any costs involved therewith or to make the withdrawals and deposits required pursuant to the terms of the Bond Indenture.

The payment of the necessary premiums, costs and expenses of any purchases or redemption of 2017 Bonds pursuant to the Bond Indenture, including, without limiting the generality of the foregoing, all legal fees, costs of advertisement, printing costs, brokerage charges and charges of the Bond Trustee incident to such purchases or redemptions shall be payable from money in the Bond Redemption Fund.

Investment of Funds

Money in each of the funds created under the Bond Indenture shall, from time to time, at the written direction of a Responsible Officer of the System, hereby designated by the Authority as the agent of the Authority for such purpose, be invested by the Bond Trustee in Authorized Investments and shall mature, or be subject to repurchase, withdrawal without penalty, or redemption at the option of the holder, on or before the dates on which the amounts are reasonably expected to be needed for the purposes of the Bond Indenture.

Accrued interest and premiums, if any, paid at the time of the purchase of such investments shall be paid from available money in the particular fund for which such investment is being made. Upon the written direction of the System or whenever the money in said funds are to be applied and paid out pursuant to any provisions of the Bond Indenture, the Bond Trustee may sell all or any part of the obligations in which the money in one or more such funds shall be invested or deposited, and the proceeds of such sale shall be deposited to the credit of the respective fund or funds. Obligations purchased as an investment of money in any such fund and deposits of money in any such Fund shall be deemed at all times to be a part of such fund and the interest accruing thereon and any profit or loss realized from such investment shall be credited to or charged against such fund. The Bond Trustee shall not be deemed to have any investment discretion.

All funds under the Bond Indenture shall be invested only in Authorized Investments. Investments on deposit in all funds and accounts established under the Bond Indenture shall be valued at market value at least quarterly.

Neither the Authority nor the Bond Trustee shall be liable or responsible for any loss resulting from any investment or deposit made in accordance with the provisions of the Bond Indenture or resulting from any sale by the Bond Trustee of any such investment or deposit. For the purpose of the Bond Indenture, investments and deposits shall be deemed to constitute unexpended money and shall be valued at the then market value thereof. The Bond Trustee may request an opinion of legal counsel satisfactory to it as to whether an investment or deposit directed under the Bond Indenture is appropriate and may rely upon such opinion and, if applicable, may refuse to follow or honor any such direction given under the Bond Indenture.

Defaults and Remedies

Each of the following events is an "event of default" under the Bond Indenture:

(A) failure to pay any interest upon any 2017 Bond at any due date expressed therefor; or

(B) failure to pay any part of the principal of, or premium, if any, on any of the 2017 Bonds at maturity as therein expressed or when the same shall become due upon call for mandatory sinking fund redemption, or by declaration or otherwise; or

(C) declaration under the Master Indenture that the principal of all Master Notes issued thereunder is due and payable; or

(D) there shall be an "Event of Default" as defined in the Loan Agreement; or

(E) the Authority shall default in the due and punctual performance (irrespective of any revenues or other money not being available for such purpose) of any other covenant, condition, agreement or provision contained in the 2017 Bonds or in the Bond Indenture on the part of the Authority required to be performed and any such default shall have continued for a period of 30 days after written notice specifying such default and requiring the same to be remedied shall have been given to the Authority by the Bond Trustee, which may give such notice in its discretion and shall give such notice upon written request of Holders of not less than 25% in aggregate principal amount of the 2017 Bonds then outstanding.

Upon the occurrence and during the continuance of an event of default, the Bond Trustee shall have the following rights and remedies:

(i) The Bond Trustee shall, at the written request of the Holders of not less than twenty-five percent (25%) in aggregate principal amount of 2017 Bonds then outstanding, by notice in writing given to the Authority and the System, declare the principal amount of all 2017 Bonds then outstanding to be immediately due and payable, whereupon that portion of the principal of the 2017 Bonds thereby coming due and the interest thereon accrued to the date of payment shall, without further action, become and be immediately due and payable, anything in the Bond Indenture or in the 2017 Bonds to the contrary notwithstanding. Upon any declaration of acceleration, the Bond Trustee shall: (1) give written notice to the Master Trustee; and (2) give notice to the Bondholders in the same manner as a notice of redemption, stating the date upon which the 2017 Bonds shall be payable, and to the extent that the principal of all the Master Notes issued under the Master Indenture shall not then have been declared to be immediately due and payable, the Bond Trustee shall request the Master Trustee to declare the principal of all Master Notes issued under the Master Indenture to be immediately due and payable, pursuant to the Master Indenture.

(ii) The Bond Trustee may, by mandamus, or other suit, action or proceeding at law or in equity, enforce the right of the Bondholders, and require the Authority or the System or both of them to carry out the agreements with or for the benefit of the Bondholders, and to perform its or their duties, under the Act, the Loan Agreement and the Bond Indenture.

(iii) The Bond Trustee may, by action or suit in equity, require the Authority to account as if it were the trustee for the Bondholders, but any such judgment against the Authority shall be enforceable only against the funds under the Bond Indenture in the hands of the Bond Trustee.

(iv) The Bond Trustee may, by action or suit in equity, enjoin any acts or things which may be unlawful or in violation of the rights of the Bondholders.

(v) The Bond Trustee may, upon the filing of a suit or other commencement of judicial proceedings to enforce the rights of the Bond Trustee and the Bondholders, have appointed a

receiver or receiver of the trust estate with such powers as the court making such appointment shall confer.

No right or remedy is intended to be exclusive of any other right or remedy, but each and every such right or remedy shall be cumulative and in addition to any other remedy given under the Bond Indenture or now or hereafter existing at law or in equity or by statute.

If any event of default shall have occurred and shall be continuing and if requested in writing by the holders of twenty-five percent (25%) in aggregate principal amount of 2017 Bonds then Outstanding, and if indemnified as provided in the Bond Indenture, the Bond Trustee shall be obligated to exercise such rights and powers conferred by the Bond Indenture as it, being advised by counsel, shall deem most expedient in the interests of such Bondholders.

Application of Moneys in Event of Default

Any money received by the Bond Trustee or by any receiver from, or in connection with, the System, upon exercise of remedies under the Bond Indenture, shall be applied:

First: to the payment of the compensation, reasonable counsel fees and expenses of the Bond Trustee and then to the payment of the compensation, reasonable counsel fees and expenses of the Authority and of the receivers, if any, and all costs and disbursements allowed by the court, if there be any court action;

Second: to the payment of the whole amount of principal and interest which shall then be owing or unpaid upon the 2017 Bonds to the Holders thereof and in case such amounts shall be insufficient to pay in full the whole sum so due and unpaid, then to the payment of such principal and interest ratably, without preference or priority of principal over interest or of interest over principal or of any installment of interest over any other installment of interest, except as provided in the Bond Indenture; and

Third: to the payment of the surplus, if any, to the System or to whomever is lawfully entitled to receive the same, or as a court of competent jurisdiction may direct.

Rights and Remedies of Bondholders

No holder of any of the 2017 Bonds shall have any right to institute any suit, action or proceeding in equity or at law for the enforcement of the Bond Indenture or for execution of any trust under the Bond Indenture, or for any other remedy under the Bond Indenture, unless such holder previously shall have given to the Bond Trustee written notice of an event of default, and unless also the holders of not less than 25% of the 2017 Bonds then outstanding shall have made written request of the Bond Trustee, after the right to exercise such powers or rights of action shall have accrued, and shall have afforded the Bond Trustee a reasonable opportunity either to proceed to exercise the powers hereinabove granted or to institute such action, suit or proceeding in its or their name, nor unless also there shall have been offered to the Bond Trustee security and indemnity satisfactory to it against the costs, expenses and liabilities to be incurred therein or thereby, and the Bond Trustee shall have refused or neglected to comply with such request within a reasonable time; and such notification, request and offer of indemnity are declared in every such case at the option of the Bond Trustee to be conditions precedent to the execution of the powers and trusts of the Bond Indenture and to any action or cause of action for the enforcement of the Bond Indenture or for any other remedy under the Bond Indenture, it being understood and intended that no one or more holders of any 2017 Bonds shall have any right in any manner whatever by his or their action to affect, disturb or prejudice the security of the Bond Indenture, or to enforce any

right under the Bond Indenture, except in the manner therein provided, and that all proceedings at law or in equity shall be instituted and maintained in the manner therein provided and for the ratable benefit (subject to all of the terms, conditions and provisions of the Bond Indenture) of all holders of outstanding 2017 Bonds.

Amendments and Modifications

Modifications or amendments of the Bond Indenture and of the rights and obligations of the Authority and of the holders of the 2017 Bonds in any particular may be made by supplemental indenture, authorized by Certified Authority Resolution, but without the consent of the Bondholders:

(A) to cure any ambiguity or formal defect or omission, to correct or supplement any provision in the Bond Indenture that may be inconsistent with any other provision in the Bond Indenture, to make any other provisions with respect to matters or questions arising under the Bond Indenture,

(B) to grant to or confer upon the Bond Trustee for the benefit of the Holders any additional rights, remedies, powers, authority or security that may lawfully be granted to or conferred upon the Holders or the Bond Trustee,

(C) to add to the provisions of the Bond Indenture other conditions, limitations and restrictions thereafter to be observed by the Authority,

(D) to add to the covenants and agreements of the Authority in the Bond Indenture other covenants and agreements thereafter to be observed by the Authority or to surrender any right or power in the Bond Indenture reserved to or conferred upon the Authority,

(E) to permit the qualification of the Bond Indenture under any federal statute now or hereafter in effect or under any state Blue Sky law, and, in connection therewith, if the Authority so determines, to add to the Bond Indenture or any supplemental trust indenture such other terms, conditions and provisions as may be permitted or required by such federal statute or Blue Sky law,

(F) to provide for the issuance of 2017 Bonds in certificated form,

(G) to provide for the maintenance of 2017 Bonds under a book-entry system,

(H) to permit the Bond Trustee to comply with any obligations imposed upon it by law,

(I) to make amendments to the provisions of the Bond Indenture relating to arbitrage matters under Section 148 of the Code, if in the opinion of Bond Counsel selected by the Authority, those amendments would not cause the interest on the 2017 Bonds outstanding to become included in the gross income of the Holders thereof for federal income tax purposes, which amendments may, among other things, change the responsibility for making the relevant arbitrage calculations, or

(J) to permit any other amendment which is not materially adverse to the interests of the Bond Trustee or the Holders.

Other modifications and amendments of the Bond Indenture may be made only with the written consent of the Holders of not less than a majority in aggregate principal amount of the 2017 Bonds then Outstanding or, in case one or more but less than all of the 2017 Bonds then Outstanding are affected by any such modification or amendment, then with the written consent of the Holders of not less than a majority in aggregate principal amount of the 2017 Bonds so affected then Outstanding; provided, however, that, without the consent of the Holders of all of the 2017 Bonds affected then Outstanding, no such modification or amendment shall be made so as to (a) alter the date fixed in any of the 2017 Bonds for the payment of the principal of, or interest on, such 2017 Bonds or otherwise modify the terms of payment of the principal at maturity of, or interest on, the 2017 Bonds or impose any conditions with respect to such payment or affect the right of any Bondholder to institute suit for the enforcement of any such payment on or after the respective due dates expressed in the 2017 Bonds, subject to the requirements of the Bond Indenture requiring the provision of satisfactory indemnity to the Bond Trustee, (b) reduce the amount of, or extend the time for making, sinking fund payments required for any 2017 Bonds, (c) alter the amount of principal of, or the rate of interest or premium (if any) payable on, any of the 2017 Bonds, (d) permit the creation by the Authority of any lien prior to the lien of the Bond Indenture upon the trust estate thereunder, or (e) reduce the percentages above stated in this paragraph.

It shall not be necessary for the consent of the Bondholders under this Section to approve the particular form of any proposed supplemental indenture, but it shall be sufficient if such consent shall approve the substance thereof. Upon the request of the Authority, accompanied by the Certified Authority Resolution and the filing with the Bond Trustee of the evidence of the consent of Bondholders, above provided for, the Bond Trustee shall join with the Authority in the execution of any such supplemental indenture unless the same adversely affects the Bond Trustee's own rights, duties or immunities under the Bond Indenture in which case the Bond Trustee may in its discretion, but shall not be obliged to, enter into such supplemental indenture.

Replacement Master Indenture

In the event that a Substitute Obligation (as defined in the Master Indenture) under a Replacement Master Indenture (as defined in the Master Indenture) is delivered to the Bond Trustee pursuant to the provisions of the Master Indenture, references to the Master Indenture and the Series B of 2017 Master Note in the Bond Indenture shall be deemed to be references to such Replacement Master Indenture and such Substitute Obligation, references to the Obligated Group shall be deemed to be references to the New Group (as defined in the Master Indenture) and references to the Master Trustee shall be deemed to be references to the New Trustee under the Replacement Master Indenture.

Defeasance

(a) If the Authority deposits with the Bond Trustee money or Defeasance Obligations sufficient to pay the principal or redemption price of any particular 2017 Bond or 2017 Bonds becoming due, either at maturity or by call for redemption or otherwise, together with all interest accruing thereon to the due date, interest on the 2017 Bond or 2017 Bonds shall cease to accrue on the due date and all liability of the Authority with respect to such 2017 Bond or 2017 Bonds shall likewise cease, except as provided in subsection (b) below. Thereafter such 2017 Bond or 2017 Bonds shall be deemed not to be Outstanding under the Bond Indenture and the holder or holders of such 2017 Bond or 2017 Bonds shall be restricted exclusively to the funds so deposited for any claim of whatsoever nature with respect to such 2017 Bond or 2017 Bonds, and the Bond Trustee shall hold such funds in trust for such holder or holders.

(b) Money deposited with the Bond Trustee which remains unclaimed four (4) years after the date payment of the interest, premium and/or principal of the 2017 Bond or 2017 Bonds for

which such money was deposited becomes due shall, upon request of the Authority, if the Authority is not at the time to the knowledge of the Bond Trustee in default with respect to any covenant in the Bond Indenture or the 2017 Bonds contained, be paid to the System; and the holders of the 2017 Bonds for which the deposit was made shall thereafter be limited to a claim against the System; provided, however, that the Bond Trustee, before making payment to the System, shall, at the expense of the System, cause a notice to be mailed by first class mail, postage prepaid, to the registered owners of the 2017 Bonds for which such money has been so deposited, stating that the money remaining unclaimed will be paid to the System after a date specified in such notice. In the absence of any such written request from the Authority, the Bond Trustee shall from time to time deliver such unclaimed funds to or as directed by pertinent escheat authority, as identified by the Bond Trustee in its sole discretion, pursuant to and in accordance with the applicable unclaimed property laws, rules or regulations. Any such delivery shall be in accordance with the customary practices and procedures of the Bond Trustee and the escheat authority. Any money held by the Bond Trustee pursuant to his Section shall be held uninvested and without any liability for interest.

(c) Whenever money and/or Defeasance Obligations are deposited with the Bond Trustee in accordance with this Section, the System shall provide to the Bond Trustee (i) a verification report from an independent certified public accountant, satisfactory in form and content to the Bond Trustee and the Authority, demonstrating that the money and/or Defeasance Obligations so deposited and the income therefrom shall be sufficient to pay the principal of, premium, if any, and all unpaid interest to maturity, or to the redemption date, as the case may be, on the 2017 Bonds to be paid or redeemed, as such principal, premium, if any, and interest become due, and (ii) an opinion of nationally recognized bond counsel, satisfactory in form and content to the Bond Trustee and the Authority, to the effect that all of the requirements of the Bond Indenture for the defeasance of the 2017 Bonds have been complied with.

Immunities -- Limitation of Liability

No recourse shall be had for the payment of the principal of or redemption premium, if any, or interest on any of the 2017 Bonds or for any claim based thereon or upon any obligation, covenant or agreement in the Bond Indenture contained against any past, present or future officer, director, member, employee or agent of the Authority, or of any successor public corporation, as such, either directly or through the Authority or any successor public corporation, under any rule of law or equity, statute or constitution, or by the enforcement of any assessment or penalty or otherwise, all such liability of such officers, directors, members, employees or agents as such is hereby expressly waived and released as a condition of and consideration for the execution of the Bond Indenture and the issuance of the 2017 Bonds.

Removal of Bond Trustee

The Bond Trustee may be removed at any time by a written instrument, executed by (i) the holders of at least a majority in aggregate principal amount of the Outstanding 2017 Bonds or by their attorneys-in-fact duly authorized and filed with the Bond Trustee, the Authority and the System or (ii) so long as no Event of Default shall have occurred and be continuing, the System, with the consent of the Authority, or the Authority, with the consent of the System, and filed with the Bond Trustee, the Authority and the System, as applicable.

Resignation of Bond Trustee

The Bond Trustee may resign and be discharged of the trusts under the Bond Indenture by executing a written instrument resigning such trusts, filing the same with the Authority and the System and mailing notice of such resignation by first class mail, postage prepaid, to all Holders of the

2017 Bonds not less than three (3) weeks prior to the date when the resignation is to take effect. Such resignation shall take effect only after such notices shall have been mailed, the appointment of a successor trustee shall have been made and such successor trustee shall have accepted the duties of the trustee under the Bond Indenture.

Appointment of Successor Bond Trustee

If the Bond Trustee shall resign or be removed as provided in the Bond Indenture or the office of the Bond Trustee shall become vacant for any reason, a successor may be appointed by the Authority, the System, with the consent of the Authority, or the Holders of at least a majority in aggregate principal amount of the Outstanding 2017 Bonds by a written instrument signed by such Bondholders or by their attorneys-in-fact duly authorized. Such instrument shall be filed with the Authority and the System and a copy thereof shall be promptly delivered by the Authority or the System, as applicable, to the predecessor Bond Trustee and to the trustee so appointed.

After any appointment by the Authority, the System or the Bondholders, the Authority, at the expense of the System, shall cause notice of such appointment to be mailed to all Registered Owners at their addresses shown on the bond register. The Authority covenants in the Bond Indenture that whenever necessary to avoid or fill a vacancy in the office of trustee, it will appoint or cause to be appointed a trustee so that there shall at all times be a trustee eligible under the Bond Indenture.

Holders of 2017 Bonds Deemed Holders of the Series B of 2017 Master Note

In the event that any request, direction or consent is requested or permitted by the Master Indenture of the registered owners of Master Notes issued thereunder, including the Series B of 2017 Master Note, the Holders of 2017 Bonds then Outstanding shall be deemed to be registered owners of the Series B of 2017 Master Note for the purpose of any such request, direction or consent in the proportion that the aggregate principal amount of 2017 Bonds then Outstanding held by each such Holder of 2017 Bonds bears to the aggregate principal amount of all 2017 Bonds then Outstanding. The provisions of this section and of the Master Indenture shall govern the execution of any such request, consent or other instrument in writing required or permitted to be signed by Holders and registered owners of the Series B of 2017 Master Note, respectively.

SUMMARY OF THE LOAN AGREEMENT

The following summarizes certain provisions of the Loan Agreement; however, it is not a comprehensive description, and reference is made to the full text of the Loan Agreement for a complete recital of its terms.

General

The Loan Agreement provides the terms of the loan of all of proceeds of the 2017 Bonds by the Authority to the System and the repayment of such loan by the System.

Loan Repayments

Pursuant to the Loan Agreement, the System agrees to pay, or cause to be paid, "Loan Repayments" in an amount sufficient to enable the Bond Trustee to make the transfers and deposits required at the times and in the amounts pursuant to the Bond Indenture. Each Loan Repayment shall be made in immediately available funds. Notwithstanding the foregoing, the System agrees to make payments, or cause payments to be made, at the times and in the amounts required to be paid as principal

or redemption price of and interest on the 2017 Bonds from time to time Outstanding under the Bond Indenture and other amounts required to be paid under the Bond Indenture, as the same shall become due whether at maturity, upon redemption, by declaration of acceleration or otherwise.

Additional Payments

The System also agrees to pay certain additional payments in connection with the issuance of the 2017 Bonds, including fees of the Authority, reasonable fees, charges, expenses and indemnities of the Authority and the Bond Trustee under the Loan Agreement and the Bond Indenture, reasonable fees and expenses of such experts engaged by the Authority or the Bond Trustee, certain taxes and assessments charged to the Authority or the Bond Trustee and all other reasonable and necessary fees and expenses attributable to the Loan Agreement or the Series B of 2017 Master Note (collectively, the "Additional Payments").

Prepayment

The System may prepay all or any part of the amounts payable under the Loan Agreement for the purpose of redeeming or providing for the redemption or payment at maturity of all or a portion of the 2017 Bonds, all as permitted under, and in accordance with the provisions of, the Bond Indenture.

No Set-Off

The obligation of the System to make the payments required by the Loan Agreement shall be absolute and unconditional. The System will pay without abatement, diminution or deduction (whether for taxes, loss of use, in whole or in part, of the Property, Plant and Equipment (as defined in the Master Indenture) of the System or otherwise) all such amounts regardless of any cause or circumstance whatsoever, which may now exist or may hereafter arise, including without limitation, any defense, set-off, recoupment or counterclaim which the System may have or assert against the Authority, the Bond Trustee, any Bondholder or any other Person.

Tax Covenant

The System covenants and agrees for itself and on behalf of the Authority that it will at all times do and perform, for itself and on behalf of the Authority, all acts and things permitted by law and the Loan Agreement which are necessary in order for the 2017 Bonds to satisfy the requirements of Sections 103 and 141 through 150 of the Code in order to assure that interest paid on the 2017 Bonds (or any of them) will be excluded from gross income for federal income tax purposes and will take no action that would result in failure of the 2017 Bonds to satisfy those requirements of the Code. Without limiting the generality of the foregoing, the System agrees to comply, and to cause the other members of the Obligated Group to comply, with the provisions of the Tax Certificate and Compliance Agreement. This covenant shall survive payment in full or defeasance of the 2017 Bonds.

Events of Default

Each of the following events shall constitute and be referred to as an "Event of Default" with respect to the Loan Agreement:

(a) Failure by the System to pay in full any payment required under the Loan Agreement or by the Obligated Group to pay in full any payment required under the Series B of 2017 Master Note when due, whether on an Interest Payment Date or at maturity, upon a date fixed for

prepayment, by declaration or upon tender of the 2017 Bonds for purchase pursuant to the Bond Indenture;

(b) If any material representation or warranty made by the System in the Loan Agreement or made by the System or any Member of the Obligated Group in any document, instrument or certificate furnished to the Bond Trustee or the Authority in connection with the issuance of the Series B of 2017 Master Note or the 2017 Bonds shall at any time prove to have been incorrect in any respect as of the time made and shall not be brought into compliance within a period of sixty (60) days after written notice has been given to the System by the Authority or the Bond Trustee;

(c) If the System shall fail to observe or perform any other covenant, condition, agreement or provision in the Loan Agreement on its part to be observed or performed, or shall breach any warranty by the System contained in the Loan Agreement, for a period of sixty (60) days after written notice, specifying such failure or breach and requesting that it be remedied, has been given to the System by the Authority or the Bond Trustee; except that, if such failure or breach can be remedied but not within such sixty (60) day period and if the System has taken all action reasonably possible to remedy such failure or breach within such sixty (60) day period, such failure or breach shall not become an Event of Default for so long as the System shall diligently proceed to remedy such failure or breach in accordance with and subject to any directions or limitations of time established by the Bond Trustee;

(d) Any Event of Default as defined in and under the Bond Indenture; or

(e) Any Event of Default as defined in and under the Master Indenture.

Remedies on Default

If an Event of Default shall occur under the Loan Agreement, then, and in each and every such case during the continuance of such Event of Default, the Bond Trustee on behalf of the Authority, but subject to the limitations in the Bond Indenture as to the enforcement of remedies, may take such action as it deems necessary or appropriate to collect amounts due under the Loan Agreement, to enforce performance and observance of any obligation or agreement of the System under the Loan Agreement or to protect the interests securing the same, and may, without limiting the generality of the foregoing, take one of the following actions:

(a) Exercise any or all rights and remedies given by the Loan Agreement or available under the Loan Agreement or given by or available under any other instrument of any kind securing the System's performance under the Loan Agreement (including, without limitation, the Series B of 2017 Master Note and the Master Indenture);

(b) By written notice to the System declare all Loan Repayments and Additional Payments to be immediately due and payable under the Loan Agreement, whereupon the same shall become immediately due and payable; and

(c) Take any action at law or in equity to collect the payment required under the Loan Agreement then due, whether on the stated due date or by declaration of acceleration or otherwise, for damages or for specific performance or otherwise to enforce performance and observance of any obligation, agreement or covenant of the System under the Loan Agreement.

Notwithstanding any other provision of the Loan Agreement or any right, power or remedy existing at law or in equity or by statute, the Bond Trustee shall not under any circumstances declare the entire unpaid aggregate amount of the payment due under the Loan Agreement to be

immediately due and payable except in accordance with the directions of the Master Trustee if the Master Trustee shall have declared the aggregate principal amount of the Series B of 2017 Master Note and all interest thereon immediately due and payable in accordance with the Master Indenture.

APPENDIX D

SUMMARY OF THE MASTER INDENTURE

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SUMMARY OF THE MASTER INDENTURE

The following is a summary of certain provisions of the Master Indenture. It is not a comprehensive description, however, and is qualified in its entirety by reference to the Master Indenture.

Amendments to Master Indenture

As described below in this Appendix D – "Summary of Master Indenture", several sections of the Master Indenture are being amended in connection with the issuance of the 2017 Bonds. Immediately upon the execution of the Thirty-Third Supplemental Indenture, the Holders of the 2017 Master Note shall be deemed to have consented to the amendments summarized below.

These amendments shall be effective as to all Holders of Obligations Outstanding under the Indenture immediately upon (a) either (i) the consent of the owners of The Berks County Municipal Authority's Revenue Note (Reading Hospital Project) Series B of 2016 (the "2016B Note") or (ii) the payment in full of the principal of and interest on the 2016B Note; provided, however, that the requirement to obtain the consent of the owners of the 2016B Note or to pay in full the principal of and interest on the 2016B Note shall only be required if the rating of the long term unenhanced Indebtedness of the Obligated Group is at or below "BBB+" by S&P, at or below "Baa1" by Moody's or at or below "BBB+" by Fitch Ratings; and (b) either (i) the consent of the owners of The Berks County Municipal Authority's Revenue Bonds (Reading Hospital Project) Series D of 2016 (the "2016D Bonds") or (ii) the payment in full of the principal of and interest on the 2016D Bonds.

The amendments to the Master Indenture described herein shall survive the payment in full of the 2017 Master Note, shall remain in full force and effect and shall become permanent amendments to the Master Indenture.

Definition of Certain Terms

In addition to the terms defined elsewhere in this Official Statement, the following are definitions of certain terms used in the Master Indenture and this Official Statement unless the context clearly otherwise requires. Reference is hereby made to the Master Indenture for complete definitions of all terms.

"Accounts Receivable Indebtedness" shall mean Indebtedness incurred or deemed incurred in connection with any sale or assignment of accounts receivable with recourse, consisting of an obligation to repurchase or accept the reassignment of all or a portion of such accounts receivable upon certain conditions.

"Additional Indebtedness" shall mean any Indebtedness incurred subsequent to the issuance of the Master Indenture Obligations which were issued under the Master Indenture as supplemented by the First Supplemental Indenture.

"Affiliate" shall mean a Person organized under the laws of the United States of America or a state thereof which is directly or indirectly controlled by the Initial Obligated Issuer or any other Affiliate. For purposes of this definition, "control" means the power to direct the

management and policies of a Person through the ownership of at least a majority of its voting securities or the right to designate or elect at least a majority of the members of its Governing Body, whether by contract or otherwise.

"Balloon Long-Term Indebtedness" shall mean Long-Term Indebtedness, other than Commercial Paper Indebtedness and Interim Indebtedness, 25% or more of the principal of which matures in a single year and which portion of the principal is not required by the documents governing such Indebtedness to be amortized by redemption prior to such date.

"Bond Insurer" shall mean the provider of a policy of municipal bond insurance with respect to any Related Bonds if any such policy is provided.

"Book Value," when used in connection with Property of any Master Indenture Obligor, shall mean the cost of such property, net of accumulated depreciation, as it is carried on the books of the Obligated Group, RH or any Master Indenture Obligor in conformity with generally accepted accounting principles, determined in such a manner that no portion of such value of such property is included more than once.

"Capitalization Ratio" shall mean the aggregate principal amount of Long-Term Indebtedness divided by Total Capitalization; provided, however, that in calculating the Capitalization Ratio, to the extent Long-Term Indebtedness matures or is subject to prepayment at par at the option of a member of the Obligated Group within one year, both Long-Term Indebtedness and Total Capitalization shall be reduced by the amount specified in an Excess Liquidity Certificate.

"Commercial Paper Indebtedness" shall mean Indebtedness with a stated maturity of 270 days or less which is incurred as part of a program which provides for continuously selling such securities with new maturity dates of 270 days or less as such securities mature.

"Completion Indebtedness" shall mean any Indebtedness incurred for the purpose of financing the completion of the constructing or equipping of facilities for which Indebtedness has heretofore been incurred in accordance with the provisions of the Master Indenture to the extent necessary to provide a completed and equipped facility of the type and scope contemplated at the time that such prior Indebtedness was originally incurred, and in accordance with the general plans and specifications for such facility as originally prepared with only such changes as have been made in conformance with the documents pursuant to which such prior Indebtedness was originally incurred.

"Consultant" shall mean a Person having the skill and experience necessary to render the particular report required by the provision of the Master Indenture in which such requirement appears. In rendering a particular report under the Master Indenture, a Consultant shall be entitled to rely on a report prepared by another Consultant qualified to render such report in accordance with the provisions of the Master Indenture.

"Corporate Trust Office" shall mean an office of the Master Trustee or its agent at which its corporate trust business with respect to the transactions contemplated by the Master Indenture is conducted.

"Derivative Agreement" means, without limitation, (i) any contract known as or referred to or which performs the function of an interest rate swap agreement, currency swap agreement, forward payment conversion agreement or futures contract, (ii) any contract providing for payments based on levels of, or charges or differences in, interest rates, currency exchange rates, or stock or other indices, (iii) any contract to exchange cash flows or payments or series of payments, (iv) any type of contract called, or designed to perform the function of, interest rate floors or caps, options, puts or calls, to hedge or minimize any type of financial risk, including, without limitation, payment, currency, rate or other financial risk, and (v) any other type of contract or arrangement that the Member of the Obligated Group entering into such contract or arrangement determines is to be used, or is intended to be used, to manage or reduce the cost of Indebtedness, to convert any element of Indebtedness from one form to another, to maximize or increase investment return, to minimize investment return risk or to protect against any type of financial risk or uncertainty.

"Discount Indebtedness" shall mean any Indebtedness issued at an original price which is less than 90% of the principal amount thereof at maturity.

"Event of Default" shall mean any one or more of those events set forth under the caption "Event of Default" below.

"Excess Liquidity Certificate" shall mean an Officer's Certificate specifying the amount by which unrestricted plus board restricted assets held in cash or liquid securities by all members of the Obligated Group exceed accumulated depreciation and amortization plus 30 days of operating expenses for all members of the Obligated Group.

"Financial Statements" shall mean the consolidated or combined financial statements of the Obligated Group or the consolidated or combined financial statements of RH and its consolidated or combined Affiliates, including the members of the Obligated Group, which contain certain summarized consolidated or combined financial information concerning the Obligated Group or, if RH is the only Master Indenture Obligor, the financial statements of RH.

"First Supplemental Indenture" shall mean the First Supplemental Master Trust Indenture, dated as of June 1, 1993, between RH and the Master Trustee.

"Governing Body" shall mean, when used with respect to RH or any other Master Indenture Obligor, its board of directors, or other board or group of individuals in which the powers of such Master Indenture Obligor are vested, either generally or solely with respect to the specific matter under consideration.

"Governmental Restrictions" shall mean federal, state or other applicable governmental laws or regulations affecting any Master Indenture Obligor and its health care or other facilities placing restrictions and limitations on the fees and charges to be fixed, charged and collected by such Master Indenture Obligor.

"Gross Revenues" means all revenue, income, receipts and money received in any period by the Obligated Group (other than the proceeds of borrowing), including, but without limiting the generality of the foregoing, (a) gross revenues derived from operations, (b) gifts, grants, bequests, donations and contributions, exclusive of any gifts, grants, bequests, donations and contributions and income therefrom, to the extent specifically restricted by the donor to a

particular purpose inconsistent with their use for the payment of principal of, redemption premium, if any, and interest on Master Indenture Obligations and (c) proceeds derived from (i) insurance, except to the extent otherwise required by the Indenture, (ii) accounts receivable, (iii) securities and other investments, unless such securities or investments are excluded under clause (b) above, in this definition, (iv) inventory and other tangible and intangible property, (v) medical or hospital insurance or indemnity programs or agreements and (vi) contract rights and other rights and assets now or hereafter owned, held or possessed by or on behalf of the Obligated Group; provided, that no determination of Gross Revenues shall take into account any revenues of an Affiliate which is not a member of the Obligated Group or any gain or loss resulting from either the extinguishment of Indebtedness or the sale, exchange or other disposition of capital assets not made in the ordinary course of business.

"Guaranty" shall mean all obligations of any Master Indenture Obligor guaranteeing in any manner whether directly or indirectly any obligation of any other person not a member of the Obligated Group which obligation of such other person would, if such obligation were the obligation of such Master Indenture Obligor, constitute Indebtedness. The term Guaranty shall also include any Pass-Through Indebtedness.

"Holder" shall mean the holder or the registered owner of any Master Indenture Obligation.

"Income Available for Debt Service" shall mean, with respect to the Obligated Group, as to any period of time, the excess of revenues over expenses, as determined in accordance with generally accepted accounting principles consistently applied, plus depreciation, amortization and interest on Long-Term Indebtedness and other non-cash charges; provided, that no determination thereof shall take into account any gain or loss resulting from either the extinguishment of Indebtedness or any other disposition of capital assets not made in the ordinary course of business or any revenue or expense of an Affiliate which is not a member of the Obligated Group, provided, however, that such determination of Income Available for Debt Service shall take into account "Net Transfers of Liquid Assets." "Net Transfers of Liquid Assets" shall mean (a) the sum of transfers of cash and investments made in the ordinary course of business to a Master Indenture Obligor from an Affiliate which is not a member of the Obligated Group for the corresponding period of time included in the determination of Income Available for Debt Service for which Financial Statements have been examined by Independent Certified Public Accountants minus (b) the sum of transfers of cash and investments made in the ordinary course of business to an Affiliate which is not a member of the Obligated Group from a Master Indenture Obligor during such period (excluding the transfers described in subparagraphs (b), (c), (d) and (e) under the caption "Sale or Other Disposition of Certain Property; Disposition of Cash and Investments" below). Income Available for Debt Service shall also include any Income Available for Debt Service of any primary obligor for which a Guaranty is Outstanding to the extent of any debt service attributed to the Obligated Group under the Master Indenture.

"Indebtedness" shall mean all outstanding obligations for borrowed money, installment sale obligations and capitalized lease obligations incurred or assumed by any member of the Obligated Group including, without limitation, Guaranties, except obligations of a member of the Obligated Group to another member of the Obligated Group.

"Indenture" shall mean the Master Indenture including all Supplemental Indentures.

"Independent Certified Public Accountant" shall mean a Person (but not an individual) which is independent in accordance with the rules of the American Institute of Certified Public Accountants.

"Initial Obligated Issuer" shall mean RH.

"Interim Indebtedness" shall mean Indebtedness having a term of 60 months or less, other than Commercial Paper Indebtedness, which is incurred in anticipation of the financing of capital improvements for a member of the Obligated Group and which is expected to be refinanced using the proceeds of Long-Term Indebtedness.

"Investment Securities" shall mean:

(a) direct obligations of, or obligations the principal and interest on which are unconditionally guaranteed by, the United States of America (hereinafter referred to as "Government Obligations");

(b) rights to receive the principal of or the interest on Government Obligations through (i) direct ownership, as evidenced by physical possession of such Government Obligations or unmatured interest coupons or by registration as to ownership on the books of the issuer or its duly authorized paying agent or transfer agent, or (ii) purchase of certificates or other instruments evidencing an undivided ownership interest in payments of the principal of or interest on Government Obligations; and

(c) debt obligations of any state or political subdivision thereof or any agency or instrumentality of such a state or political subdivision, provided that the principal or redemption price of and interest on such obligations are secured by and payable from amounts received (without reinvestment) in respect of the principal of and interest on non-callable Government Obligations, and provided further that, at the time of purchase, such obligations are rated by S&P and by Moody's in the highest rating category assigned by each such rating service (or, upon the discontinuance of either such rating service, by another nationally recognized rating service or services).

"Lien" shall mean any mortgage or pledge of, security interest in or encumbrance on any Property which secures any indebtedness to any Person other than a member of the Obligated Group.

"Long-Term Debt Service Coverage Ratio" shall mean for any period of time the ratio determined by dividing Income Available for Debt Service by Maximum Annual Debt Service.

"Long-Term Debt Service Requirement" shall mean, for any period of time for which such determination is made, the aggregate of the payments to be made in respect of principal and interest on Long-Term Indebtedness of each member of the Obligated Group during such period, as adjusted (i) with respect to Interim Indebtedness, the amount of the principal and interest determined under subparagraph (a) under the caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" below, (ii) with respect to Balloon Long-Term Indebtedness, the amount of principal and interest during such period determined

under subparagraph (a) under the caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" below, (iii) with respect to Variable Rate Long-Term Indebtedness, the amount of principal and interest determined under subparagraph (b) under the caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" below, (iv) with respect to Put Indebtedness, the amount of principal and interest determined under subparagraph (b) under the caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" below, and (v) with respect to any Guaranty, the amount of debt service determined under subparagraph (c) under the caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" below, provided, however, that debt service on Long-Term Indebtedness incurred to finance capital improvements shall be excluded from the determination of the Long-Term Debt Service Requirement for the period of construction of such capital improvements. Notwithstanding the foregoing, in calculating the Long-Term Debt Service Requirement for any particular period there shall be excluded any and all amounts payable from funds available in a Qualified Escrow.

"Long-Term Indebtedness" shall mean Indebtedness with an original stated maturity of more than one year and Commercial Paper Indebtedness. In determining the amount of Long-Term Indebtedness outstanding at any time, Discount Indebtedness shall be valued at its then current compounded (semi-annual) accreted value.

"Master Indenture Obligation" shall mean (i) any Note issued, authenticated and delivered under the Master Indenture and (ii) any other contract, agreement or instrument authenticated and delivered under the Master Indenture (including, without limitation, Guaranties) evidencing the obligation of a Master Indenture Obligor to repay amounts or otherwise satisfy and discharge obligations and liabilities set forth in such contract, agreement or instrument.

"Master Indenture Obligor" shall mean the Initial Obligated Issuer and any Affiliate or other Person that has become a Master Indenture Obligor under the Master Indenture in accordance with the provisions thereof or any successor thereto.

"Master Trustee" shall mean The Bank of New York Mellon Trust Company, N.A., a banking association organized under the laws of the United States of America, and its successors.

"Maximum Annual Debt Service" shall mean the highest Long-Term Debt Service Requirement for any succeeding calendar year over the remaining term of Outstanding Master Indenture Obligations using the assumptions provided in the Master Indenture.

"Moody's" shall mean Moody's Investors Service and any successor thereto.

"Non-Recourse Indebtedness" shall mean any Indebtedness secured by a Lien, liability for which is effectively limited to the Property subject to such Lien and any revenues derived therefrom, with no recourse, directly or indirectly, to any other Property of any member of the Obligated Group.

"Note" shall mean any Note issued, authenticated and delivered under the Master Indenture in connection with the issuance of a Related Bond. References to a series of Notes or to Notes of a series shall mean the Notes or series of Notes issued pursuant to a single Supplemental Indenture.

"Obligated Group" shall mean the Initial Obligated Issuer and all other Master Indenture Obligors.

"Officer's Certificate" shall mean a certificate signed by the chief executive officer, chief financial officer or some other individual designated pursuant to a resolution adopted by the Governing Body of RH and of each Master Indenture Obligor whose financial statements are not combined or consolidated with those of RH in accordance with generally accepted accounting principles.

"Opinion of Bond Counsel" shall mean an opinion in writing signed by an attorney or firm of attorneys experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

"Opinion of Counsel" shall mean an opinion in writing signed by an attorney or firm of attorneys, who may be counsel (including inside counsel) for RH.

"Outstanding", when used with reference to Master Indenture Obligations, shall mean, as of any date of determination, all Master Indenture Obligations theretofore issued or incurred and not paid and discharged other than (i) Master Indenture Obligations theretofore canceled by the Master Trustee or delivered to the Master Trustee for cancellation, (ii) Master Indenture Obligations deemed paid and no longer Outstanding and Master Indenture Obligations which are defeased pursuant to the Master Indenture, (iii) Master Indenture Obligations paid or in lieu of which other Master Indenture Obligations have been authenticated and delivered pursuant to the Master Indenture and (iv) Master Indenture Obligations held by members of the Obligated Group. For the purposes of making any calculation of Long-Term Debt Service Requirement under the Master Indenture, the term "Outstanding" shall not include any Master Indenture Obligations, or other Indebtedness, issued to refund other obligations during the period when any such Master Indenture Obligations or other Indebtedness is payable solely from its proceeds, the interest earnings thereon, escrowed monies provided from any other source or any letter of credit. In addition, if two or more obligations which constitute Indebtedness represent the same underlying obligation (as when a Master Indenture Obligation secures an issue of Related Bonds and another Master Indenture Obligation secures repayment obligations to a bank incurred in connection with such issue of Related Bonds) for purposes of the various financial covenants contained in the Master Indenture, but only for such purposes, only one of such obligations shall be deemed Outstanding.

"Pass Through Indebtedness" shall mean any Indebtedness the proceeds of which are to be utilized by a Person outside the Obligated Group if an Officer's Certificate is presented to the Master Trustee stating that the Person utilizing the proceeds has executed a note in favor of a member of the Obligated Group in at least the amount of the Pass Through Indebtedness.

"Permitted Liens" shall have the meaning given under the caption "Limitations on Creation of Liens" below.

"Person" shall include an individual, association, unincorporated organization, corporation, partnership, joint venture, business trust or a government or an agency or a political subdivision thereof, or any other entity.

"Property" shall mean any and all rights, titles and interests in and to any and all tangible property of the Obligated Group, whether real or personal, and wherever situated.

"Property, Plant and Equipment" shall mean all Property which is property, plant and equipment under generally accepted accounting principles.

"Put Indebtedness" shall mean Indebtedness a feature of which is an option on the part of the holders of such Indebtedness to tender such Indebtedness to a member of the Obligated Group or a trustee or other fiduciary for the Obligated Group, prior to its stated maturity date.

"Qualified Escrow" shall mean a segregated escrow fund or other similar fund or account which (a) is established as security for Long Term Indebtedness previously incurred and then outstanding (herein referred to as "Prior Indebtedness") or for Refunding Indebtedness and is held by the holder of the Prior Indebtedness or Refunding Indebtedness secured thereby or by a trustee or agent acting on behalf of such holder and is subject to a perfected security interest in favor of such holder, trustee or agent, (b) is held in cash or invested in Investment Securities, and (c) is to be applied toward a Master Indenture Obligor's payment obligations in respect of the Prior Indebtedness or Refunding Indebtedness, provided that, if the fund or account is funded in whole or in part with the proceeds of Refunding Indebtedness, the documents establishing the same may require specified payments of principal or interest (or both) in respect of the Refunding Indebtedness to be made from the fund or account prior to the date on which the Prior Indebtedness is repaid in full.

"Refunding Indebtedness" shall mean Indebtedness incurred for the purpose of refunding any Outstanding Long-Term Indebtedness if the Governing Body of RH shall have adopted a resolution finding that such refunding is in the best interest of the Obligated Group and stating the reasons for such finding.

"Related Bonds" shall mean the revenue bonds or other obligations issued by any state, territory or possession of the United States or any municipal corporation or political subdivision formed under the laws thereof or any constituted authority or agency or instrumentality of any of the foregoing empowered to issue obligations on behalf thereof ("governmental issuer"), pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to any Master Indenture Obligor in consideration of the execution, authentication and delivery of one or more Master Indenture Obligations to or for the order of such governmental issuer.

"Related Bond Indenture" shall mean any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds are issued.

"Related Bond Issuer" shall mean the issuer of any issue of Related Bonds.

"Related Bond Master Trustee" shall mean the master trustee and its successors in the trusts created under any Related Bond Indenture, and if there is no such trustee, shall mean the Related Bond Issuer.

"RH" shall mean Reading Hospital, a not-for-profit corporation organized and existing under the laws of the Commonwealth of Pennsylvania, and its successors and assigns, including,

without limitation, any other member of the Obligated Group which shall have been designated to assume certain responsibilities of RH pursuant to the Master Indenture.

"S&P" shall mean Standard & Poor's, a division of The McGraw-Hill Companies, Inc., and any successor thereto.

"Short-Term Indebtedness" shall mean Indebtedness having an original stated maturity of one year or less, other than Commercial Paper Indebtedness, Interim Indebtedness, Put Indebtedness and Non-Recourse Indebtedness.

"Subordinated Indebtedness" shall mean any Long-Term Indebtedness or Short-Term Indebtedness which: (a) is incurred pursuant to the provisions described in paragraph (e) under the caption "Limitations on Incurrence of Additional Indebtedness" below; (b) is unsecured; (c) is payable as to principal, redemption price or interest only if, at the time in question, the principal or redemption price of and interest on all Master Indenture Obligations (except for Non-Recourse Indebtedness or other Subordinated Indebtedness) then due or overdue (by acceleration or otherwise) has first been paid; and (d) is not subject to acceleration upon a default unless all Master Indenture Obligations (except for Non-Recourse Indebtedness or other Subordinated Indebtedness) have also been accelerated.

"Supplemental Indenture" shall mean an indenture supplemental to, and authorized and executed pursuant to the terms of, the Master Indenture for the purpose, among others, of creating a particular series of Master Indenture Obligations thereunder.

"Thirty-Third Supplemental Indenture" shall mean the Thirty-Third Supplemental Master Trust Indenture dated as of October 1, 2017, by and between the Obligated Group and the Master Trustee pursuant to which the System has issued the 2017 Master Note.

"Total Capitalization" shall mean the sum of the aggregate Long-Term Indebtedness Outstanding of the members of the Obligated Group, plus the aggregate unrestricted fund balance of the non-profit members of the Obligated Group, plus the aggregate excess of assets over liabilities of the proprietary members of the Obligated Group, all as calculated in accordance with generally accepted accounting principles, less any Indebtedness not deemed to be Outstanding under the provisions of the Master Indenture; provided that in determining Total Capitalization, Discount Indebtedness shall be valued at its semi-annual compounded accreted value.

"Total Operating Expenses" shall mean the aggregate of operating expenses of each Master Indenture Obligor, determined in accordance with generally accepted accounting principles consistently applied.

"Total Revenues" shall mean, for the period under consideration, the sum of the following for any one or more of the Master Indenture Obligors or, as the context requires, of the entire Obligated Group:

(a) all amounts constituting operating revenues under generally accepted accounting principles, before deduction of operating expenses, but after deduction of (i) contractual allowances and discounts, and (ii) provision for free care and doubtful accounts; and

(b) all amounts constituting nonoperating revenues under generally accepted accounting principles.

"2017 Master Note" shall mean the Series B of 2017 Master Note (Berks County Industrial Development Authority) dated the date of issuance of the 2017 Bonds.

"Unsecured Indebtedness" shall mean any Indebtedness not secured by any Lien.

"Value" shall mean Book Value or fair market value, as RH may elect.

"Variable Rate Indebtedness" shall mean any Indebtedness with respect to which the interest rate is not established, at the time in question, at a fixed or constant rate to maturity.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", the definitions described above under "Definition of Certain Terms" will be amended and supplemented by the addition, amendment or restatement, as appropriate, of the following capitalized terms:

"Balloon Long-Term Indebtedness" means (1) means Long-Term Indebtedness, fifteen percent (15%) or more of the initial principal amount of which Long-Term Indebtedness matures (or is payable at the option of the holder) in any twelve month period, if such fifteen percent (15%) or more is not to be amortized to below fifteen percent (15%) by mandatory redemption prior to such twelve month period, or (2) any portion of an issue of Indebtedness which, if treated as a separate issue of Long-Term Indebtedness, would meet the test set forth in clause (1) of this definition and which Indebtedness is designated as Balloon Long-Term Indebtedness in an Officer's Certificate stating that such portion shall be deemed to constitute a separate issue of Balloon Long-Term Indebtedness.

"Bond Index" means, at the option of the System as set forth in an Officer's Certificate, either (i) the 30-year Revenue Bond Index published most recently by The Bond Buyer or a comparable index if such Revenue Bond Index is not so published, (ii) the SIFMA Index or (iii) such other interest rate or interest index as may be certified in writing to the Master Trustee as appropriate to the situation by the System.

"GAAP" means generally accepted accounting principles as applied in the United States of America, consistently applied.

"Income Available for Debt Service" means the excess of (i) revenues (after adjustments, discounts or contractual allowances) and gains over (ii) expenses and losses other than depreciation, amortization and interest; provided, however, that the following items shall be excluded from the computation of "Income Available for Debt Service": (a) extraordinary items of income or loss; (b) gain or loss from the extinguishment of Indebtedness; (c) unrealized gains and losses on investments or Derivative Agreements; (d) any gain or loss from the disposition of assets not in the ordinary course of business: (e) any loss from impairment of the value of assets; (f) financing costs that are treated as a current expense, rather than amortized; (g) gain or loss from the termination of any retirement or pension plan; and (h) any other item that is non-recurring and also a non-cash item.

"SIFMA" means the Securities Industry and Financial Markets Association, any successor thereto, or any person acting in cooperation with or under the sponsorship of SIFMA and acceptable to the System.

"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 (the SIFMA Municipal Swap Index), as produced by Municipal Market Data and published or made available by SIFMA, or any person acting in cooperation with or under the sponsorship of SIFMA and acceptable to the System, and effective from such date.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", the Master Indenture will be amended and restated to revise the provisions addressing Accounting Principles and Financial Reporting to read as follows:

Accounting Principles and Financial Reporting. All accounting terms not specifically defined herein shall be construed in accordance with GAAP consistently applied, except as otherwise stated herein. If any change in accounting principles from those used in the preparation of the financial statements of the System or the Obligated Group as of June 30, 2017 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 this Indenture, at the option of the System, 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 Obligated Group or the System with all financial covenants and tests contained in this 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 or the Obligated Group as of June 30, 2017 had been made. If any such modification of the accounting terms used in this Indenture shall occur and the System elects to have the accounting terms used in this Indenture modified as provided in the preceding sentence, the System 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 Holders or result in materially different criteria for evaluating the compliance of the Obligated Group or the System with all financial covenants and tests contained in this Indenture.

General Obligation; Pledge of Gross Revenues; Security Interest

Each Master Indenture Obligation issued pursuant to the Master Indenture will entitle each holder thereof to the protection of the covenants, restrictions and other obligations imposed upon each Master Indenture Obligation by the Master Indenture. Such Master Indenture Obligations will be the joint and several, general obligations of each Master Indenture Obligor. To secure the prompt payment of the principal of, redemption premium, if any, and interest on Master Indenture Obligations and the performance by the members of the Obligated Group of their other obligations under the Master Indenture, each member of the Obligated Group shall pledge and assign to the Master Trustee, for the equal and ratable benefit to the Holders, from time to time, of Master Indenture Obligations, all Gross Revenues.

On or before the date of issuance of a series of Master Indenture Obligations under the Master Indenture, each member of the Obligated Group shall file one or more financing statements evidencing the security interests granted to the Master Trustee in the Master Indenture in such form as is required by applicable law, with copies thereof to be delivered to the Master Trustee.

The pledge, assignment and grant of security interest made by the Master Indenture shall not inhibit, and the Master Indenture allows, the sale or other transfer of Gross Revenues for expenditures of the Obligated Group, provided the Obligated Group is in compliance with the terms of the Master Indenture.

Conditions to Issue of Master Indenture Obligations

The following conditions, among others, must be satisfied simultaneously with or prior to the execution, authentication and delivery of any Master Indenture Obligations:

(a) The issuer of such Master Indenture Obligations shall have delivered to the Master Trustee an Opinion or Opinions of Counsel to the effect that (1) registration of such Master Indenture Obligations under the Securities Act of 1933, as amended, and qualification of the Master Indenture or any supplement thereto under the Trust Indenture Act of 1939, as amended, is not required, or, if such registration or qualification is required, that all applicable registration and qualification provisions of said Acts have been complied with (at the request of the Master Trustee, any other opinions delivered in connection with the issuance of each series of Master Indenture Obligations shall also be addressed to the Master Trustee) and (2) the Master Indenture Obligations are valid, binding and enforceable obligations of the respective Master Indenture Obligors in accordance with their terms, except as limited by bankruptcy laws, insolvency laws and other laws affecting creditors' rights generally and usual equity principles and (3) all applicable corporate policies of members of the Obligated Group respecting issuance of Master Indenture Obligations have been complied with; and

(b) RH shall have delivered to the Master Trustee an Officer's Certificate stating that (1) RH consents to and approves the issuance of the Master Indenture Obligations and (2) no Event of Default has occurred and is continuing.

Insurance

Each member of the Obligated Group agrees that it will maintain insurance, which may include self-insurance programs, covering such risks and in such amounts as, in its judgment, are adequate to protect it and its Properties and operations; provided, however, there shall be no self-insurance on Property, Plant and Equipment. The insurance or self-insurance required to be maintained shall be subject to the periodic review of an insurance Consultant. RH agrees that it will follow and cause each member of the Obligated Group to follow any reasonable recommendations of the insurance Consultant and will, annually (for any self-insurance programs) and every third year (with respect to insurance provided by third parties), deliver or cause to be delivered to the Master Trustee as soon as practicable, but in no event later than three months after the end of each such year or third year, as applicable, a report of the insurance Consultant setting forth a description of the insurance or self-insurance maintained, or caused to be maintained, by members of the Obligated Group then in effect and stating whether, in the opinion of the insurance Consultant, such insurance or self-insurance and any reductions or

eliminations of the amount of any insurance or self-insurance coverage (including amounts on deposit or to be deposited to self-insurance funds or trusts) during the period covered by such report adequately protect the members of the Obligated Group and their respective Properties and operations. If such Consultant's opinion is that such Properties and operations are not adequately protected, the insurance Consultant's report shall contain recommendations as to what additional types and amounts of insurance are necessary to provide such adequate protection.

Amounts received by any Master Indenture Obligor as insurance proceeds with respect to any casualty loss or as condemnation awards may be used in such manner as the recipient may determine, including, without limitation, applying such moneys to the payment or repayment of any Master Indenture Obligations in accordance with the terms thereof and of any Supplemental Indenture, subject to compliance with the provisions of the Master Indenture respecting the disposition of cash, investments and other liquid assets.

Limitations on Creation of Liens

(a) Each member of the Obligated Group agrees that it will not create or suffer to be created or permit the existence of any Lien upon Property now owned or hereafter acquired by it other than Permitted Liens.

(b) Permitted Liens shall consist of the following:

(i) Liens arising by reason of good faith deposits by any member of the Obligated Group in connection with leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any member of the Obligated Group 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;

(ii) 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 any member of the Obligated Group to maintain self-insurance or to participate in any funds established to cover any insurance risks or in connection with workers' compensation, unemployment insurance, pension or profit sharing plans or other social security, or to share in the privileges or benefits required for companies participating in such arrangements;

(iii) Any judgment lien against any member of the Obligated Group so long as such judgment is being contested in good faith and execution thereon is stayed;

(iv) (A) Rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law; (B) any liens on any property for taxes, assessments, levies, fees, water and sewer rents, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such property, which are not due and payable or which are

not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed or, if execution with respect to the same has not been stayed, neither the lien of the Master Indenture nor the use of the property in question will be materially impaired or which, with respect to liens of mechanics, materialman, laborers, suppliers or vendors, have been due for less than 4 months; (C) easements, rights-of-way, servitudes, restrictions, oil, gas or other mineral reservation and other minor defects, encumbrances, and irregularities in the title to any property which do not materially impair the use of such property or materially and adversely affect the value thereof; (D) to the extent that it affects title to any property, the Master Indenture; and (E) landlord's liens;

(v) Any Lien which is existing on the date of authentication and delivery of the initial Notes issued under the Master Indenture and of which the Master Trustee has received written notice at the time of such initial issuance;

(vi) Any Lien on Property acquired by a member of the Obligated Group securing Indebtedness permitted by the provisions described under the caption "Limitation on Incurrence of Additional Indebtedness" below that was assumed in connection with the acquisition of such Property;

(vii) Purchase money Liens securing Indebtedness permitted as set forth under the caption "Limitation on Incurrence of Additional Indebtedness" below. Notwithstanding anything contained in the Master Indenture to the contrary, the Book Value of the Property pledged under any Lien permitted by this subsection (vii), subsection (viii) and subsection (xvii) shall not exceed in the aggregate 15% of the Value of all Property, Plant and Equipment of the Obligated Group;

(viii) Liens securing Indebtedness permitted as set forth under the caption "Limitation on Incurrence of Additional Indebtedness" below so long as (A) the Book Value of the Property pledged in aggregate under all such Liens allowed pursuant to this provision is less than the greater of (1) 20% of Total Revenue of the Obligated Group, as shown on the most recent audited Financial Statements, or (2) 10% of the Value of all Property, Plant and Equipment of the Obligated Group, or (B) immediately after the incurrence of such Indebtedness the aggregate principal amount of all Long-Term Indebtedness does not exceed 65% of Total Capitalization, without, in the case of Non-Recourse Indebtedness, including the aggregate Value of the Property so pledged under all Liens allowed pursuant to this provision in Total Capitalization or the Non-Recourse Indebtedness incurred to purchase such Property in Long-Term Indebtedness or Total Capitalization. Notwithstanding anything contained in the Master Indenture to the contrary, the Book Value of the Property pledged under any Lien permitted by subsection (vii), this subsection (viii) and subsection (xvii) shall not exceed in the aggregate 15% of the Value of all Property, Plant and Equipment of the Obligated Group;

(ix) Any Lien in favor of a creditor or a trustee on the proceeds of Indebtedness and any earnings thereon prior to the application of such proceeds and such earnings;

(x) Any Lien securing all Master Indenture Obligations on a parity basis;

(xi) Liens on property received by any member of the Obligated Group through gifts, grants or bequests, such Liens being due to restrictions on such gifts, grants or bequests of property or the income thereon;

(xii) Liens on property due to rights of third party payors for recoupment of amounts paid to any member of the Obligated Group;

(xiii) Rights of the United States of America under Title 42 United States Code Section 291;

(xiv) Any Lien arising by reason of any escrow established to pay debt service with respect to Indebtedness;

(xv) Liens on property of Affiliates or other entities that become members of the Obligated Group pursuant to the provisions described under the caption "Parties Becoming Master Indenture Obligors" below that were incurred in the ordinary course of business prior to becoming Members of the Obligated Group;

(xvi) Any Lien arising by virtue of a lease, sub-lease or loan agreement entered into by a Master Indenture Obligor and that is reasonably necessary to the business operations and affairs of such Master Indenture Obligor;

(xvii) Any Lien on Gross Revenues now or hereafter granted by any member of the Obligated Group to secure Indebtedness permitted as described under the caption "Limitation on Incurrence of Additional Indebtedness" below or granted in connection with the incurrence of such Indebtedness. Notwithstanding anything contained in the Master Indenture to the contrary, the Book Value of the Property pledged under any Lien permitted by subsection (vii), subsection (viii) and this subsection (xvii) shall not exceed in the aggregate 15% of the Value of all Property, Plant and Equipment of the Obligated Group; and

(xviii) Any Lien on assets securing a Derivative Agreement or for the purpose of meeting collateral posting requirements under a Derivative Agreement.

Limitations on Incurrence of Additional Indebtedness

Each member of the Obligated Group covenants and agrees that it will not incur any Additional Indebtedness except in the manner and pursuant to the terms set forth below and as described under the caption "Assumptions with Respect to Computation of Maximum Annual Debt Services" below.

(a) Long-Term Indebtedness may be incurred if prior to the incurrence of such Long-Term Indebtedness there is delivered to the Master Trustee:

(i) An Officer's Certificate certifying that:

(A) Immediately after the incurrence of the proposed Long-Term Indebtedness the Capitalization Ratio does not exceed 60%; or

(B) The Long-Term Debt Service Coverage Ratio for any period of twelve (12) full consecutive calendar months during the most recent period of eighteen (18) full consecutive calendar months preceding the date of delivery of the Officer's Certificate for which there are Financial Statements available or the most recent fiscal year, taking all Outstanding Long-Term Indebtedness and the proposed Long-Term Indebtedness into account, is not less than 1.20; or

(ii) A written report of a Consultant demonstrating and stating that (A) the Long-Term Debt Service Coverage Ratio for the period mentioned in paragraph (a)(i)(B) above, excluding the proposed Long-Term Indebtedness, is at least 1.10 and (B) the expected Long-Term Debt Service Coverage Ratio for each of the two full fiscal years succeeding the date of completion of use of the proceeds of such proposed Long-Term Indebtedness is not less than 1.20, as shown by pro forma Financial Statements for each such period, accompanied by a statement of the relevant assumptions upon which such pro forma Financial Statements are based; provided, however, that compliance with the tests set forth in this paragraph (a)(ii) may be evidenced by an Officer's Certificate in lieu of a Consultant's report where (i) the aggregate proceeds of such Long-Term Indebtedness incurred during the time period described in paragraph (a)(i)(B) above is less than 20% of the Total Revenues of the Obligated Group or (ii) the ratios set forth in this paragraph (a)(ii) are equal to or greater than 1.50; provided further, however, that if the report of a Consultant states that Governmental Restrictions have been imposed which make it impossible for the coverage requirements of this paragraph to be met, then such coverage requirements shall be reduced to the maximum coverage permitted by such Governmental Restrictions but in no event less than 1.00.

(b) Refunding Indebtedness may be incurred without limitation if the Master Trustee receives an Officer's Certificate stating and demonstrating that the Maximum Annual Debt Service for any succeeding fiscal year on all Long-Term Indebtedness to be Outstanding will not exceed 110% of the Maximum Annual Debt Service on all Long-Term Indebtedness Outstanding immediately prior to the incurring of the proposed Refunding Indebtedness.

(c) Completion Indebtedness may be incurred without limitation.

(d) Short-Term Indebtedness may be incurred if immediately after the incurrence of such Indebtedness, the unpaid principal balance of all such Indebtedness to be incurred together with the unpaid principal balance of all Short-Term Indebtedness Outstanding does not exceed 20% of the Total Revenues of the Obligated Group for the most recent period of twelve (12) full consecutive calendar months for which Financial Statements are available; provided, however, that the unpaid principal balance of such Short-Term Indebtedness shall not exceed 5% of the Total Revenues of the Obligated Group for a period of at least 15 consecutive calendar days during each fiscal year of RH, and provided further, however, that any failure to comply with the covenant to reduce the aggregate principal amount of outstanding Short Term Indebtedness in accordance with this paragraph (d) shall not constitute an Event of Default under the Master Indenture. However, the principal amount of all Short Term Indebtedness

outstanding as of the end of the fiscal year in which such failure occurs shall be treated as Long Term Indebtedness for the purposes of any calculation of Long Term Debt Service Requirements made during the next succeeding fiscal year.

(e) Subordinated Indebtedness may be incurred without limitation.

(f) Long-Term Indebtedness may be incurred without complying with the provisions of paragraph (a) above if the Master Trustee receives an Officer's Certificate stating and demonstrating that the principal amount of the Long-Term Indebtedness to be incurred, together with the principal amount of all other Long-Term Indebtedness incurred during the current fiscal year of RH pursuant to the provisions of this paragraph (f), does not exceed 5% of the Total Revenues of the Obligated Group for the fiscal year of RH immediately preceding the incurrence in question. For the purpose of any Officer's Certificate delivered pursuant to this paragraph (f), the principal amount of all Non-Recourse Indebtedness and Subordinated Indebtedness shall be excluded.

(g) Non-Recourse Indebtedness may be incurred without limitation.

(h) Accounts Receivable Indebtedness may be incurred without limitation, provided that the amount of such Indebtedness shall not exceed the monetary consideration actually received from any such sale or assignment; and provided further that, the Master Trustee receives an Officer's Certificate stating and demonstrating that the aggregate amount of Accounts Receivable Indebtedness incurred pursuant to this subparagraph (h) shall not exceed 35% of the outstanding accounts receivable of the Obligated Group.

Notwithstanding the foregoing provisions, nothing shall preclude a member of the Obligated Group from incurring any obligation under a line of credit, letter of credit, standby bond purchase agreement or similar credit enhancement or liquidity facility established in connection with any Related Bonds incurred in accordance with this section which are required to be purchased at the option of the holders thereof.

Assumptions with Respect to Computations of Maximum Annual Debt Service

For purposes of the computation of Maximum Annual Debt Service for the purposes of the provisions described under "Limitations on Incurrence of Additional Indebtedness" above, and generally for any covenants or computations required by the Master Indenture, the following rules shall apply:

(a) For any Balloon Long-Term Indebtedness, Commercial Paper Indebtedness or Interim Indebtedness it shall be assumed that the principal balance of such Indebtedness is to be amortized over a twenty-five year period or such shorter period which is the useful life of the assets being financed, beginning on the date of incurrence of such Indebtedness, assuming level annual debt service and a rate of interest equal to the higher of (i) ninety percent (90%) of the interest rate borne by United States Treasury obligations having a comparable maturity; or (ii) the equivalent of the 25-year Revenue Bond Index published by The Bond Buyer, or its successors, for the most recent week preceding the date of calculation; provided, however, that in the case of Interim Indebtedness which is expected to be refinanced using a taxable borrowing, the assumed rate of interest shall be equal to one hundred and ten

percent (110%) of the interest rate borne by United States Treasury obligations having a comparable maturity.

(b) The interest on Variable Rate Indebtedness or Put Indebtedness shall be assumed to be the higher of (i) the interest rate in effect on similar securities as of the date of calculation; or (ii) the average interest rate on similar securities in effect for the twelve (12) month period preceding the date of such calculation; or (iii) the equivalent of the 25-year Revenue Bond Index published by The Bond Buyer, or its successors, for the most recent week preceding the date of calculation. For purposes of this paragraph, the interest rate on similar securities shall be the rates on such Indebtedness or, if such Indebtedness has been Outstanding for less than one year, the rates on securities identified as comparable in a certificate of (i) a nationally known investment banking firm or (ii) a commercial bank.

(c) Guaranties (including Pass-Through Indebtedness) shall be treated as Indebtedness for all purposes hereunder, except there shall be excluded from the Indebtedness of any member of the Obligated Group an amount equal to 80% of the obligation incurred under such Guaranty during each fiscal year of such member of the Obligated Group in which no payment is made pursuant to such Guaranty. In the event that any such payment is made, such Guaranty shall be treated as Indebtedness for all purposes under the Master Indenture during the remaining term of the Guaranty.

For the purposes of the calculations described in paragraph (c) above, the amount of hypothetical Long-Term Indebtedness referred to above shall be reduced to the extent that a Guaranty is a joint and several obligation of any Person not a member of the Obligated Group that has Outstanding Long-Term Indebtedness rated at least investment grade by S&P and Moody's.

(d) (i) For any Indebtedness for which a binding commitment, letter of credit or other credit arrangement providing for the extension of such Indebtedness beyond its original maturity date exists, the computation of Maximum Annual Debt Service shall, at the option of the member of the Obligated Group, be made on the assumption that such Indebtedness will be amortized in accordance with such credit arrangement.

(ii) For any Indebtedness which converts to a different form, the conversion shall not be deemed to be an incurrence of Indebtedness but for purposes of all subsequent calculations of Maximum Annual Debt Service such debt shall be considered in its converted form; provided, however, if the conversion is not at the election of the Obligated Group and can be reversed (as in the conversion of Put Indebtedness to Short-Term Indebtedness because of a failed remarketing of the Put Indebtedness and a corresponding draw on a credit facility), the provisions of this paragraph shall not apply until the conversion has remained in effect for 30 days.

(e) In the event that any member of the Obligated Group incurs a form of Long-Term Indebtedness which is neither fixed rate Long-Term Indebtedness nor any of the other types of Indebtedness referred to in this section, upon the prior written consent of a Bond Insurer, the Maximum Annual Debt Service on such Indebtedness shall be that stated in a certificate of a nationally known investment banking firm or Consultant which determines such

Maximum Annual Debt Service using principles consistent with the provisions of the Master Indenture.

(f) Notwithstanding anything contained in this section to the contrary, the maximum term of any Balloon Long-Term Indebtedness or Variable Rate Indebtedness incurred by any member of the Obligated Group shall be twenty-five years.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", subsection (a) of the Master Indenture which is summarized above in this caption "Assumptions with Respect to Computations of Maximum Annual Debt Service" will be amended and restated in its entirety to read as follows:

For purposes of the computation of Maximum Annual Debt Service for the purposes of the provisions described under "Limitations on Incurrence of Additional Indebtedness" above, and generally for any covenants or computations required by the Master Indenture, the following rules shall apply:

(a)(i) For any Commercial Paper Indebtedness or Interim Indebtedness it shall be assumed that the principal balance of such Indebtedness shall, at the election of the System, be amortized (i) pursuant to an amortization schedule determined by the System or (ii) over a thirty (30) year period or such shorter period which is the useful life of the assets being financed, beginning on the date of incurrence of such Indebtedness, assuming level annual debt service, as determined by an Officer's Certificate, and a rate of interest equal to (i) ninety percent (90%) of the interest rate borne by United States Treasury obligations having a comparable maturity; or (ii) that derived from the Bond Index, as determined by an Officer's Certificate; provided, however, that in the case of Interim Indebtedness which is expected to be refinanced using a taxable borrowing, the assumed rate of interest shall be equal to one hundred and ten percent (110%) of the interest rate borne by United States Treasury obligations having a comparable maturity.

(ii) For purposes of the calculation of the Long-Term Debt Service Requirements, whether historic or projected, Balloon Long-Term Indebtedness shall, at the election of the System, be deemed to be Indebtedness which is payable over (a) thirty (30) years from the date of such calculation with level annual debt service on such Indebtedness at a rate of interest equal to (i) the actual rate of interest on such Indebtedness, or (ii) that derived from the Bond Index, as determined by an Officer's Certificate, and in each case with level annual debt service on such Indebtedness, or (b) the remaining term to maturity of such Indebtedness with level annual debt service on such Indebtedness, at a rate of interest equal to (i) the actual rate of interest on such Indebtedness, or (ii) that derived from the Bond Index, as determined by an Officer's Certificate, or (c) a principal amortization schedule provided by the System at a rate of interest equal to (i) the actual rate of interest on such Indebtedness, or (ii) that derived from the Bond Index, as determined by an Officer's Certificate. In addition, upon delivery to the Master Trustee of (a) an Officer's Certificate, dated within 90 days of the date of calculation of the Long-Term Debt Service Requirements, stating that financing of a stated term (which shall not extend beyond 30 years after such date of calculation), amortization, and interest rate is reasonably attainable to refund or otherwise directly or indirectly to refinance any amount of such Balloon Long-Term Indebtedness, then the principal of and premium, if any, and interest

and other debt service charges on the amount of such Balloon Long-Term Indebtedness so certified to be refundable or refinanceable shall be excluded from the calculation of the Long-Term Debt Service Requirements and the principal of and premium, if any, and interest and other debt service charges on the refunding Indebtedness as so certified which would result from such refunding or refinancing if incurred on the first day of the Fiscal Year for which the Long-Term Debt Service Requirements are being calculated, shall be added to the calculation of such Long-Term Debt Service Requirements; or (b) the written consent of the obligor of such Balloon Long-Term Indebtedness agreeing to retire (and such Balloon Long-Term Indebtedness shall permit the retirement of), or to fund a sinking fund for, the principal of such Balloon Long-Term Indebtedness according to a fixed schedule stated in such consent ending on or before the Fiscal Year in which such amount is due or could become due or payable in respect of any required purchase of such Balloon Long-Term Indebtedness, then the principal of (and, in the case of retirement, the premium, if any, and interest and other debt service charges on) such Balloon Long-Term Indebtedness shall be computed as if the same were due in accordance with such schedule; provided that this clause (b) shall only be applicable to Balloon Long-Term Indebtedness for which the installments of principal previously scheduled have been paid or funded on or before the times required by such previous schedule.

Debt Service Coverage Ratio

(a) Each member of the Obligated Group covenants to set rates and charges for its facilities such that the Long-Term Debt Service Coverage Ratio, calculated at the end of each fiscal year of the Obligated Group, will not be less than 1.10.

(b) If the Long-Term Debt Service Coverage Ratio required by paragraph (a) above is not met, the Obligated Group covenants to retain a Consultant to make recommendations to increase such Long-Term Debt Service Coverage Ratio for subsequent fiscal years of the Obligated Group to the level required or, if in the opinion of the Consultant the attainment of such level is impracticable, to the most practicable level. Each member of the Obligated Group agrees that it will, to the extent permitted by law, follow the recommendations of the Consultant. In the event the recommendations of the Consultant are implemented by each member of the Obligated Group affected thereby and the Long-Term Debt Service Coverage Ratio does not meet the requirements of the foregoing rate covenant, there shall be no Event of Default under the Master Indenture, so long as the Long-Term Debt Service Coverage Ratio is not less than 1.00, but the Obligated Group shall be under a continuing obligation to engage a Consultant for the purposes set forth above.

(c) If a report of a Consultant is delivered to the Master Trustee stating that Governmental Restrictions have been imposed which make it impossible for the ratios in paragraph (a) above to be met, then such ratio requirement shall be reduced to the maximum coverage permitted by such Governmental Restrictions, but in no event less than 1.00.

Sale or Other Disposition of Certain Property; Disposition of Cash and Investments

Nothing hereinafter contained in this section shall be construed as limiting the ability of any member of the Obligated Group to purchase or sell Property in the ordinary course of business or to transfer cash, securities and other investment properties in connection with ordinary investment transactions where such purchases, sales and transfers are for substantially

equivalent value. To the extent that any such transaction is for partially equivalent value, only that part of the transaction for which no value is received shall be subject to the provisions of this section (e.g., if a piece of equipment with a fair market value of $100,000 is sold for $50,000 to any Person not a member of the Obligated Group, such transaction shall be subject to the provisions of this section to the extent of $50,000).

Each member of the Obligated Group agrees that it will not sell, transfer (including, without limitation, any transaction which is deemed to be a sale or transfer of the assets in question under generally accepted accounting principles) or otherwise dispose of (all of the foregoing activities being collectively referred to as "Dispositions") (i) Property or (ii) cash and other liquid assets except (A) in the case of any member other than RH, with the prior consent of RH, and (B) in accordance with one or more of the following:

(a) Dispositions of Property may be made to any Person not a member of the Obligated Group if prior to such Disposition there is delivered to the Master Trustee an Officer's Certificate stating that, in the judgment of the signer, such Property has become inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary, and the sale, lease, removal or other disposition thereof will not impair the structural soundness, efficiency or economic value of any remaining Property;

(b) Dispositions of cash and other liquid assets in any fiscal year of such member may be made to any Person not a member of the Obligated Group if the aggregate value of such cash and other liquid assets is less than 2% of the Total Revenues of the Obligated Group;

(c) Dispositions of Property in any fiscal year of such member may be made to any Person not a member of the Obligated Group if the aggregate Value of such Property is less than 10% of the Value of the Property, Plant and Equipment of the Obligated Group;

(d) Dispositions may be made to any Person not a member of the Obligated Group if prior to such Disposition there is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that any condition described in paragraph (a) under the caption "Limitations on Incurrence of Additional Indebtedness" above has been satisfied for the incurrence of an additional one dollar ($1.00) of Additional Indebtedness, assuming such Disposition occurred at the beginning of the period of twelve (12) full consecutive calendar months for which Financial Statements were available; provided, however, that neither cash nor other liquid assets with an aggregate value greater than 5% of Total Revenues of the Obligated Group, nor Property with an aggregate Value greater than 15% of the Value of Property, Plant and Equipment of the Obligated Group, may be transferred in any fiscal year unless the Master Trustee receives an Officer's Certificate stating and demonstrating that immediately after such transfer:

(i) The Long-Term Debt Service Coverage Ratio for the most recent period of twelve (12) full consecutive calendar months preceding the proposed date of such transaction for which Financial Statements have been examined by Independent Certified Public Accountants, assuming such transaction actually occurred at the beginning of such period, would not have been reduced or, if reduced, would not have been reduced to less than 1.50; or

(ii) The average of the Long-Term Debt Service Coverage Ratios for the two periods of 12 full consecutive calendar months immediately succeeding the proposed date of such transaction is expected to be greater than the Long-Term Debt Service Coverage Ratio for the most recent period of twelve (12) full consecutive calendar months preceding the proposed date of such transaction for which Financial Statements have been examined by Independent Certified Public Accountants; or

(iii) The Long-Term Debt Service Coverage Ratio for the period of 12 full consecutive calendar months immediately succeeding the proposed date of such transaction is expected to be greater than it would have been had the transaction not occurred;

(e) Dispositions may be made to another member of the Obligated Group;

(f) Dispositions may be made to an Affiliate that is not a Master Indenture Obligor if such Affiliate immediately thereafter becomes a Master Indenture Obligor;

(g) Dispositions may be made to a successor corporation pursuant to a merger or consolidation permitted by the Master Indenture;

(h) Dispositions may be made if such disposition will increase the projected Long-Term Debt Service Coverage Ratio of the Person making such Disposition in the fiscal year of such Person immediately following such Disposition over what such Long-Term Debt Service Coverage Ratio would have been in such fiscal year had such Disposition not occurred; or

(i) Dispositions of accounts receivable may be made to any Person not a member of the Obligated Group if such Disposition is made pursuant to an arms-length transaction or upon terms at least as favorable as an arms-length transaction.

Any loan to, guaranty for the benefit of, or any other financial arrangement for or with, any referring physician, staff physician or other professional staff person, in connection with the establishment of any professional staff or referral physician recruitment or similar program established by or for any member of the Obligated Group, shall not be deemed a transfer of assets or otherwise be prohibited by this section; provided, however, that such program shall be reviewed by nationally recognized bond counsel acceptable to the issuer of any federally tax-exempt obligations secured by a Master Indenture Obligation, and such counsel's opinion, to the effect that such program and any financial transaction undertaken thereunder shall not adversely affect the validity or tax exemption of any such obligations, shall be delivered to such issuer.

Consolidation, Merger, Sale or Conveyance

(a) Each member of the Obligated Group covenants that it will not merge or consolidate with, or sell or convey all or substantially all of its assets to, or acquire all or substantially all of the assets from, any Person which is not a member of the Obligated Group without the prior consent of RH, and unless:

(i) Either a member of the Obligated Group will be the successor corporation, or if the successor corporation is not a member of the Obligated Group such successor corporation shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Master Trustee, containing the agreement of such successor corporation to become a Master Indenture Obligor pursuant to the applicable provisions of the Master Indenture; and

(ii) No member of the Obligated Group immediately after such merger or consolidation, or such sale or conveyance, would be in default in the performance or observance of any covenant or condition of the Master Indenture; and

(iii) If all amounts due or to become due on any Related Bond have not been fully paid to the holder thereof, there shall have been delivered to the Master Trustee an Opinion of Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance, whether or not contemplated on any date of the delivery of such Related Bond, would not adversely affect the exemption from Federal income taxation of interest payable on such Related Bond; and

(iv) There is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that (1) any condition described in paragraph (a) under the caption "Limitations on Incurrence of Additional Indebtedness" above has been satisfied for the issuance of an additional one dollar ($1.00) of Additional Indebtedness, assuming such merger, consolidation or sale of assets had occurred at the beginning of the most recent period of twelve (12) full consecutive calendar months for which Financial Statements are available or (2) the Long-Term Debt Service Coverage Ratio for the period of 12 full consecutive calendar months immediately succeeding the proposed date of the applicable transaction is expected to be greater than it would have been had the transaction not occurred; and

(v) There is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that the unrestricted fund balance of the Obligated Group, calculated in accordance with generally accepted accounting principles consistently applied, immediately following such merger, consolidation, sale or conveyance will be not less than 90% of the unrestricted fund balance of the Obligated Group immediately preceding such merger, consolidation, sale or conveyance.

(b) In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor, with the same effect as if it had been named as a Master Indenture Obligor or had become a Master Indenture Obligor pursuant to the applicable provisions of the Master Indenture, as the case may be. Any successor corporation may cause to be signed, and may issue in its own name, Master Indenture Obligations; and upon the order of such successor corporation and subject to all the terms, conditions and limitations in the Master Indenture prescribed, the Master Trustee shall authenticate and shall deliver Master Indenture Obligations that such successor corporation shall have caused to be signed and delivered to the Master Trustee. All Outstanding Master Indenture Obligations so issued by such successor corporation under the Master Indenture shall in all respects have the same legal rank and benefit

under the Master Indenture as Outstanding Master Indenture Obligations theretofore or thereafter issued in accordance with the terms of the Master Indenture as though all such Master Indenture Obligations had been issued under the Master Indenture without any such consolidation, merger, sale or conveyance having occurred.

(c) In case of any such consolidation, merger, sale or conveyance such changes in phraseology and form (but not in substance) may be made in Master Indenture Obligations thereafter to be issued as may be appropriate.

(d) The Master Trustee may accept an Opinion of Counsel as conclusive evidence that any such consolidation, merger, sale or conveyance, and any such assumption, complies with the provisions of this section and that it is proper for the Master Trustee under the Master Indenture to join in the execution of any instrument required to be executed and delivered.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", subsection (a)(iv) above in this caption "Consolidation, Merger, Sale or Conveyance" will be amended and restated in its entirety to read as follows:

(a)(iv) There is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that (1) any condition described in Section 5.05(a) has been satisfied for the issuance of an additional one dollar ($1.00) of Additional Indebtedness, assuming such merger, consolidation or sale of assets had occurred at the beginning of the most recent period of twelve (12) full consecutive calendar months for which Financial Statements are available; or (2) the Long Term Debt Service Coverage Ratio for the period of twelve (12) full consecutive calendar months immediately succeeding the proposed date of the applicable transaction is expected to be greater than it would have been had the transaction not occurred; or (3) the unrestricted net assets of all of the members of the Obligated Group immediately after the proposed transaction will be at least equal to 70% of the unrestricted net assets of all of the members of the Obligated Group immediately prior to the proposed transaction, based on the financial statements of the Obligated Group for the most recent Fiscal Year.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", subsection (a)(v) above in this caption "Consolidation, Merger, Sale or Conveyance" will be deleted in its entirety.

Filing of Financial Statements, Certificate of No Default, Other Information

Each member of the Obligated Group covenants that it will:

(a) As soon as practicable but in no event later than six (6) months after the end of each fiscal year, file with the Master Trustee a copy of its audited Financial Statements as of the end of such fiscal year accompanied by the opinion of Independent Certified Public Accountants. Such audited Financial Statements shall be prepared in accordance with generally accepted accounting principles and shall include such statements as are necessary for a fair presentation of unrestricted fund financial position, results of operations and changes in unrestricted fund balance and financial position as of the end of such fiscal year.

(b) As soon as practicable but in no event later than six (6) months after the end of each fiscal year, file with the Master Trustee, and with each Holder who may have so requested in writing or on whose behalf the Master Trustee may have so requested, an Officer's Certificate and a report of Independent Certified Public Accountants stating the Long-Term Debt Service Coverage Ratio for such fiscal year and stating that nothing has come to their attention which would lead them to believe that any Master Indenture Obligor is in default in the performance of any covenant contained in the Master Indenture or specifying each default of which the signers have knowledge.

(c) If an Event of Default shall have occurred and be continuing, (i) file with the Master Trustee such other financial statements and information concerning its operations and financial affairs (or of any consolidated or combined group of companies, including RH and its consolidated or combined Affiliates, including any other Master Indenture Obligor) as the Master Trustee may from time to time reasonably request, excluding specifically donor records, patient records and personnel records and (ii) provide access to its facilities for the purpose of inspection by the Master Trustee during regular business hours or at such other times as the Master Trustee may reasonably request.

(d) Within ten (10) days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture required to be prepared by a Consultant or an Insurance Consultant.

Parties Becoming Master Indenture Obligors

Any Affiliate which is not a Master Indenture Obligor may become a Master Indenture Obligor, if:

(a) The Affiliate which is becoming a Master Indenture Obligor shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Master Trustee, containing the agreement of such Affiliate (i) to become a Master Indenture Obligor under the Master Indenture and thereby become subject to compliance with all provisions of the Master Indenture pertaining to a Master Indenture Obligor, including the performance and observance of all covenants and obligations of a Master Indenture Obligor thereunder, and (ii) guaranteeing to the Master Trustee and each other member of the Obligated Group that all Master Indenture Obligations Outstanding will be paid in accordance with the terms thereof and of the Master Indenture, when due.

(b) Each instrument executed and delivered to the Master Trustee in accordance with paragraph (a) shall be accompanied by an Opinion of Counsel, addressed to and satisfactory to the Master Trustee, to the effect that such instrument has been duly authorized, executed and delivered by such Affiliate, and constitutes a valid and binding obligation enforceable in accordance with its terms, except as limited by bankruptcy laws, insolvency laws and other laws affecting creditors' rights generally.

(c) The Master Trustee shall also have received (i) an Officer's Certificate stating and demonstrating that, (A) immediately upon any Affiliate becoming a Master Indenture Obligor, RH and each other Master Indenture Obligor would not, as part of such transaction, be in default in the performance or observance of any covenant or condition to be performed or observed by it under the Master Indenture (including any covenant or provision applicable to the

Master Indenture Obligors); (B)(1) RH or any other Master Indenture Obligor could meet any condition described in paragraph (a) under the caption "Limitations on Incurrence of Additional Indebtedness" above for the incurrence of one dollar of Additional Indebtedness or (2) the Long-Term Debt Service Coverage Ratio for the period of 12 full consecutive calendar months immediately succeeding the proposed date of the applicable transaction is expected to be greater than it would have been had the transaction not occurred; and (C) the unrestricted fund balance of the Obligated Group, calculated in accordance with generally accepted accounting principles consistently applied, immediately upon an Affiliate becoming a Master Indenture Obligor will not be less than 90% of the unrestricted fund balance of the Obligated Group immediately preceding such Affiliate becoming a Master Indenture Obligor, and (ii) if all amounts due or to become due on any Related Bond have not been paid to the Holder thereof, an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such transaction will not adversely affect the exemption from federal income taxation of interest payable on any such Related Bond.

(d) RH shall have approved in writing any such Affiliate becoming a Master Indenture Obligor.

Persons that are not Affiliates and that are not Master Indenture Obligors may become Master Indenture Obligors upon compliance with the provisions of subparagraphs (a), (b), (c) and (d) above.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", subsection (b) and subsection (c) above in this caption "Parties Becoming Master Indenture Obligors" will be amended and restated in its entirety to read as follows:

(b) Each instrument executed and delivered to the Master Trustee in accordance with subsection (a) of this Section shall be accompanied by (i) an Opinion of Counsel, addressed to and satisfactory to the Master Trustee, to the effect that such instrument has been duly authorized, executed and delivered by such Affiliate, and constitutes a valid and binding obligation enforceable in accordance with its terms, except as limited by bankruptcy laws, insolvency laws and other laws affecting creditors' rights generally; and (ii) if all amounts due or to become due on any Related Bond have not been paid to the Holder thereof, an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such transaction will not adversely affect the exemption from federal income taxation of interest payable on any such Related Bond.

(c) The Master Trustee shall also have received an Officer's Certificate stating and demonstrating that (1) any condition described in Section 5.05(a) has been satisfied for the issuance of an additional one dollar ($1.00) of Additional Indebtedness, assuming such Affiliate had become a Master Indenture Obligor at the beginning of the most recent period of twelve (12) full consecutive calendar months for which Financial Statements are available; or (2) the Long Term Debt Service Coverage Ratio for the period of twelve (12) full consecutive calendar months immediately succeeding the proposed date of such Affiliate becoming a Master Indenture Obligor is expected to be greater than it would have been had the Affiliate not become a Master Indenture Obligor; or (3) the unrestricted net assets of all of the members of the Obligated Group immediately after the proposed transaction will be at least equal to 70% of the unrestricted net

assets of all of the members of the Obligated Group immediately prior to the proposed transaction, based on the financial statements of the Obligated Group for the most recent Fiscal Year.

Cessation of Status as Master Indenture Obligor

(a) Each member of the Obligated Group covenants that it will not take any action which would cause it to cease to be a Master Indenture Obligor unless prior to taking any such action there is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that immediately after such action (i) the Long-Term Debt Service Coverage Ratio for the period of twelve (12) full consecutive calendar months immediately succeeding the proposed date of the applicable transaction is expected to be greater than it would have been had the transaction not occurred or (ii) RH or any other Master Indenture Obligor could meet any condition described in paragraph (a) under the caption "Limitations on Incurrence of Additional Indebtedness" above for the incurrence of one dollar of Additional Indebtedness on the date immediately succeeding the proposed transaction.

(b) Anything in the preceding paragraph to the contrary notwithstanding, in no event shall any entity or entities the Total Revenues of which constituted more than 40% of the Total Revenues of the Obligated Group in the most recent year for which Financial Statements are available take any action which would cause such entity to cease being a member of the Obligated Group unless the Officer's Certificate delivered pursuant to the preceding paragraph either (A) meets condition (i) of such paragraph or (B) demonstrates that the remaining members of the Obligated Group (i) have a Capitalization Ratio not in excess of 65% or (ii) would have had a Long Term Debt Service Coverage Ratio greater than 1.50 in the most recent year for which Financial Statements are available. No member of the Obligated Group will take any action which would cause it to cease to be a Master Indenture Obligor without the prior written consent of RH.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", the provisions of the Master Indenture which is summarized above in this caption "Cessation of Status as Master Indenture Obligor" will be amended and restated in its entirety to read as follows:

(a) Each member of the Obligated Group covenants that it will not take any action which would cause it to cease to be a Master Indenture Obligor unless prior to taking any such action there is delivered to the Master Trustee an Officer's Certificate stating and demonstrating that immediately after such action either:

(i) Any condition described in Section 5.05(a) has been satisfied for the issuance of an additional one dollar ($1.00) of Additional Indebtedness, assuming such transaction had occurred at the beginning of the most recent period of twelve (12) full consecutive calendar months for which Financial Statements were available; or

(ii) The Long-Term Debt Service Coverage Ratio for the most recent period of twelve (12) full consecutive calendar months preceding the proposed date of such transaction for which Financial Statements have been examined by Independent Certified Public Accountants, assuming such transaction actually occurred at the beginning of such

period, would not have been reduced or, if reduced, would not have been reduced to less than 1.50; or

(iii) The average of the Long-Term Debt Service Coverage Ratios for the two periods of twelve (12) full consecutive calendar months immediately succeeding the proposed date of such transaction is expected to be greater than the Long-Term Debt Service Coverage Ratio for the most recent period of twelve (12) full consecutive calendar months preceding the proposed date of such transaction for which Financial Statements have been examined by Independent Certified Public Accountants; or

(iv) The Long-Term Debt Service Coverage Ratio for the period of 12 full consecutive calendar months immediately succeeding the proposed date of such transaction is expected to be greater than it would have been had the transaction not occurred.

(b) In the event that Reading Hospital ceases to be a member of the Obligated Group, the remaining members of the Obligated Group shall designate one or more members to assume the various reporting and decision-making responsibilities, on behalf of the Obligated Group, previously assigned to Reading Hospital hereunder and shall send written notice of such designation to the Master Trustee.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", a new section will be added to the Master Indenture which is summarized as follows:

Substitution of Master Indenture Obligations upon Replacement of Master Indenture. All Master Indenture Obligations issued pursuant to this Indenture shall, upon request of the System, be surrendered to the Master Trustee upon delivery to the Master Trustee of:

(a) one or more original replacement master indenture obligations (the "Substitute Obligations") issued by or on behalf of the members of a new credit group (collectively, the "New Group") under and pursuant to and secured by a master trust indenture (the "Replacement Master Indenture") executed by or on behalf of the New Group and an independent corporate trustee (the "New Trustee") meeting the eligibility requirements of the Master Trustee as set forth in Article VII of the Master Indenture, which Substitute Obligations have been duly authenticated by the New Trustee under the terms of the Replacement Master Indenture;

(b) an Opinion of Bond Counsel that the surrender of the Master Indenture Obligations and the delivery to the Master Trustee of the Substitute Obligations will not adversely affect the validity of the Related Bonds or any exemption for the purpose of federal income taxation to which interest on any Master Indenture Obligations or any Related Bonds would otherwise be entitled;

(c) an executed counterpart of the Replacement Master Indenture;

(d) an Opinion of Counsel to the Obligated Group addressed to the Master Trustee, the trustee for each series of Related Bonds, the Related Bond Issuer and any credit enhancer for the Related Bonds to the effect that:

(i) the Replacement Master Indenture has been duly authorized, executed and delivered by each member of the New Group; each Substitute Obligation has been duly authorized, executed and delivered by or on behalf of a member of the New Group; and the Replacement Master Indenture and each Substitute Obligation is a legal, valid and binding obligation of each member of the New Group, subject in each case to customary exceptions for bankruptcy, insolvency and other laws generally affecting enforcement of creditors' rights and application of general principles of equity;

(ii) all requirements and conditions to the issuance of the Substitute Obligations in the Replacement Master Indenture have been complied with and satisfied;

(iii) registration of the Substitute Obligations under the Securities Act of 1933, as amended, is not required or, if such registration is required, the New Group has complied with all applicable provisions of said Act; and

(iv) qualification of the Replacement Master Indenture under the Trust Indenture Act of 1939, as amended, is not required, or if such qualification is required, the New Group has complied with all applicable provisions of such Act;

(e) either evidence that (i)(A) written notice of such substitution of Master Indenture Obligations shall have been given by the New Group to each Rating Agency then maintaining a rating on any Master Indenture Obligation or Related Bond and (B) the then current rating shall not be withdrawn if such withdrawal will result in less than two Rating Agencies remaining or, if the then current rating is below A3 or its equivalent, the then current rating shall not be lowered by any Rating Agency as a result of such substitution of Master Indenture Obligations and delivery of the Replacement Master Indenture; or (ii)(A) any condition described in Section 5.05(a) has been satisfied for the issuance of an additional one dollar ($1.00) of Additional Indebtedness assuming such substitution of the Master Indenture Obligations and delivery of the Replacement Master Indenture had occurred at the beginning of the most recent period of twelve (12) full consecutive calendar months for which Financial Statements were available or (B) the unrestricted net assets of the New Group will be not less than 70% of the unrestricted net assets of the Obligated Group for the most recent Fiscal Year of the Obligated Group for which audited financial statements are available;

(f) any prior written consents required by any credit enhancer of any Outstanding Related Bonds; and

(g) such other opinions and certificates as the Master Trustee may reasonably require, together with payment of all outstanding fees and expenses of the Master Trustee and with such reasonable indemnities as are satisfactory to it.

Please note that under the circumstances described above under the caption "Amendments to the Master Indenture", a new section will be added to the Master Indenture which is summarized as follows:

Notification to Holders of Master Indenture Obligations. The Master Trustee shall, within five (5) Business Days after receipt of the items set forth in Section 5.16 hereof, mail to all Holders of Master Indenture Obligations, as the names and addresses of such Holders appear upon the register or registers maintained by the Master Trustee, notice that the

requirements of Section 5.16 hereof have been satisfied and that all Master Indenture Obligations issued hereunder are required to be replaced with the Substitute Obligations, and directing such Holders to surrender all Master Indenture Obligations to the Master Trustee for cancellation. Each Holder of a Master Indenture Obligation shall surrender its Master Indenture Obligations to the Master Trustee, at the designated operations office of the Master Trustee, within ten (10) Business Days of receipt from the Master Trustee of the notice required by this Section 5.17, against receipt of a Substitute Obligation. Upon delivery of the Substitute Obligations, the Master Trustee shall cancel the surrendered Master Indenture Obligations. Thereupon the Master Trustee shall be discharged hereunder.

Events of Default

Event of Default, as used in the Master Indenture, shall mean any of the following events:

(a) Any Master Indenture Obligor shall fail to make any payment required by any Master Indenture Obligation when and as the same shall become due and payable, in accordance with the terms thereof and of the Master Indenture and any supplement thereto and any grace period with respect thereto shall have expired.

(b) Any Master Indenture Obligor shall fail duly to observe or perform any covenant or agreement on its part to be observed or performed under the Master Indenture for a period of thirty (30) days after the date on which written notice of such failure, requiring the same to be remedied, shall have been given to RH by the Master Trustee, or to RH and the Master Trustee by the Holders of at least 20% in aggregate principal amount of Master Indenture Obligations then Outstanding; provided, however, if said failure be such that it cannot be corrected within the applicable period, it shall not constitute a Default if corrective action is instituted by RH or any other Master Indenture Obligor within the applicable period and diligently pursued until the failure is corrected and provided further, however, that there shall be no Event of Default by reason of the breach of the covenant set forth in paragraph (a) under the caption "Debt Service Coverage Ratio" above if a Consultant has been hired in accordance with the provisions of paragraph (b) under such caption.

(c) An event of default shall occur under a Related Bond Indenture or upon a Related Bond.

(d) Any Master Indenture Obligor shall fail to make any required payment with respect to any Indebtedness the principal amount of which is greater than 5% of the Total Revenues of the Obligated Group (other than Non-Recourse Indebtedness), whether such Indebtedness now exists or shall hereafter be created, and any period of grace with respect thereto shall have expired, or an event of default as defined in any mortgage, indenture or instrument under which there may be issued, or by which there may be secured or evidenced, any Indebtedness, whether such Indebtedness now exists or shall hereafter be created, shall occur, provided, however, that such failure shall not constitute an Event of Default if within 30 days, or within the time allowed for service of a responsive pleading if any proceeding to enforce payment of the Indebtedness is commenced (i) RH or such other Master Indenture Obligor, or both, in good faith commence proceedings to contest the existence or payment of such Indebtedness, and (ii) sufficient moneys are escrowed with a bank or trust company for the payment of such Indebtedness.

(e) The entry of a decree or order by a court having jurisdiction in the premises adjudging any Master Indenture Obligor a bankrupt or insolvent, or approving as properly filed a petition seeking reorganization, arrangement, adjustment or composition of or in respect of any Master Indenture Obligor under the Federal Bankruptcy Code or any other applicable federal or state law, or appointing a receiver, liquidator, assignee, or sequestrator (or other similar official) of any Master Indenture Obligor or of any substantial part of its Property, or ordering the winding up or liquidation of its affairs, and the continuance of any such decree or order unstayed and in effect for a period of ninety (90) consecutive days.

(f) The institution by any Master Indenture Obligor of proceedings to be adjudicated a bankrupt or insolvent, or the consent by it to the institution of bankruptcy or insolvency proceedings against it, or the filing by it of a petition or answer or consent seeking reorganization or relief under the Federal Bankruptcy Code or any other similar applicable federal or state law, or the consent by it to the filing of any such petition or to the appointment of a receiver, liquidator, assignee, trustee or sequestrator (or other similar official) of any Master Indenture Obligor or of any substantial part of its Property, or the making by it of an assignment for the benefit of creditors, or the admission by it in writing of its inability to pay its debts generally as they become due.

(g) An Event of Default as defined in any agreement or instrument delivered by an Affiliate pursuant to Section 5.11(a) of the Master Indenture (Parties Becoming Master Indenture Obligors) shall occur and such event shall be continuing from and after the expiration of any grace period permitted with respect thereto.

Acceleration; Annulment of Acceleration

(a) Upon the occurrence and during the continuation of an Event of Default, the Master Trustee may and, upon the written request of the Holders of not less than 51% in aggregate principal amount of Master Indenture Obligations Outstanding, shall, by notice to the members of the Obligated Group, declare all Master Indenture Obligations Outstanding immediately due and payable, anything in the Master Indenture Obligations or in the Master Indenture to the contrary notwithstanding. In such event, there shall be due and payable on the Master Indenture Obligations an amount equal to the total principal amount of all such Master Indenture Obligations, plus all interest accrued thereon and, to the extent permitted by applicable law, interest on such interest which accrues to the date of payment.

(b) At any time after the principal of the Master Indenture Obligations shall have been so declared to be due and payable and before the entry of final judgment or decree in any suit, action or proceeding instituted on account of such default, if (i) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee moneys sufficient to pay all matured installments of interest and interest on installments of principal and interest and principal or redemption prices then due (other than the principal then due only because of such declaration) of all Master Indenture Obligations Outstanding; (ii) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee moneys sufficient to pay the charges, compensation, expenses, disbursements, advances and liabilities of the Master Trustee and any paying agents; (iii) all other amounts then payable by the Obligated Group under the Master Indenture shall have been paid or a sum sufficient to pay the same shall have been deposited with the Master Trustee; and (iv) every Event of Default (other than a default in the payment of the

principal of such Master Indenture Obligations then due only because of such declaration) shall have been remedied, then the Master Trustee may annul such declaration and its consequences with respect to any Master Indenture Obligations or portions thereof not then due by their terms. No such annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon.

Additional Remedies and Enforcement of Remedies

Upon the occurrence and continuance of any Event of Default, the Master Trustee may, and upon the written request of the Holders of not less than 51% in aggregate principal amount of the Master Indenture Obligations Outstanding, together with indemnification of the Master Trustee to its satisfaction therefor, shall proceed forthwith to protect and enforce its rights and the rights of the Holders of Master Indenture Obligations by such suits, actions or proceedings as the Master Trustee, being advised by counsel, shall deem expedient, including but not limited to:

(i) enforcement of the right of the Holders of Master Indenture Obligations to collect and enforce the payment of amounts due or becoming due under the Master Indenture Obligations;

(ii) suit upon all or any part of the Master Indenture Obligations;

(iii) civil action to require any person holding moneys, documents or other property pledged to secure payment of amounts due or to become due on the Master Indenture Obligations to account as if it were the trustee of an express trust for the Holders of Master Indenture Obligations;

(iv) civil action to enjoin any acts or things which may be unlawful or in violation of the rights of the Holders of Master Indenture Obligations; and

(v) enforcement of any other right of the Holders of Master Indenture Obligations conferred by law or by the Master Indenture.

Establishment of Default Revenue Fund; Application of Revenues and Other Moneys after Default

Upon the occurrence and during the continuance of an Event of Default, the Master Trustee shall maintain a separate fund established under the Master Indenture known as the "Default Revenue Fund."

During the continuance of an Event of Default all money received by the Master Trustee pursuant to any Master Indenture Obligation or pursuant to any right given or action taken under the provisions of Article VI of the Master Indenture (entitled "Default and Remedies"), after payment of the costs and expenses of the proceedings resulting in the collection of such moneys and of the expenses and advances incurred or made by the Master Trustee with respect thereto and all other fees and expenses of the Master Trustee under the Master Indenture, shall be deposited in the Default Revenue Fund and applied as follows:

(a) Unless the principal of all Outstanding Master Indenture Obligations shall have become or have been declared due and payable:

First: To the payment to the persons entitled thereto of all installments of interest then due on the Master Indenture Obligations in the order of the maturity of such installments, and, if the amount available shall not be sufficient to pay in full any installment or installments maturing on the same date, then to the payment thereof ratably according to the amounts due thereon to the persons entitled thereto, without any discrimination or preference; and

Second: To the payment to the persons entitled thereto of the unpaid principal installments of any Master Indenture Obligations which shall have become due, whether at maturity or by call for redemption, in the order of their due dates, and if the amounts available shall not be sufficient to pay in full all the Master Indenture Obligations due on any date, then to the payment thereof ratably, according to the amounts of principal installments due on such date, to the persons entitled thereto, without any discrimination or preference.

(b) If the principal of all Outstanding Master Indenture Obligations shall have become or have been declared due and payable, to the payment of the principal and interest then due and unpaid upon the Master Indenture Obligations without preference or priority of principal over interest or of interest over principal, or of any installment of interest over any other installment of interest, or of any Master Indenture Obligation over any other Master Indenture Obligation, ratably, according to the amounts due respectively for principal and interest, to the persons entitled thereto without any discrimination or preference.

(c) If the principal of all Outstanding Master Indenture Obligations shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled, then, subject to the provisions of paragraph (b) of this section in the event that the principal of all Outstanding Master Indenture Obligations shall later become due or be declared due and payable, the moneys shall be applied in accordance with the provisions of paragraph (a) of this section.

Whenever moneys are to be applied by the Master Trustee pursuant to the provisions of this section, such moneys shall be applied by it at such times, and from time to time, as the Master Trustee shall determine, having due regard for the amount of such moneys available for application and the likelihood of additional moneys becoming available for such application in the future. Whenever the Master Trustee shall apply such moneys it shall fix the date upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates shall cease to accrue. The Master Trustee shall give such notice as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and shall not be required to make payment to the Holder of any unpaid Master Indenture Obligation until such Master Indenture Obligation shall be presented to the Master Trustee for appropriate endorsement of any partial payment or for cancellation if fully paid.

Whenever all Master Indenture Obligations and interest thereon have been paid in accordance with these provisions and all expenses and charges of the Master Trustee have been paid, any balance remaining shall be paid to the person entitled to receive the same; if no other person shall be entitled thereto then the balance shall be paid to the members of the Obligated Group, their successors, or as a court of competent jurisdiction may direct.

Control of Proceedings

If an Event of Default shall have occurred and be continuing, notwithstanding anything in the Master Indenture to the contrary, the Holders of at least a majority in aggregate principal amount of Master Indenture Obligations then Outstanding shall have the right, at any time, by any instrument in writing executed and delivered to the Master Trustee and accompanied by indemnity satisfactory to the Master Trustee, to direct the method and place of conducting any proceeding to be taken in connection with the enforcement of the terms and conditions of the Master Indenture or for the appointment of a receiver or any other proceedings under the Master Indenture, provided that such direction is not in conflict with any applicable law or the provisions thereof and provided further, that the Master Trustee shall have the right to decline to follow any such direction if the Master Trustee in good faith shall determine that the proceeding so directed would involve it in personal liability, and, in the sole judgment of the Master Trustee, is not unduly prejudicial to the interest of Holders of Master Indenture Obligations not joining in such direction and provided further that nothing in this section shall impair the right of the Master Trustee in its discretion to take any other action under the Master Indenture which it may deem proper and which is not inconsistent with such direction by Holders of Master Indenture Obligations.

Supplemental Indentures Not Requiring Consent of Holders

RH, and every other Master Indenture Obligor, when authorized by resolution or other action of equal formality by its Governing Body, and the Master Trustee may, without the consent of or notice to any of the Holders, enter into one or more Supplemental Indentures for one or more of the following purposes:

(a) To cure any ambiguity or formal defect or omission in the Master Indenture.

(b) To correct or supplement any provision in the Master Indenture which may be inconsistent with any other provision in the Master Indenture, or to make any other provisions with respect to matters or questions arising under the Master Indenture and which shall not, in the opinion of the Master Trustee, materially and adversely affect the interests of the Holders.

(c) To grant or confer ratably upon all of the Holders any additional rights, remedies, powers or authority that may lawfully be granted or conferred upon them.

(d) To qualify the Master Indenture under the Trust Indenture Act of 1939, as amended, or corresponding provisions of federal laws from time to time in effect.

(e) To create and provide for the issuance of a series of Master Indenture Obligations as permitted under the Master Indenture.

(f) To obligate a successor to any Master Indenture Obligor, or an Affiliate or other Person becoming a Master Indenture Obligor, as permitted under the Master Indenture.

Supplemental Indentures Requiring Consent of Holders

(a) Other than Supplemental Indentures referred to in Section 8.01 (Supplemental Indentures Not Requiring Consent of Holders) and subject to the terms and provisions and limitations contained in this Article and not otherwise, the Holders of not less than a majority in aggregate principal amount of the Master Indenture Obligations then Outstanding shall have the right, from time to time, anything contained in the Master Indenture to the contrary notwithstanding, to consent to and approve the execution by RH and each other Master Indenture Obligor, when authorized by resolution or other action of equal formality by its Governing Body, and the Master Trustee of such Supplemental Indentures as shall be deemed necessary and desirable for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Master Indenture, including, but not limited to the provisions contained in Article V hereof; provided, however, nothing in this section shall permit or be construed as permitting a Supplemental Indenture which would:

(i) extend the stated maturity of or time for paying interest on any Note or reduce the principal amount of or the redemption premium or rate of interest payable on any Note, or in comparable fashion change the payment terms of other Master Indenture Obligations, without the consent of the Holder of such Note or other Master Indenture Obligation; or

(ii) reduce the aggregate principal amount of Master Indenture Obligations then Outstanding the consent of the Holders of which is required to authorize such Supplemental Indentures without the consent of the Holders of all Master Indenture Obligations then Outstanding.

(b) If at any time the Master Indenture Obligors, or RH on their behalf, shall request the Master Trustee to enter into a Supplemental Indenture, which request is accompanied by a copy of the resolution or other action of the Governing Body of each Master Indenture Obligor certified by its secretary or if it has no secretary, its comparable officer, and the proposed Supplemental Indenture and if within such period, not exceeding three years, as shall be prescribed by the Master Indenture Obligors, or RH on their behalf, following the request, the Master Trustee shall receive an instrument or instruments purporting to be executed by the Holders of not less than the aggregate principal amount or number of Master Indenture Obligations specified in paragraph (a) above for the Supplemental Indenture in question which instrument or instruments shall refer to the proposed Supplemental Indentures and shall specifically consent to and approve the execution thereof in substantially the form of the copy thereof as on file with the Master Trustee, thereupon, but not otherwise, the Master Trustee may execute such Supplemental Indenture in substantially such form, without liability or responsibility to any Holder of any Master Indenture Obligation, whether or not such Holder shall have consented thereto.

(c) Any such consent shall be binding upon the Holder of the Master Indenture Obligation giving such consent and upon any subsequent Holder of such Master Indenture Obligation and of any Master Indenture Obligation issued in exchange therefor (whether or not such subsequent Holder thereof has notice thereof), unless such consent is revoked in writing by the Holder of such Master Indenture Obligation giving such consent or by

a subsequent Holder thereof by filing with the Master Trustee, prior to the execution by the Master Trustee of such Supplemental Indenture, such revocation. At any time after the Holders of the required principal amount or number of Master Indenture Obligations shall have filed their consents to the Supplemental Indenture, the Master Trustee shall make and file with RH a written statement to that effect. Such written statement shall be conclusive that such consents have been so filed.

Satisfaction and Discharge of Indenture

If (i) RH or any other Master Indenture Obligor shall deliver to the Master Trustee for cancellation all Master Indenture Obligations theretofore authenticated (other than any Master Indenture Obligations which shall have been mutilated, destroyed, lost or stolen and which shall have been replaced or paid as provided therein) and not theretofore canceled, or (ii) all Master Indenture Obligations not theretofore canceled or delivered to the Master Trustee for cancellation shall have become due and payable and have been paid, or (iii) the members of the Obligated Group shall deposit with the Master Trustee (or with a bank or trust company acceptable to the Master Trustee) as trust funds the entire amount of money or direct general obligations of, or obligations the payment of principal and interest on which are unconditionally guaranteed by, the United States of America, or both, the principal of and the interest on which, when due, will be sufficient to pay at maturity or upon redemption all Master Indenture Obligations not theretofore canceled or delivered to the Master Trustee for cancellation, including principal and interest due or to become due to such date of maturity or redemption date, as the case may be, and if in either case the members of the Obligated Group shall also pay or cause to be paid all other sums payable hereunder by the members of the Obligated Group, then the Master Indenture shall cease to be of further effect, and the Master Trustee, on demand of the members of the Obligated Group, and at the cost and expense of the members of the Obligated Group, shall execute proper instruments acknowledging satisfaction of and discharging the Master Indenture.

Payment of Master Indenture Obligations

Notwithstanding the discharge of the Master Indenture, the Master Trustee shall nevertheless retain such rights, powers and duties thereunder as may be necessary and convenient for the payment of amounts due or to become due on the Master Indenture Obligations and the registration, transfer, exchange and replacement of Master Indenture Obligations as provided therein. Nevertheless, any moneys held by the Master Trustee or any paying agent for the payment of amounts due on the Master Indenture Obligations remaining unclaimed for five years after all such amounts have become due and payable, whether at maturity or upon proceedings for redemption or by declaration as provided therein or otherwise, shall then be paid to the members of the Obligated Group and the Holders of any Master Indenture Obligations not theretofore presented for payment shall thereafter be entitled to look only to the members of the Obligated Group for payment thereof as unsecured creditors and all liability of the Master Trustee or any paying agent with respect to such moneys shall thereupon cease.

APPENDIX E

FORM OF APPROVING OPINION OF BOND COUNSEL

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October 31, 2017

RE: $590,500,000 Berks County Industrial Development Authority
Health System Revenue Bonds (Tower Health Project) Series of 2017
(the "Bonds")

TO: THE REGISTERED OWNERS OF THE ABOVE-CAPTIONED BONDS

We have acted as Bond Counsel in connection with the issuance by the Berks County Industrial Development Authority (the "Authority") of the above-captioned Bonds under the Pennsylvania Economic Development Financing Law, Act of August 23, 1967, P.L. 251, as amended (the "Act"). The Bonds are being issued pursuant to the provisions of a Trust Indenture, dated as of October 1, 2017 (the "Trust Indenture"), by and between the Authority and Manufacturers and Traders Trust Company, Harrisburg, Pennsylvania, as bond trustee (the "Bond Trustee"). The proceeds of the Bonds, together with other available funds, will be used by the Authority to finance a project (the "2017 Project") for the benefit of Tower Health, a Pennsylvania non-profit corporation (the "System"), consisting of, among other things: (a) the advance refunding of a portion of The Berks County Municipal Authority's Fixed Rate Revenue Bonds (The Reading Hospital and Medical Center Project) Series 2009A-3; (b) the design, construction, installation and furnishing of the Reading HealthPlex for Advanced Surgical & Patient Care, which is a 476,000 square foot surgical and inpatient tower located in West Reading, Pennsylvania; (c) the refunding of a bridge loan a portion of the proceeds of which were used to finance (i) the acquisition of Brandywine Hospital, a 234-bed acute care hospital located in Coatesville, Pennsylvania, including related office buildings, parking facilities and related facilities; (ii) the acquisition of Chestnut Hill Hospital, a 135-bed acute care hospital located in Philadelphia, Pennsylvania, including related medical office buildings, surgery centers and parking facilities; (iii) the acquisition of Jennersville Regional Hospital, a 63-bed acute care hospital located in West Grove, Pennsylvania, including related medical office buildings and related facilities; (iv) the acquisition of Phoenixville Hospital, a 151-bed acute care hospital located in Phoenixville, Pennsylvania, including related medical office buildings and related facilities; and (v) the acquisition of Pottstown Memorial Medical Center, a 232-bed acute care hospital located in Pottstown, Pennsylvania, including related medical office buildings and surgery centers; and (d) the payment of the costs and expenses incident to the issuance of the Bonds. All capitalized terms used in this opinion and not defined herein shall have the meanings assigned to them in the Trust Indenture unless the context clearly requires otherwise.

The Authority and the System have entered into a Loan Agreement, dated as of October 1, 2017 (the "Loan Agreement"), pursuant to which the Authority has agreed to loan the proceeds of the Bonds to the System to finance the 2017 Project and the System has agreed, among other things, to make certain loan payments to the Authority in such amounts and at such times as to permit the Authority to pay, among other things, the principal of, premium, if any, and interest on the Bonds when due.

Pursuant to the provisions of the Trust Indenture, the Authority has, among other things, pledged, assigned and granted to the Bond Trustee all of its right, title and interest in and to the Loan Agreement (except for certain indemnification rights, rights to be reimbursed for certain costs and expenses that it may incur as provided in the Loan Agreement).

The System, Reading Hospital, a Pennsylvania not-for-profit corporation ("RH") and The Bank of New York Mellon Trust Company, N.A., as successor master trustee (the "Master Trustee"), have entered into a Master Trust Indenture, dated as of June 1, 1993, as previously supplemented (the "Master Trust Indenture"). Pursuant to a Joinder Agreement dated as of September 30, 2017 (the "Joinder Agreement"), Brandywine Hospital, LLC ("BH"), Chestnut Hill Hospital, LLC ("CHH"), Jennersville Hospital, LLC ("JH"), Phoenixville Hospital, LLC ("PHH"), and Pottstown Hospital, LLC ("POH"), each a Pennsylvania limited liability company, have each become a Master Indenture Obligor and an Obligated Group member as each such term is defined in the Master Trust Indenture. The System, RH, BH, CHH, JH, PHH and POH are collectively referred to as the "Obligated Group".

The Bonds will be secured by, among other things, a Series B of 2017 Master Note (Berks County Industrial Development Authority), dated October 31, 2017 (the "Master Note"), issued by the System pursuant to the provisions of the Master Trust Indenture, as supplemented by a Thirty-third Supplemental Master Trust Indenture, dated as of October 1, 2017 (the "Supplemental Master Indenture" and together with the Master Trust Indenture, the "Master Indenture"), by and between the Obligated Group and the Master Trustee.

The Bonds issued this date are dated, mature and bear interest and are subject to redemption and purchase prior to maturity upon the terms and conditions stated therein and in the Trust Indenture. The Bonds are issuable as registered bonds in denominations of $5,000 or any integral multiple of $5,000 in excess thereof.

In our capacity as Bond Counsel, we have reviewed the following:

1. The Act;

2. A certified copy of the Articles of Incorporation of the Authority;

3. Sections 103 and 141 through 150 of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations and rulings promulgated thereunder;

4. The General Certificate of the Authority and all exhibits thereto;

5. The General Certificate of each member of the Obligated Group and all exhibits thereto;

6. The opinion of Georgeadis Setley, Wyomissing, Pennsylvania, in its capacity as counsel to the Authority;

7. The Bond Purchase Agreement among the Authority, the System and Citigroup Global Markets, Inc., acting on its own behalf and on behalf of Barclays Capital, Inc., dated October 17, 2017;

8. A specimen copy of one of the Bonds;

9. An executed Nonarbitrage Certificate and Compliance Agreement of the Authority delivered this day;

10. An executed Confirmation Certificate of the Obligated Group delivered this day;

11. An executed Certificate Regarding Information Contained in Form 8038 delivered this day;

12. The information return of the Authority on Form 8038 delivered this day; and

13. Original counterparts or certified copies of the Loan Agreement, the Trust Indenture, the Supplemental Master Indenture, the Master Note and the other documents, agreements, certificates and opinions delivered at the closing held this day.

Based and in reliance upon the foregoing, our attendance at the closing held this day and subject to the caveats, qualifications, exceptions and assumptions set forth herein, it is our opinion that, as of the date hereof, under existing law:

1. The Authority is a body corporate and politic, validly existing under the laws of the Commonwealth of Pennsylvania (the "Commonwealth"), with full power and authority to execute and deliver the Trust Indenture and the Loan Agreement and to issue and sell the Bonds.

2. The Trust Indenture and the Loan Agreement have each been duly authorized, executed and delivered by the Authority and each such document constitutes the valid and binding obligation of the Authority.

3. The issuance of the Bonds has been duly authorized by the Authority. The Bonds have been duly and validly authorized, executed and delivered by the Authority and, when duly authenticated by the Bond Trustee, will constitute valid and binding obligations of the Authority.

4. Under the laws of the Commonwealth, the Bonds and interest on the Bonds shall be free from taxation for State and local purposes within the Commonwealth, but this exemption does not extend to gift, estate, succession or inheritance taxes or any other taxes not levied directly on the Bonds or the interest thereon. Under the laws of the Commonwealth, profits, gains or income derived from the sale, exchange or other disposition of the Bonds are subject to State and local taxation within the Commonwealth.

5. Interest on the Bonds is not includable in gross income under Section 103(a) of the Code.

6. Under the Code, interest on the Bonds held by persons other than corporations (as defined for federal tax purposes) does not constitute an item of tax preference under Section 57 of the Code and thus is not subject to alternative minimum tax for federal income tax purposes.

7. Under the Code, interest on the Bonds held by a corporation (as defined for federal tax purposes) does not constitute an item of tax preference under Section 57 of the Code; however, corporations subject to alternative minimum tax will be required to include, among other things, amounts treated as interest on the Bonds as an adjustment in computing alternative minimum taxable income in the manner provided in Section 56 of the Code.

In connection with providing the foregoing opinions, we call to your attention the following:

A. As to questions of fact material to our opinion, we have relied upon the representations, statements, expectations and certifications contained in the documents and other certified proceedings reviewed by us (including, without limitation, certificates, agreements and representations by the Authority and the Obligated Group as to the expected use of the proceeds of the Bonds and as to continuing compliance with Section 148 of the Code to assure that the

Bonds do not become "arbitrage bonds" and continue to be "qualified 501(c)(3) bonds" within the meaning of Section 145 of the Code), without undertaking to verify the same by independent investigation. We have also relied upon the genuineness, authenticity, truthfulness and completeness of all facts, information, representations, and certifications contained in the agreements, certificates, documents, records and other instruments executed and delivered at or in connection with the closing held this day and have assumed compliance with the state and federal securities laws. We have also assumed the genuineness of the signatures appearing upon all the certificates, documents and instruments executed and delivered at the closing held this day.

B. In connection with the opinions set forth in paragraphs 2 and 3 above, we call to your attention that the legality, validity, binding nature and enforceability of the documents referred to therein may be limited by: (a) the availability or unavailability of equitable remedies including, but not limited to, specific performance and injunctive relief; (b) the effect of bankruptcy, insolvency, reorganization, moratorium, fraudulent conveyance or other similar laws or equitable principles generally affecting creditors' rights or remedies; and (c) the effect of certain laws and judicial decisions limiting on constitutional or public policy grounds any provisions set forth in such documents purporting to waive rights of due process and legal procedure.

C. In providing the opinion set forth in paragraph 5 above, we have assumed continuing compliance by the Authority and the Obligated Group with requirements of the Code and the applicable regulations thereunder which must be met subsequent to the issuance of the Bonds in order that the interest thereon be and remain excluded from gross income for federal income tax purposes. The Authority and the Obligated Group have covenanted to comply with such requirements. Failure to comply with such requirements could cause the interest on the Bonds to be included in gross income retroactive to the date of issuance of such Bonds. We further advise you that we have not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring) after the date of issuance of the Bonds may affect the tax status of interest on the Bonds.

D. In providing the opinions set forth in paragraphs 6 and 7 above, we have assumed continuing compliance by the Authority and the Obligated Group with requirements of the Code and applicable regulations thereunder which must be met subsequent to the issuance of the Bonds in order that the interest thereon not constitute an item of tax preference under Section 57 of the Code. Failure to comply with such requirements could cause the interest on the Bonds to constitute an item of tax preference under Section 57 of the Code retroactive to the date of issuance of the Bonds.

E. Except as specifically set forth above, we express no opinion regarding other federal income tax consequences arising with respect to the Bonds, including, without limitation, the treatment for federal income tax purposes of gain or loss, if any, upon the sale, redemption or other disposition of the Bonds prior to the maturity of the Bonds subject to original issue discount and the effect, if any, of certain other provisions of the Code which could result in collateral federal income tax consequences to certain investors as a result of adjustments in the computation of tax liability dependent on tax-exempt interest.

F. The Bonds are special limited obligations of the Authority, payable only out of amounts that may be held by or available to the Bond Trustee under the Trust Indenture, the Loan Agreement and the Master Indenture, including amounts payable pursuant to the Master Note. The Bonds do not pledge the credit or taxing power of the Commonwealth or any political subdivision thereof. The Authority has no taxing power.

G. We have not been engaged to verify, nor have we independently verified, nor do we herein express any opinion to the registered owners of the Bonds with respect to, the accuracy, completeness or truthfulness of any statements, certifications, information or financial statements set forth in the Preliminary Official Statement dated October 2, 2017, as amended (the "Preliminary Official Statement"), or in the Official Statement dated October 17, 2017 (the "Official Statement"), or with respect to any other materials used in connection with the offer and sale of the Bonds.

H. We express no opinion with respect to whether the Authority or the Obligated Group, in connection with the sale of the Bonds or the preparation of the Preliminary Official Statement or the Official Statement has made any untrue statement of a material fact or omitted to state a material fact necessary in order to make any statements made therein, not misleading. Further, we have not verified, and express no opinion as to the accuracy of, any "CUSIP" identification number which may be printed on any Bond.

Very truly yours,

STEVENS & LEE, P.C.

APPENDIX F

FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement (this "Disclosure Agreement") dated as of October 1, 2017 is executed and delivered by Tower Health, (the "Borrower"), Tower Health, as a member of, and on behalf of the obligated group (the "Obligated Group") and Digital Assurance Certification, L.L.C., as exclusive Disclosure Dissemination Agent (the "Dissemination Agent" or "DAC"), in connection with the issuance of $590,500,000 aggregate principal amount of Berks County Industrial Development Authority Health System Revenue Bonds (Tower Health Project) Series of 2017 (the "Bonds"). The Bonds are being issued pursuant to a Trust Indenture, dated as of October 1, 2017 (the "Indenture") between the Berks County Industrial Development Authority (the "Authority") and Manufacturers and Traders Trust Company, as trustee (the "Trustee"). The Authority is lending the proceeds of the Bonds to the Borrower pursuant to a Loan Agreement dated as of October 1, 2017 (the "Loan Agreement") between the Authority and the Borrower. The payment obligations of the Borrower under the Loan Agreement initially will be evidenced by a promissory note (the "Note") issued pursuant to a Master Trust Indenture dated as of June 1, 1993, as amended and supplemented to the date hereof, between the Obligated Group and The Bank of New York Mellon Trust Company, N.A., as master trustee. The parties hereto agree as follows:

SECTION 1. Purpose of the Disclosure Agreement. This Disclosure Agreement is being executed and delivered by, the Borrower, the Obligated Group and the Dissemination Agent for the benefit of the Holders and Beneficial Owners of the Bonds and in order to assist the Underwriters in complying with the Rule. The Borrower, the Obligated Group and the Dissemination Agent acknowledge 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 Holder or Beneficial Owner of the Bonds, with respect to the Rule.

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 herein, the following capitalized terms shall have the following meanings:

"Annual Report" means any Annual Report provided by the Borrower, including schedules detailing Obligated Group information, pursuant to, and as described in, Sections 3 and 4 of this Disclosure Agreement.

"Beneficial Owner" means any person which 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).

"Disclosure Representative" means the Chief Financial Officer of the Borrower, or his or her designee, or such other person as such member shall designate in writing to the Dissemination Agent from time to time.

"Dissemination Agent" means initially, DAC, acting in its capacity as Dissemination Agent hereunder, or any successor Dissemination Agent designated in writing by the Borrower.

"EMMA" means Electronic Municipal Market Access system of the MSRB as provided at http://www.emma.msrb.org, or any similar system that is acceptable to or as may be prescribed by the MSRB for purposes of the Rule and approved by the Securities and Exchange Commission from time to time. A current list of such systems may be obtained from the Securities and Exchange Commission at http://www.sec.gov/info/municipal/nrmsir.htm.

"Listed Events" means any of the events listed in Section 5(a) of this Disclosure Agreement.

"MSRB" means the Municipal Securities Rulemaking Board.

"System" means Tower Health and its consolidated subsidiaries and affiliates.

"Underwriters" means Citigroup Global Markets Inc., as representative on behalf of itself and Barclays Capital, Inc., the underwriters for the Bonds.

"Rule" means Rule 15c2-12(b)(5) 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 Commonwealth of Pennsylvania.

SECTION 3. Provision of Annual Reports and Quarterly Reports.

(a) The Borrower shall, or shall cause the Dissemination Agent to, not later than 150 days after the end of the Borrower's fiscal year (presently June 30), commencing with the report for the 2018 Fiscal Year, provide to EMMA an Annual Report which is consistent with the requirements of Section 4 of this Disclosure Agreement. In addition, the Borrower shall, or shall cause the Dissemination Agent to, not later than 60 days after the end of each fiscal quarter, commencing with the report for the fiscal quarter ending December 31, 2017 provide to EMMA quarterly unaudited consolidated financial statements for the System ("Quarterly Reports") which are consistent with the requirements of Section 4 of this Disclosure Agreement. In each case, the Annual Report and Quarterly Reports 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. If the fiscal year of any member of the Obligated Group changes, such member of the Obligated Group, shall give notice of such change in the same manner as for a Listed Event under Section 5(g) herein.

(b) Not later than 15 Business Days prior to the date specified in subsection (a) for providing the Annual Report to the MSRB, the Borrower shall provide its Annual Report to the Dissemination Agent.

(c) If DAC is unable to verify that an Annual Report has been provided to the MSRB by the date required in subsection (a), DAC shall send a notice to the MSRB in substantially the form attached as Exhibit 1 hereto.

SECTION 4. Content of Annual Reports.

(a) Each Annual Report shall contain or include by reference the following:

(i) The audited financial statements of the Borrower on a consolidated basis with supplementary consolidating information for the members of the Obligated Group for the prior fiscal year, prepared in accordance with generally accepted accounting principles as promulgated from time to time by the Financial Accounting Standards Board.

(ii) For the prior fiscal year just ended, the financial information and operating data set forth for the System or the Obligated Group, as the case may be, under the following headings in Appendix A to the Official Statement:

- MANAGEMENT'S DISCUSSION AND ANALYSIS-Consolidated Statements of Operations; Historical Utilization of Services; Utilization Statistics; Sources of Revenue; and Total Expenses (all for the System)

- SUMMARY OF FINANCIAL INFORMATION- Trends In Liquidity (for the System);

- SUMMARY OF FINANCIAL INFORMAITON –Debt Service Coverage (for the Obligated Group)

(b) Each Quarterly Report shall contain the unaudited financial statements of the System for the applicable fiscal quarter, prepared in accordance with generally accepted accounting principles (except for the exclusion of footnotes required under generally accepted accounting principles), including all adjustments necessary to present fairly the financial position and operating results of the System for such fiscal quarter.

(c) Any or all of the items listed above may be included by specific reference to other documents, including official statements or offering documents of debt issues with respect to which the Borrower or the Obligated Group is an "obligated person" (as defined by the Rule), which have been filed with the MSRB or the Securities and Exchange Commission. If the document included by reference is a final official statement, it must be available from the MSRB. The Borrower or the Obligated Group, as applicable, shall clearly identify each such other document so included by reference.

SECTION 5. Reporting of Significant Events.

(a) In a timely manner not in excess of ten business days after the occurrence of the event, the Borrower shall file, or deliver to the Dissemination Agent for filing, with the MSRB notice of the occurrence of any of the following events with respect to the Bonds:

1. Principal and interest payment delinquencies;

2. Non-payment related defaults, if material;

3. Unscheduled draws on debt service reserves reflecting financial difficulties;

4. Unscheduled draws on credit enhancements reflecting financial difficulties;

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

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

7. Modifications to rights of the Holders of the Bonds, if material;

8. Bond calls, if material, and tender offers;

9. Defeasances;

10. Release, substitution, or sale of property securing repayment of the Bonds, if material;

11. Rating changes;

12. Bankruptcy, insolvency, receivership or similar event of the Borrower or a member of the Obligated Group;

13. The consummation of a merger, consolidation, or acquisition involving the Borrower or a member of the Obligated Group or the sale of all or substantially all of the assets of the Borrower or of a member of the Obligated Group, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

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

(b) Concurrently with the delivery to the MSRB of any information required pursuant to Section 3(a), Section 3(b), or Section 5(a) above, the Dissemination Agent shall file a certificate with the Borrower, the Obligated Group and the Authority certifying that such information has been provided to the MSRB pursuant to this Disclosure Agreement and stating the date it was provided.

(c) [Reserved].

(d) [Reserved].

(e) If the Borrower has determined that knowledge of the occurrence of a Listed Event would be material under applicable federal securities laws, the Borrower shall promptly notify the Dissemination Agent in writing. Such notice shall instruct the Dissemination Agent to report the occurrence pursuant to subsection (g).

(f) If in response to a request under subsection (c), the Borrower determines that the Listed Event would not be material under applicable federal securities laws, the Borrower, shall so notify the Dissemination Agent in writing and instruct the Dissemination Agent not to report the occurrence pursuant to subsection (g).

(g) If the Dissemination Agent has been instructed by the Borrower to report the occurrence of a Listed Event, the Dissemination Agent shall file a notice of such occurrence with the MSRB with a copy to the Obligated Group. Notwithstanding the foregoing, notice of Listed Events described in subsections (a)(4) and (5) of this Section 5 need not be given under this subsection any earlier than the notice (if any) of the underlying event is given to the Holders of affected Bonds pursuant to the Indenture.

SECTION 6. Termination of Reporting Obligation.

The obligations of the Borrower under this Disclosure Agreement shall terminate upon the legal defeasance, prior redemption or payment in full of all of the Bonds. If any member of the Obligated Group's obligations under the Note 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 a member of the Obligated Group, and such original Obligated Group member shall have no further responsibility hereunder. If the termination or substitution occurs prior to the final maturity of the Bonds, the Borrower, on behalf of the Obligated Group, shall give notice of such termination or substitution in the same manner as for a Listed Event under Section 5(g).

SECTION 7. Dissemination Agent. If at any time there is not any other designated Dissemination Agent, the Borrower shall be the Dissemination Agent. The initial Dissemination Agent shall be DAC.

SECTION 8. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Agreement, the Borrower, the Obligated Group and the Trustee 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(a), 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 Holders of the Bonds in the same manner as provided in the Indenture for amendments to the Indenture with the consent of Holders, or (ii) does not, in the opinion of nationally recognized bond counsel, materially impair the interests of the Holders or Beneficial Owners of the Bonds.

In the event of any amendment or waiver of a provision of this Disclosure Agreement, the Borrower shall describe such amendment in its 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 System or the Obligated Group, as applicable. 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(g), 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 9. Additional Information. Nothing in this Disclosure Agreement shall be deemed to prevent any member of the Obligated Group 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 any member of the Obligated Group 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, such member, as the case may be, shall have no obligation under this Agreement to update such information or include it in any future Annual Report or notice of occurrence of a Listed Event.

SECTION 10. Default. In the event of a failure of the Borrower to comply with any provision of this Disclosure Agreement, the Trustee may (and, at the request of the Underwriters or the Holders of at least 25% aggregate principal amount of Outstanding Bonds, shall), or any Holder 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 the Borrower or DAC, 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 or the Loan Agreement and the sole remedy under this Disclosure Agreement in the event of any failure of the Borrower or the Trustee to comply with this Disclosure Agreement shall be an action to compel specific performance.

SECTION 11. Duties, Immunities and Liabilities of Trustee and Dissemination Agent. The Dissemination Agent shall have no responsibility or liability for the Borrower's compliance with this Disclosure Agreement or in connection with the Borrower's obligations under this Disclosure Agreement, or for the compliance of this Disclosure Agreement or the contents of the Annual Report or Quarterly Report or notices provided hereunder with the requirements of the Rule. The Dissemination Agent shall have only those duties specifically set forth in this Disclosure Agreement and no further duties or responsibilities shall be implied. The Dissemination Agent shall not have any liability under, nor duty to inquire into the terms and

provisions of any agreement or instructions, other than as outlined in the Disclosure Agreement. The Dissemination Agent may rely and shall be protected in acting or refraining from acting upon any written notice, instruction or request furnished to it hereunder and believed by it to be genuine and to have been signed or presented by the proper party or parties. The Dissemination Agent shall be under no duty to inquire into or investigate the validity, accuracy or content of any such document. The Dissemination Agent shall not be liable for any action taken or omitted by it in good faith unless a court of competent jurisdiction determines that the Dissemination Agent's own negligence or willful misconduct was the primary cause of any loss to the Borrower. The Dissemination Agent shall not incur any liability for following the instructions herein contained or expressly provided for, or written instructions given by the parties hereto. In the administration of this Disclosure Agreement, the Dissemination Agent may execute any of its powers and perform its duties hereunder directly or through agents or attorneys and may consult with counsel, accountants and other skilled persons to be selected and retained by it. The Dissemination Agent shall not be liable for anything done, suffered or omitted in good faith by it in accordance with the advice or opinion of any such counsel, accountants or other skilled persons. The Dissemination Agent may resign and be discharged of its duties and obligations hereunder by giving notice in writing of such resignation specifying a date when such resignation shall take effect. The Borrower agrees to indemnify and save the Dissemination Agent, its officers, directors, employees and agents (the "Indemnitees") harmless against any claim, loss, expense or liability (including reasonable attorneys' fees and expenses and the allocated costs and expenses of in-house counsel and legal staff) ("Losses") that may be imposed on, incurred by, or asserted against the Indemnitees or any of them for following any instruction or other direction upon which the Dissemination Agent is authorized to rely pursuant to the terms of this Disclosure Agreement. In addition to and not in limitation of the immediately preceding sentence, the Borrower also covenants and agrees to indemnify and hold the Indemnitees and each of them harmless from and against any and all Losses that may be imposed on, incurred by, or asserted against the Indemnitees or any of them in connection with or arising out of the Dissemination Agent's performance under this Disclosure Agreement, except to the extent such Losses resulted from the Dissemination Agent's own negligence or willful misconduct. The provisions of this Section 11 shall survive the termination of this Disclosure Agreement and the resignation or removal of the Dissemination Agent for any reason. Anything in this Disclosure Agreement to the contrary notwithstanding, in no event shall the Dissemination Agent be liable for special, indirect or consequential loss or damage of any kind whatsoever (including but not limited to lost profits), even if the Dissemination Agent has been advised of such loss or damage and regardless of the form of action. Any corporation or association into which the Dissemination Agent in its individual capacity may be merged or converted or with which it may be consolidated, or any corporation or association resulting from any merger, conversion or consolidation to which the Dissemination Agent in its individual capacity shall be a party, or any corporation or association to which all or substantially all the corporate trust business of the Dissemination Agent in its individual capacity may be sold or otherwise transferred, shall be the Dissemination Agent under this Disclosure Agreement without further act.

This Section 11 shall survive termination of this Disclosure Agreement and the resignation or removal of DAC for any reason.

SECTION 12. Indemnification of Authority. The Authority shall have no responsibility or liability for the Borrower's compliance with this Disclosure Agreement or in connection with

the Borrower's obligations under this Disclosure Agreement, or for the compliance of this Disclosure Agreement or the contents of the Annual Report or Quarterly Report or notices provided hereunder with the requirements of the Rule. The Borrower agrees to indemnify and save the Authority, its members, officers, employees and agents, harmless against any claim, loss, expense (including reasonable attorneys' fees and expenses) or liability arising from or based upon (i) any breach by the Borrower of this Disclosure Agreement or (ii) any Annual Report or Quarterly Report or notices provided under this Disclosure Agreement or any omission therefrom.

SECTION 13. Transmission of Information and Notices. Unless otherwise required by law, all documents provided to the MSRB in compliance with Sections 3 and 4 hereof shall be provided to the MSRB in an electronic format and shall be accompanied by identifying information, in each case as prescribed by the MSRB. As of the date of this Disclosure Agreement, the MSRB has established EMMA as its continuing disclosure service for purposes of the Rule, and unless and until otherwise prescribed by the MSRB, all documents provided to the MSRB in compliance with Sections 3 and 4 hereof shall be submitted through EMMA in the format prescribed by the MSRB. The filings required to be made pursuant to Sections 3 and 4 hereof shall be made by, or at the direction of, the Borrower, or such members of the financial staff as may be designated by its Chief Financial Officer.

SECTION 14. Notices. Any notices or communications to or among any of the parties to this Disclosure Agreement may be given as follows:

To the Obligated Group:

Tower Health
Sixth Avenue and Spruce Streets
West Reading, Pennsylvania 19611
Attention: Senior Vice President Finance, CFO and Treasurer
Telephone: (610) 988-8181
Fax: (610) 988-5193

To the Borrower:

Tower Health
Sixth Avenue and Spruce Streets
West Reading, Pennsylvania 19611
Attention: Senior Vice President Finance, CFO and Treasurer
Telephone: 610) 988-8181
Fax: (610) 988-5193

To the Dissemination Agent:

Digital Assurance Certification, L.L.C.
315 East Robinson Street, Suite 300
Orlando, Florida 32801
Attention: Client Service Manager
Telephone: (407) 515-1100
Fax: (407) 515-6513

Any person may, by written notice to the other persons listed above, designate a different address or telephone number(s) to which subsequent notices or communications should be sent.

SECTION 15. Beneficiaries. This Disclosure Agreement shall inure solely to the benefit of the Authority, the Borrower, the Obligated Group, the Dissemination Agent, the Underwriters, and Holders and Beneficial Owners from time to time of the Bonds, and shall create no rights in any other person or entity.

SECTION 16. Severability. In case any one or more of the provisions of this Agreement shall for any reason be held to be illegal or invalid, such illegality or invalidity shall not affect any other provision of this Agreement, but this Agreement shall be construed and enforced as if such illegal or invalid provision had not been contained herein.

SECTION 17. Governing Law. This Disclosure Agreement shall be governed by and construed in accordance with the laws of the State.

SECTION 18. Counterparts. This Disclosure Agreement may be executed in several counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Continuing Disclosure Agreement to be executed and delivered as of the date first indicated above.

TOWER HEALTH, as a member of and on behalf of the Obligated Group

By: _____
Title:

DIGITAL ASSURANCE CERTIFICATION, L.L.C.

By: _____
Name:
Title:

EXHIBIT 1

NOTICE TO MSRB OF
FAILURE TO FILE ANNUAL REPORT

Name of Issuer:	Berks County Industrial Development Authority
Name of Bond Issue:	Berks County Industrial Development Authority Health System Revenue Bonds (Tower Health Project), Series of 2017
Name of Borrower:	Tower Health
Date of Issuance:	October 31, 2017

NOTICE IS HEREBY GIVEN that the Borrower has not provided an Annual Report with respect to the above-named Bonds as required by Section 3(a) of the Continuing Disclosure Agreement dated as of October 1, 2017 between the Borrower and Digital Assurance Certification, L.L.C. The Borrower anticipates that the Annual Report will be filed by _____.

Dated _____, 20___

Digital Assurance Certification, L.L.C.,
on behalf of the Borrower

cc: the Borrower

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