NEW ISSUE - BOOK-ENTRY ONLY

Ratings: **Moody's: A3**
S&P: A-
Fitch: A-
(See **"RATINGS"** herein)

In the opinion of Bond Counsel, under existing law and assuming compliance by the Agency and the Corporation with the tax covenants described herein, interest on the Series 2016A Bonds is not includable in the gross income of the owners of the Series 2016A Bonds for purposes of federal income taxation. Interest on the Series 2016A Bonds may be included in the calculation of certain taxes, including the alternative minimum tax imposed on corporations, as described under "TAX EXEMPTION" herein. The Act provides that the Series 2016A Bonds and the income therefrom shall at all times be exempt from taxation in the State of Vermont, except for transfer and estate taxes. See the caption "TAX EXEMPTION" herein.

THE University of Vermont HEALTH NETWORK

$176,375,000
VERMONT EDUCATIONAL AND HEALTH BUILDINGS FINANCING AGENCY
Revenue Bonds
(The University of Vermont Medical Center Project)
Series 2016A

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

The $176,375,000 Vermont Educational and Health Buildings Financing Agency (the "Agency") Revenue Bonds (The University of Vermont Medical Center Project), Series 2016A Bonds (the "Series 2016A Bonds") are being issued pursuant to the Trust Agreement, dated as of February 1, 2016 (the "Trust Agreement"), between the Agency and People's United Bank, N.A., as bond trustee (the "Bond Trustee") to refund all of the Agency's Variable Rate Hospital Revenue Bonds (Fletcher Allen Health Care Project), Series 2004B and the Agency's Hospital Revenue Bonds (Fletcher Allen Health Care Project), Series 2007A and paying certain costs incidental to the issuance and sale of the Series 2016A Bonds. The Series 2016A Bonds are issuable only as fully registered bonds without coupons, and, when issued, will be registered in the name of Cede & Co., as registered owner and nominee for The Depository Trust Company ("DTC"), New York, New York. DTC will act as securities depository for the Series 2016A Bonds. Purchases of the Series 2016A Bonds will be made in book-entry form, in denominations of $5,000 or any integral multiple thereof. Purchasers will not receive certificates representing their respective interests in Series 2016A Bonds purchased. So long as Cede & Co. is the registered owner, as nominee for DTC, references herein to the registered owners of Series 2016A Bonds shall mean Cede & Co., as aforesaid, and shall not mean the Beneficial Owners (defined herein) of the Series 2016A Bonds. See "THE SERIES 2016A BONDS - Book-Entry Only System" herein.

So long as DTC or its nominee, Cede & Co., is the registered owner of the Series 2016A Bonds, payments of principal or redemption price of and interest on the Series 2016A Bonds will be made directly to DTC. Disbursement of such payments to the Direct Participants (defined herein) is the responsibility of DTC and disbursements of such payments to the Beneficial Owners is the responsibility of the Direct Participants and the Indirect Participants (defined herein), as more fully described herein. Interest will be payable on June 1, 2016 and semiannually thereafter on June 1 and December 1 of each year (each an "Interest Payment Date") to the registered owner of record as of the close of business on the fifteenth day of the month next preceding each such Interest Payment Date.

The Series 2016A Bonds are subject to redemption prior to maturity, including optional redemption and extraordinary redemption, as described herein. See "THE SERIES 2016A BONDS – Redemption" herein.

The principal of or redemption price of and interest on the Series 2016A Bonds are payable solely from payments to be made by The University of Vermont Medical Center Inc., a Vermont non-profit corporation located in Burlington, Vermont (the "Corporation"), under a Loan Agreement, dated as of February 1, 2016 (the "Loan Agreement"), between the Agency and the Corporation. The payments to be made pursuant to the Loan Agreement are general obligations of the Corporation. In addition, the obligations of the Corporation under the Loan Agreement are evidenced by an obligation ("Obligation No. 21") issued pursuant to the Amended and Restated Master Trust Indenture, dated as of March 1, 2004, as supplemented (the "Master Indenture"), by and between the Corporation (formerly known as Fletcher Allen Health Care, Inc.) and People's United Bank, N.A. (successor to Chittenden Trust Company), as master trustee. Upon issuance of the Series 2016A Bonds, the Corporation, The University of Vermont Health Network Inc. ("UVM Health Network"), and Central Vermont Medical Center, Inc. ("CVMC") will be the only Members of the Obligated Group established pursuant to the Master Indenture, and Obligation No. 21 securing the Series 2016A Bonds will constitute a joint and several obligation of the Corporation, UVM Health Network, CVMC and any future Member of the Obligated Group. Reference is made to this Official Statement for relevant security provisions of the Series 2016A Bonds.

There are certain risks associated with the purchase of the Series 2016A Bonds. See "BONDHOLDERS' RISKS" herein.

THE SERIES 2016A BONDS SHALL BE LIMITED OBLIGATIONS OF THE AGENCY PAYABLE SOLELY FROM THE REVENUES OF THE AGENCY, INCLUDING PAYMENTS TO THE BOND TRUSTEE FOR THE ACCOUNT OF THE AGENCY DERIVED FROM AND TO BE MADE BY THE CORPORATION, IN ACCORDANCE WITH THE PROVISIONS OF THE LOAN AGREEMENT AND THE TRUST AGREEMENT AND FROM CERTAIN OTHER FUNDS, ALL AS MORE FULLY DESCRIBED HEREIN. THE AGENCY HAS NO TAXING POWER. NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE STATE OF VERMONT OR OF ANY MUNICIPALITY OR POLITICAL SUBDIVISION OF THE STATE OF VERMONT IS PLEDGED TO THE PAYMENT OF THE SERIES 2016A BONDS.

This cover page and the inside cover page contain information for quick reference only. Investors must read the entire Official Statement, including all Appendices, to obtain information essential to making an informed investment decision.

The Series 2016A Bonds are offered when, as and if issued by the Agency, and delivered and received by the Underwriter, subject to prior sale, or withdrawal or modification of the offer without notice, and to the approval of their legality and certain other matters by Sidley Austin LLP, New York, New York, Bond Counsel. Certain legal matters will be passed upon for the Underwriter by its counsel, Ropes & Gray, LLP, Boston, Massachusetts; for the Corporation by its counsel, Dinse, Knapp & McAndrew, P.C.; and for the Agency by its counsel, Deppman & Foley, P.C. The Series 2016A Bonds are expected to be available for delivery through the facilities of DTC in New York, New York on or about February 3, 2016.

Citigroup

Date: January 22, 2016

$176,375,000
Vermont Educational and Health Buildings Financing Agency
Revenue Bonds
(The University of Vermont Medical Center Project)
Series 2016A

Maturities, Principal Amounts, Interest Rates, Yields and CUSIP Numbers

Maturity Date (December 1)	Principal Amount	Interest Rate	Yield	CUSIP†
2016	$3,390,000	3.0%	0.60%	924166HK0
2017	3,395,000	3.0	0.92	924166HL8
2018	3,800,000	3.0	1.16	924166HM6
2019	3,270,000	4.0	1.37	924166HN4
2020	4,025,000	4.0	1.55	924166HP9
2021	3,735,000	5.0	1.76	924166HQ7
2022	4,060,000	5.0	1.96	924166HR5
2023	100,000	5.0	2.13	924166HS3
2024	4,055,000	5.0	2.28	924166HB0
2025	4,535,000	5.0	2.40	924166HC8
2026	4,135,000	5.0	2.55*	924166HD6
2027	4,775,000	5.0	2.64*	924166HE4
2028	4,365,000	5.0	2.73*	924166HF1
2029	4,750,000	3.0	3.17	924166HG9
2030	4,555,000	5.0	2.85*	924166HH7
2031	18,235,000	5.0	2.94*	924166HT1
2032	19,085,000	5.0	3.00*	924166HU8
2033	19,645,000	5.0	3.05*	924166HV6
2034	17,785,000	5.0	3.10*	924166HW4
2035	21,770,000	5.0	3.15*	924166HX2
2036	17,910,000	5.0	3.17*	924166HJ3
2036	5,000,000	3.5	3.64	924166HY0

* Priced at the stated yield to the June 1, 2026 optional redemption date at a redemption price equal to the principal amount thereof.

† CUSIP is a registered trademark of the American Bankers Association. CUSIP data herein is provided by CUSIP Global Services, managed by Standard & Poor's Financial Services LLC on behalf of The American Bankers Association. The CUSIP number is included solely for the convenience of Bondholders and neither the Agency nor the Corporation is responsible for the selection or the correctness of the CUSIP number printed herein. CUSIP numbers assigned to securities may be changed during the term of such securities based on a number of factors, including, but not limited to, the refunding or defeasance of such securities or the use of secondary market financial products.

IN CONNECTION WITH THE OFFERING OF THE SERIES 2016A BONDS, THE UNDERWRITER MAY OVER-ALLOT OR EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICES OF THE SERIES 2016 BONDS AT LEVELS ABOVE THOSE WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZATION, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME WITHOUT PRIOR NOTICE.

No dealer, broker, salesman or other person has been authorized by the Agency or the Corporation to give any information or to make representations with respect to the Series 2016A Bonds, other than those contained in the 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, nor shall there be any sale of the Series 2016A Bonds by any person in any jurisdiction in which it is unlawful for such person to make such offer, solicitation or sale.

Certain information as contained herein has been obtained from the Corporation and other sources, including DTC, which are believed to be reliable, but information obtained from sources other than the Agency is not guaranteed as to accuracy or completeness by, and is not to be construed as a representation of, the Agency. The information herein under the heading "THE AGENCY" has been supplied by the Agency. The information and expressions of opinion herein are subject to change without notice and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the parties referred to above since the date hereof.

The Underwriter has provided the following sentence for inclusion in this Official Statement. The Underwriter has reviewed the information in this Official Statement in accordance with, and as part of, its responsibility to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information.

THE SERIES 2016A BONDS HAVE NOT BEEN REGISTERED WITH THE SECURITIES AND EXCHANGE COMMISSION UNDER THE SECURITIES ACT OF 1933, AS AMENDED, NOR HAS THE TRUST AGREEMENT OR MASTER INDENTURE BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE REGISTRATION OR QUALIFICATION OF THE SERIES 2016A BONDS IN ACCORDANCE WITH APPLICABLE PROVISIONS OF THE SECURITIES LAWS OF THE STATES, IF ANY, IN WHICH THE SERIES 2016A BONDS HAVE BEEN REGISTERED OR QUALIFIED AND THE EXEMPTION FROM REGISTRATION OR QUALIFICATION IN CERTAIN OTHER STATES CANNOT BE REGARDED AS A RECOMMENDATION THEREOF. NEITHER THESE STATES NOR ANY OF THEIR AGENCIES HAVE PASSED UPON THE MERITS OF THE SERIES 2016A BONDS OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY MAY BE A CRIMINAL OFFENSE.

This Official Statement contains a general description of the Series 2016A Bonds, the Agency, the Corporation and the plan of finance and sets forth summaries of certain provisions of the Act (as defined herein), the Trust Agreement, the Loan Agreement, the Master Indenture and Obligation No. 21. The descriptions and summaries herein do not purport to be complete and are not to be construed to be a representation of the Agency or the Underwriter. Persons interested in purchasing the Series 2016A Bonds should carefully review this Official Statement (including the Appendices attached hereto) as well as copies of the documents referred to herein in their entirety, which documents are held by the Bond Trustee at its principal corporate trust office in Burlington, Vermont.

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

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OFFICIAL STATEMENT
Relating to
$176,375,000
Vermont Educational and Health Buildings Financing Agency
Revenue Bonds
(The University of Vermont Medical Center Project)
Series 2016A

INTRODUCTION

This Official Statement, including the cover page, the inside cover page and Appendices, sets forth certain information concerning the offering by Vermont Educational and Health Buildings Financing Agency (the "Agency") of its Revenue Bonds (The University of Vermont Medical Center Project), Series 2016A, in the aggregate principal amount of $176,375,000 (the "Series 2016A Bonds"). Certain capitalized terms used in this Official Statement and not otherwise defined herein shall have the meanings given to such terms under the heading "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL LEGAL DOCUMENTS" in Appendix C hereto. This Introduction is not a summary of this Official Statement. It is only a brief description of and guide to the entire Official Statement of which a full review should be made by potential investors.

The Agency

The Agency is a body corporate and politic constituting a public instrumentality of the State of Vermont (the "State") organized and existing under and by virtue of the Vermont Educational and Health Buildings Financing Agency Act, being Chapter 131, Sections 3851 to 3862, inclusive, of Title 16, Vermont Statutes Annotated, as amended (the "Act"). For a further discussion of the Agency, see "THE AGENCY" herein.

The Series 2016A Bonds

The Series 2016A Bonds are being issued under the Trust Agreement, dated as of February 1, 2016 (the "Trust Agreement"), between the Agency and People's United Bank, N.A., as bond trustee (the "Bond Trustee"). The Series 2016A Bonds are also being issued in accordance with the provisions of the Act.

The Series 2016A Bonds will be dated their date of delivery, and will bear interest from such date, payable on June 1, 2016 and semiannually on each June 1 and December 1 thereafter. The Series 2016A Bonds will bear interest at the rates and mature on the dates and in the amounts set forth on the inside cover page hereof. The Series 2016A Bonds are subject to redemption prior to maturity. For a further description of the Series 2016A Bonds, see "THE SERIES 2016A BONDS" herein.

The Series 2016A Bonds are issuable as fully registered bonds in denominations of $5,000 or any integral multiple thereof, and, when issued, will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York ("DTC"), which will act as securities depository for the Series 2016A Bonds. See "THE SERIES 2016A BONDS – Book-Entry Only System" herein.

Use of Proceeds

The proceeds of the Series 2016A Bonds will be applied by the Agency to make a loan (the "Loan") to The University of Vermont Medical Center Inc. (formerly known as Fletcher Allen Health Care, Inc., the "Corporation") pursuant to a Loan Agreement, dated as of February 1, 2016 (the "Loan Agreement"), by and between the Agency and the Corporation. In accordance with the Loan Agreement, the Loan will be used by the Corporation to (i) refund all of the Agency's outstanding Variable Rate

Hospital Revenue Bonds (Fletcher Allen Health Care Project), Series 2004B (converted in 2008 to bear interest at a fixed rate) (the "Series 2004B Bonds") and the Agency's Hospital Revenue Bonds (Fletcher Allen Health Care Project), Series 2007A (the "Series 2007A Bonds" and, together with the Series 2004B Bonds, the "Refunded Bonds") and (ii) pay certain costs incidental to the issuance and sale of the Series 2016A Bonds. See "PLAN OF REFUNDING" and "ESTIMATED SOURCES AND USES OF FUNDS" herein.

Security for the Series 2016A Bonds

Master Indenture and Security Therefor

The Series 2016A Bonds are limited obligations of the Agency, payable solely from money to be paid by the Corporation pursuant to the terms of the Loan Agreement and money to be paid by the Obligated Group pursuant to Obligation No. 21 ("Obligation No. 21") issued to the Agency under an Amended and Restated Master Trust Indenture, dated as of March 1, 2004 (the "Master Trust Indenture"), between the Corporation and People's United Bank, N.A., successor to Chittenden Trust Company as master trustee (the "Master Trustee") and Supplemental Indenture for Obligation No. 21, dated as of February 1, 2016 ("Supplement No. 21"). See "SUMMARY OF THE MASTER INDENTURE" in Appendix C attached hereto. The Master Trust Indenture, as supplemented in accordance with the provisions thereof, is referred to in this Official Statement as the "Master Indenture."

Payments on Obligation No. 21 will be required to be sufficient to pay the principal of and interest and any premium on the Series 2016A Bonds, as due and payable. To secure the payment of the Series 2016A Bonds, the Agency will assign to the Bond Trustee all of its interest in Obligation No. 21 and, with certain exceptions, the Loan Agreement. Obligation No. 21 will be a joint and several obligation of the Corporation, UVM Health Network, and Central Vermont Medical Center, Inc. ("CVMC"), currently the only Members of the Obligated Group, and any future Members of the Obligated Group under the Master Indenture, and will be secured by a security interest in the Pledged Assets (as defined herein) of each Member of the Obligated Group and the Mortgage (as defined herein) each granted to the Master Trustee. The Master Indenture permits any Person to become a Member of the Obligated Group upon compliance with certain financial tests and other conditions. The Master Indenture also permits, upon compliance with the terms thereof, any Member to withdraw from the Obligated Group. The Corporation has covenanted in Supplement No. 21 not to withdraw from the Obligated Group so long as any Series 2016A Bonds are Outstanding unless it has the prior written consent of the Agency to do so. Appendix A contains a description of the Corporation.

There are currently twelve outstanding Obligations in the aggregate amount of $420,924,090.

Obligation No. 21 will be secured pari passu with the foregoing Obligations (the "Prior Obligations"), under the Master Indenture and any other Obligations (as defined herein) issued under the Master Indenture from time to time.

The Corporation, UVM Health Network, CVMC and all future Members of the Obligated Group have agreed in the Master Indenture that they will not create or suffer to be created or exist any Lien other than Permitted Liens upon their Pledged Assets or on other Property now owned or hereafter acquired. The Lien created by the Mortgage is a Permitted Lien. In addition, the Corporation and all other current and any future Members of the Obligated Group are subject to covenants under the Master Indenture containing restrictions or limitations with respect to indebtedness, consolidation or merger, and transfer of assets, among others.

The assets pledged under the Master Indenture to secure the Prior Obligations and Obligation No. 21 and any additional Obligations that may be issued on a parity with such Obligations (collectively, the "Obligations") consist of all Gross Receipts (as defined herein) of the Members of the Obligated Group,

now owned or hereafter acquired, and all proceeds thereof (the "Pledged Assets"). See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2016A BONDS" herein.

The Corporation has also granted to the Master Trustee, as security for all Obligations issued under the Master Indenture, a mortgage on certain property located on the Medical Center Campus at 111 Colchester Avenue, Burlington, Vermont (the "Mortgaged Property"). The Corporation and the Master Trustee entered into the Mortgage Deed on December 17, 2003 (the "Mortgage"). See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2016A BONDS – The Mortgage" herein.

For more detailed descriptions of the obligations of the Corporation and the other Members of the Obligated Group under the Master Indenture and Obligation No. 21, including a description of the rate covenant, conditions under which additional Obligations may be issued and other Indebtedness may be incurred, conditions under which other organizations may join or withdraw from the Obligated Group and conditions under which Members of the Obligated Group may acquire or dispose of property and merge with or acquire other organizations, see Appendix C hereto.

The Master Indenture contains provisions pursuant to which, under certain conditions, Holders of Obligations would be required to surrender such Obligations in exchange for a new note or obligation from a new obligated group issued under a different master indenture. See "SUBSTITUTION OF MASTER INDENTURE" herein and "SUMMARY OF THE MASTER INDENTURE – Replacement Master Indenture" in Appendix C hereto.

Brief descriptions and summaries of the Series 2016A Bonds, the Master Indenture, the Loan Agreement and the Trust Agreement are included in Appendix C to this Official Statement. Those descriptions and summaries do not purport to be comprehensive or definitive, and all references in this Official Statement to the Master Indenture, the Loan Agreement and the Trust Agreement are qualified by reference to those documents in their entirety, and all references to the Series 2016A Bonds are qualified by reference to the definitive form of the Series 2016A Bonds contained in the Trust Agreement.

Bondholders' Risks

Certain risks associated with the purchase of the Series 2016A Bonds are set forth in the section entitled "BONDHOLDERS' RISKS" herein. Careful evaluation should be made of the risks set forth in such section and elsewhere in this Official Statement concerning the factors which may affect the payment of the principal or redemption price of and interest on the Series 2016A Bonds when due.

Limited Obligations of the Agency

The Series 2016A Bonds are limited obligations of the Agency. The Agency is not obligated to pay the principal of, or the premium, if any, or the interest on, the Series 2016A Bonds except from revenues and receipts derived in respect of Obligation No. 21 as described above, the Loan Agreement and amounts held by the Trustee under the Trust Agreement and, under certain circumstances, proceeds of insurance, sale and condemnation awards and proceeds derived from the exercise of remedies. The Agency has no taxing power. The Series 2016A Bonds do not constitute or create any debt, liability or obligation of the State or any political subdivision or instrumentality thereof (other than the Agency) or a pledge of the faith and credit of the State or any political subdivision or agency of the State, and neither the faith and credit nor the taxing power of the State or any political subdivision or any agency thereof is pledged as security for the payment of the principal of, or premium, if any, or the interest on the Series 2016A Bonds.

Miscellaneous

Copies of the Trust Agreement, the Loan Agreement, the Master Indenture and Obligation No. 21 are available for inspection at the principal corporate trust office of the Bond Trustee. All inquiries should

be directed in writing to the Bond Trustee at People's United Bank, N.A., Corporate Trust, Two Burlington Square, Burlington, Vermont 05401 Attention: Corporate Trust Department.

THE AGENCY

The Agency was created as a body corporate and politic constituting a public instrumentality of the State of Vermont for the purpose of exercising the powers conferred on it by virtue of the Act. The purpose of the Agency is essentially to assist certain health care and educational institutions in the acquisition, construction, financing and refinancing of their related projects.

Agency Membership and Organization

Under the Act, the Board of the Agency consists of the Commissioner of Education of the State, the State Treasurer, the Secretary of the Agency of Human Services, and the Secretary of Administration of the State, all *ex officio*, seven members appointed by the Governor of the State, with the advice and consent of the Senate, for terms of six years, and two members appointed by the members appointed by the Governor for terms of two years. The members of the Board annually elect a Chair, a Vice Chair, a Treasurer and a Secretary. The day-to-day administration of the Agency is handled by the Executive Director of the Agency.

The present officers and members of the Agency and their places of business or residences are set forth below (there is currently one vacancy):

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Officers

James B. Potvin, Chairman
Certified Public Accountant
Stevens, Wilcox, Baker, Potvin, Cassidy & Jakubowski
Rutland, Vermont

[Vacancy], Vice Chair

Edward Ogorzalek, Treasurer
Chief Financial Officer
Rutland Regional Medical Center
Rutland, Vermont

Neil E. Robinson, Secretary
Vice President for Finance
St. Michael's College
Colchester, Vermont

Ex-Officio Members

Elizabeth Pearce
State Treasurer
Montpelier, Vermont

Justin Johnson
Secretary of Administration
Montpelier, Vermont

Rebecca Holcombe
Secretary of Education
Montpelier, Vermont

Hal Cohen
Secretary of the Agency of Human Services
Williston, Vermont

Appointed and Elected Members

Kenneth Linsley
President
Green Mountain Transformer Consultants, LLC
Colchester, Vermont

Kenneth Gibbons
Business and Financial Consultant
Morrisville, Vermont

Anita Bourgeois
Vice President
Merchants Bank
South Burlington, Vermont

Frederick Burkhardt
Assistant Professor
Champlain College
Burlington, Vermont

Stuart W. Weppler
Business and Financial Consultant
Morrisville, Vermont

Executive Director

Robert Giroux
Executive Director
Vermont Educational and Health
Buildings Financing Agency
20 Winooski Falls Way
Winooski, Vermont

Deppman & Foley, P.C., Middlebury, Vermont, is general counsel to the Agency.

Sidley Austin LLP, New York, New York, is Bond Counsel to the Agency and will submit its approving opinion with regard to the legality of the Series 2016A Bonds in substantially the form attached hereto as Appendix D.

Public Financial Management, Inc., Boston, Massachusetts, is the financial advisor to the Agency.

Financing Programs of the Agency

The Agency was duly created under the Act as a body corporate and politic constituting a public instrumentality of the State of Vermont. The Act empowers the Agency, among other things, to finance or assist in the financing of eligible institutions, through financing agreements, which may include loan agreements, lease agreements, conditional sales agreements, purchase money mortgages, installment sale contracts, and other types of contracts to acquire property, both real and personal, including leasehold and other interests in land, necessary or convenient for its corporate purposes; to acquire or make loans with respect to facilities, including buildings, improvements to real property, equipment, furnishings appurtenances, utilities and other property, determined by the Agency to be necessary or convenient in the operation of any eligible institution; to lease or to make loans with respect to such facilities to any such eligible institution; and to issue refunding bonds of the Agency whether the bonds to be refunded have or have not matured.

The Agency has heretofore authorized and issued numerous series of its bonds and notes, including bonds issued for the benefit of the Corporation and CVMC. All outstanding Agency bond and note issues have been authorized and issued pursuant to financing documents separate from and unrelated to the Loan Agreement and the Trust Agreement for the Series 2016A Bonds and are payable from certain revenues other than those pledged for payment of the Series 2016A Bonds. Inasmuch as each such series of bonds and notes of the Agency is secured separately from all other bonds and notes issued thereby, the moneys on deposit in the respective funds (including cash and securities in the respective reserve accounts) established to provide for the timely payment of the debt service requirements on the various issues of outstanding bonds and notes of the Agency cannot be commingled or be used for any purpose other than servicing the requirements of the specific series of bonds or notes in connection with which such funds were created. Prior Agency bonds issued for the benefit of the Corporation and CVMC are, however, effectively secured on a parity basis with the Series 2016A Bonds as such bonds are also additionally secured by obligations issued under the Master Indenture. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2016A BONDS – Master Indenture and Security Therefor" and " – the Mortgage" below.

The Agency under the Act may issue from time to time other bonds and notes under separate resolutions to assist certain health care and educational institutions in the acquisition, construction, financing and refinancing of their related projects payable from revenues derived by the Agency from such institutions.

Other than with respect to the description of the Agency provided herein, and the information with respect to the Agency under "LITIGATION" herein, the Agency has not prepared or reviewed, and expresses no opinion with respect to the accuracy or completeness of, any of the information set forth in this Official Statement.

No recourse shall be had for any claim based on the Series 2016A Bonds, the Loan Agreement or the Trust Agreement against any past, present or future member, officer, employee or agent, as such, of the Agency or of any predecessor or successor corporation, either directly or through the Agency or otherwise, whether by virtue of any constitution, statute or rule of law, or by the enforcement of any assessment or penalty or otherwise.

THE MEMBERS OF THE OBLIGATED GROUP

Currently, the Corporation, UVM Health Network and CVMC are the only Members of the Obligated Group. For a discussion of the Corporation, UVM Health Network and CVMC, see Appendix A to this Official Statement.

PLAN OF REFUNDING

The proceeds of the sale of Series 2016A Bonds will be used to (i) refund the Refunded Bonds and (ii) pay all of the expenses incurred in connection with the issuance of the Series 2016A Bonds. Set forth below are the Refunded Bonds:

Series 2004B Bonds

Maturity (December 1)	Principal Amount	Redemption Date	Redemption Price
2016	$2,950,000	Maturity	-
2017	3,450,000	Maturity	-
2018	3,675,000	Maturity	-
2019	3,175,000	June 1, 2018	100%
2022	11,675,000	June 1, 2018	100
2028	21,975,000	June 1, 2018	100
2034	90,800,000	June 1, 2018	100

Series 2007A Bonds

Maturity (December 1)	Principal Amount	Redemption Date	Redemption Price
2016	$475,000	Maturity	N/A
2018	240,000	December 1, 2016	100%
2019	235,000	December 1, 2016	100
2020	245,000	December 1, 2016	100
2021	455,000	December 1, 2016	100
2036	53,615,000	December 1, 2016	100

On the date of the issue of the Series 2016A Bonds, a portion of the proceeds of the Series 2016A Bonds will be deposited into one or more escrow funds established by an escrow deposit agreement, dated as of the date of delivery of the Series 2016A Bonds among the Agency, the Corporation, and the trustee for the Refunded Bonds (the "Escrow Deposit Agreement"), for the purpose of redeeming the Refunded Bonds on December 1, 2016 (in the case of the Series 2007A Bonds) and on June 1, 2018 (in the case of the Series 2004B Bonds), in each case, at a redemption price equal to the principal amount thereof and interest accrued thereon to the applicable redemption date. Moneys in the escrow funds will be applied to the purchase of certain direct United States Government obligations (the "Defeasance Obligations") or held in cash, as described in the Escrow Deposit Agreement. According to the report described under the heading "VERIFICATION OF MATHEMATICAL CALCULATIONS," the Defeasance Obligations will mature at such times and earn interest in such amounts that, together with any initial cash deposit, will produce sufficient moneys to provide for the payment of principal of and redemption premium, if any, and interest on the Refunded Bonds. Upon the deposit of the proceeds of the Series 2016A Bonds to the escrow fund or funds, the Refunded Bonds will be defeased in accordance with their terms and will no longer be outstanding.

None of the monies in any escrow funds for the Refunded Bonds will serve as security for or be available to pay principal of or interest on the Series 2016A Bonds.

ESTIMATED SOURCES AND USES OF FUNDS

The proceeds of the Series 2016A Bonds are expected to be used as follows:

Sources of Funds		
	Par Amount	$176,375,000
	Net Original Issue Discount/Premium	27,456,137
	Other Available Funds	7,192,199
	Total	$211,023,336
Uses of Funds		
	Deposit to Series 2004B Bonds Refunding Escrow Fund	$151,489,161
	Deposit to Series 2007A Bonds Refunding Escrow Fund	57,619,127
	Deposit to Expense Fund for Costs of Issuance[1]	1,915,049
	Total	$211,023,336[2]

[1] Costs of issuance include underwriting discount, legal fees, the Bond Trustee's fee, the Agency's fee, rating agency fees, printing expenses, and other miscellaneous costs and expenses related to the issuance and sale of the Series 2016A Bonds.

[2] Total may not sum due to rounding.

ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth, for each fiscal year ending September 30, the amounts required each year to pay debt service on indebtedness issued by or for the benefit of the Obligated Group coming due in such year, including the Series 2016A Bonds. The principal amounts with respect to the Series 2016A Bonds will be payable on December 1 and interest on the Series 2016A Bonds will be payable on December 1 and June 1.

For the purposes of the following debt service table, the interest rate for hedged variable rate debt has been calculated using the fixed rate plus any other fixed amounts payable by the Obligated Group under the allocable hedges, as permitted by the Master Indenture. Specifically, the Obligated Group is party to an interest rate swap with a notional amount as of September 30, 2015 of $55,190,000 that is being used to hedge the interest rate exposure with respect to the Agency's Variable Rate Hospital Revenue Refunding Bonds (Fletcher Allen Health Care Project), Series 2008A Bonds (the "Series 2008A Bonds").

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Year Ending September 30,	Principal on the Series 2016A Bonds	Interest on the Series 2016A Bonds*	Total Debt Service on Other Long-Term Indebtedness*	Total Debt Service on All Long-Term Indebtedness*
2016	$ -	$ 5,529,599	$ 23,262,764	$ 28,792,364
2017	3,390,000	8,279,350	16,641,284	28,310,634
2018	3,395,000	8,177,525	16,138,320	27,710,845
2019	3,800,000	8,065,550	15,956,843	27,822,393
2020	3,270,000	7,937,550	15,996,718	27,204,268
2021	4,025,000	7,781,583	15,919,277	27,725,860
2022	3,735,000	7,599,125	15,272,551	26,606,676
2023	4,060,000	7,398,833	15,802,627	27,261,461
2024	100,000	7,360,833	14,753,708	22,214,542
2025	4,055,000	7,191,042	5,510,471	16,756,512
2026	4,535,000	6,968,292	5,510,700	17,013,992
2027	4,135,000	6,758,208	5,510,953	16,404,162
2028	4,775,000	6,524,792	14,111,201	25,410,992
2029	4,365,000	6,303,125	18,985,989	29,654,114
2030	4,750,000	6,148,000	19,135,318	30,033,318
2031	4,555,000	5,934,458	19,268,362	29,757,820
2032	18,235,000	5,136,708	2,589,746	25,961,454
2033	19,085,000	4,189,542	2,589,746	25,864,288
2034	19,645,000	3,211,958	2,589,746	25,446,704
2035	17,785,000	2,307,208	2,589,746	22,681,954
2036	21,770,000	1,251,917	2,589,746	25,611,663
2037	22,910,000	178,417	2,589,745	25,678,162
2038	-	-	-	-
2039	-	-	-	-
2040	-	-	-	-
2041	-	-	-	-
2042	-	-	-	-
2043	-	-	-	-
2044	-	-	-	-
2045	-	-	-	-
Total	$ 176,375,000	$ 130,233,616	$ 253,315,563	$ 559,924,179

* Amounts shown are calculated in accordance with the Master Indenture. Total Debt Service on Other Long Term Indebtedness encompasses all existing outstanding bonds of the Obligated Group, as well as other long-term obligations of the Obligated Group. This information excludes the debt service of the Refunded Bonds. Debt service for the Series 2008A Bonds was calculated at the synthetic fixed swap rate of 3.76%. Debt service for a commercial mortgage loan was calculated at the synthetic fixed swap rate of 2.67%.

THE SERIES 2016A BONDS

Description of the Series 2016A Bonds

The Series 2016A Bonds are being issued by the Agency under the Act and pursuant to the Trust Agreement, will be dated their date of delivery and will bear interest from such date of delivery, payable on June 1, 2016 and semiannually thereafter on December 1 and June 1 in each year (each an "Interest Payment Date"). The Series 2016A Bonds will bear interest at the rates per annum and mature on the dates and in the amounts set forth on the inside cover page hereof. The Series 2016A Bonds will be subject to the redemption provisions set forth below.

The Series 2016A Bonds are issuable as fully registered bonds in the denomination of $5,000 or any integral multiple thereof and, when issued, will be registered in the name of Cede & Co., as nominee for DTC. DTC will act as a securities depository for the Series 2016A Bonds. Purchases of the Series 2016A Bonds will be made in book-entry form. See "THE SERIES 2016A BONDS – Book-Entry Only System" herein.

As long as DTC or its nominee, Cede & Co., is the registered owner of the Series 2016A Bonds, payments of principal of and redemption premium, if any, and interest on the Series 2016A Bonds will be made directly to Cede & Co. Interest on the Series 2016A Bonds which is payable and is punctually paid or duly provided for on any Interest Payment Date will be paid to each person who is a registered owner as of the 15th day (whether or not a Business Day) of the calendar month next preceding each Interest Payment Date.

Redemption

Optional Redemption. The Series 2016A Bonds maturing on or after December 1, 2026 are subject to redemption by the Agency prior to maturity, at the direction of the Hospital Representative, on or after June 1, 2026 in whole or in part on any date at par plus accrued interest to the redemption date.

Extraordinary Redemption. The Series 2016A Bonds are also subject to redemption prior to maturity in whole or in part on any date by the Agency, at the direction of the Hospital Representative, upon the occurrence of certain events set forth below. Any such redemption shall be made at a redemption price equal to 100% of the principal amount of the Series 2016A Bonds to be redeemed, plus accrued interest to the redemption date.

The Corporation shall have the option to prepay the unpaid aggregate amount of the Loan in whole at such price or in part at such price on any date upon the occurrence of any damage to or destruction of all or any part of the Property and Equipment by fire or casualty, or loss of title to or use of all or any part of the Property and Equipment as a result of the failure of title or as a result of Eminent Domain proceedings or proceedings in lieu thereof if such damage, destruction, loss of title or loss of use cause such Property and Equipment to be impracticable to operate; provided, however, that any redemption in part shall be in the aggregate principal amount of not less than $100,000.

General Redemption Provisions

The Series 2016A Bonds may be redeemed only in whole multiples of $5,000. The Bond Trustee will select the Series 2016A Bonds to be redeemed in accordance with the terms and provisions of the Trust Agreement.

If less than all of the Series 2016A Bonds of any maturity are to be called for redemption, the Bond Trustee is to select, in such manner as the Bond Trustee in its discretion may determine, the Series 2016A Bonds to be redeemed within each maturity, each $5,000 portion of principal being counted as one Series 2016A Bond for this purpose; provided that for so long as the only Holder is a Securities

Depository Nominee, such selection will be made by the Securities Depository. If less than the principal amount of a Series 2016A Bond is called for redemption, the Agency is to execute and the Bond Trustee is to authenticate and deliver, upon surrender of such Series 2016A Bond, without charge to the Holder thereof in exchange for the unredeemed principal amount of such Series 2016A Bond at the option of such Holder, Series 2016A Bonds in any of the Authorized Denominations and of the same maturity and interest rate or, if the Series 2016A Bonds are held in the Book-Entry System, the Securities Depository shall, acting pursuant to its rules and procedures, reflect in the Book-Entry System the partial redemption and the Bond Trustee shall either (i) exchange the Series 2016A Bond or Series 2016A Bonds held by the Securities Depository for a new Series 2016A Bond or Series 2016A Bonds of the same maturity and interest rate in the appropriate principal amount, if such Bond is presented to the Bond Trustee by the Securities Depository, or (ii) obtain from the Securities Depository a written confirmation of the reduction in the principal amount of the Series 2016A Bonds held by such Securities Depository.

Notice of Redemption

So long as DTC or its nominee is the registered owner of the Series 2016A Bonds, the Bond Trustee, the Agency and People's United Bank, N.A., as the Bond Registrar (the "Bond Registrar") will recognize DTC or its nominee as the registered owner of the Series 2016A Bonds for all purposes, including notices and voting. 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 and regulatory requirements as may be in effect from time to time.

The Bond Trustee shall give notice of redemption to the Holders of the Series 2016A Bonds to be redeemed by mail, first-class postage prepaid, not less than 30 days nor more than 60 days prior to the date fixed for redemption. In the case of an optional or extraordinary redemption of the Series 2016A Bonds, the redemption notice may state that (a) it is conditioned upon the deposit of moneys, or Defeasance Obligations (as defined in the Trust Agreement), or a combination of both, in an amount equal to the amount necessary to effect the redemption, with the Bond Trustee no later than the scheduled redemption date or (b) the Corporation retains the right to rescind such notice on or prior to the scheduled redemption date (in either case, a "Conditional Redemption"), and such notice and optional redemption will be of no effect if such moneys are not so deposited or if the notice is rescinded. In the case of a Conditional Redemption subject to the deposit of moneys or Defeasance Obligations, the failure of the Corporation or any other Person to make such moneys or Defeasance Obligations available in part or in whole on or before the scheduled redemption date will not constitute an Event of Default under the Trust Agreement and any Series 2016A Bonds subject to such Conditional Redemption will remain Outstanding. Any Conditional Redemption subject to rescission may be rescinded in whole or in part at any time on or prior to the scheduled redemption date if a Hospital Representative instructs the Bond Trustee in writing to rescind the redemption notice. Any Series 2016A Bonds subject to Conditional Redemption where redemption has been rescinded will remain Outstanding, and the rescission will not constitute an Event of Default under the Trust Agreement.

So long as DTC or its nominee is the registered owner of the Series 2016A Bonds, any failure on the part of DTC or failure on the part of a nominee of a Beneficial Owner (having received notice from a DTC Participant or otherwise) to notify the Beneficial Owner so affected, will not affect the validity of the redemption of such Series 2016A Bonds.

Payment of Redeemed Bonds

Notice having been given in the manner provided above, Series 2016A Bonds or portions thereof so called for redemption shall become due and payable on the redemption date so designated at the redemption price, plus interest accrued and unpaid to the redemption date. If moneys or Defeasance Obligations, or a combination of both, sufficient to pay the redemption price of the Series 2016A Bonds

to be redeemed, plus accrued interest thereon to the date fixed for redemption, are held by the Bond Trustee in trust for the Holders of Series 2016A Bonds to be redeemed, interest on the Series 2016A Bonds called for redemption will cease to accrue, such Series 2016A Bonds will cease to be entitled to any benefit or security under the Trust Agreement or to be deemed Outstanding and the Holders of such Series 2016A Bonds shall have no rights in respect thereof except to receive payment of the redemption price thereof, plus accrued interest to the date fixed for redemption.

Book-Entry Only System

The information in this section has been provided by DTC and is not deemed to be a representation of the Agency, the Underwriter, the Bond Trustee or any Member of the Obligated Group.

The Depository Trust Company ("DTC"), New York, NY, will act as securities depository for the Series 2016A Bonds. The Series 2016A Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond certificate will be issued for each issue of the Series 2016A Bonds, each in the aggregate principal amount of such issue, 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"). The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission.

Purchases of the Series 2016A Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Series 2016A Bonds on DTC's records. The ownership interest of each actual purchaser of each Series 2016A Bond ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Series 2016A 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 Series 2016A Bonds, except in the event that use of the book-entry system for the Series 2016A Bonds is discontinued. See "— Discontinuance of DTC Services."

To facilitate subsequent transfers, all Series 2016A 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 the Series 2016A 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 Series 2016A Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such the Series 2016A 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 Series 2016A Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Series 2016A Bonds, such as redemptions, tenders, defaults, and proposed amendments to the Series 2016A Bond documents. For example, Beneficial Owners of the Series 2016A Bonds may wish to ascertain that the nominee holding the Series 2016A 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 Series 2016A Bonds within an issue are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Series 2016A Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Agency as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Series 2016A Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and dividend payments on the Series 2016A 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 Agency 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 Agency, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and dividend payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Agency or 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.

The Agency and the Bond Trustee may treat DTC (or its nominee) as the sole and exclusive registered owner of the Series 2016A Bonds registered in its name for the purposes of payment of the principal or redemption premium, if any, of, or interest on, the Series 2016A Bonds, giving any notice permitted or required to be given to registered owners under the Trust Agreement, registering the transfer of the Series 2016A Bonds, or other action to be taken by registered owners and for all other purposes whatsoever. Neither the Agency, the Corporation nor the Bond Trustee shall have any responsibility or

obligation to any Participant, any person claiming a beneficial ownership interest in the Series 2016A Bonds under or through DTC or any Participant, or any other person which is not shown on the registration books of the Agency (kept by the Bond Registrar) as being a registered owner, with respect to the accuracy of any records maintained by DTC or any Participant; the payment by DTC or any Participant of any amount in respect of the principal, redemption premium, if any, or interest on the Series 2016 Bonds; any notice which is permitted or required to be given to registered owners thereunder or under the conditions to transfers or exchanges adopted by the Agency; or other action taken by DTC as a registered owner.

Discontinuance of DTC Services

DTC may discontinue providing its service as securities depository with respect to the Series 2016A Bonds at any time by giving reasonable notice to the Agency and the Bond Trustee and discharging its responsibilities with respect thereto under applicable law, or the Agency or the Bond Trustee may terminate its participation in the system of book-entry transfer through DTC at any time by giving notice to DTC. In either event, the Agency may retain another securities depository for the Series 2016A Bonds or may direct the Bond Trustee to deliver bond certificates in accordance with instructions from DTC or its successor. If the Agency directs the Bond Trustee to deliver such bond certificates, such Series 2016A Bonds may thereafter be exchanged for an equal aggregate principal amount of Series 2016A Bonds in other authorized denominations and of the same series and maturity as set forth in the Trust Agreement, upon surrender thereof at the principal corporate trust office of the Bond Trustee, who will then be responsible for maintaining the registration books of the Agency.

Certain of the information contained in the preceding paragraphs of this subsection "Book-Entry Only System" has been extracted from information given by DTC. Neither the Agency, the Corporation, the Bond Trustee nor the Underwriter makes any representation as to the completeness or the accuracy of such information or as to the absence of material adverse changes in such information subsequent to the date hereof.

THE INFORMATION IN THIS SECTION CONCERNING DTC AND DTC'S BOOK-ENTRY SYSTEM HAS BEEN OBTAINED FROM SOURCES THAT THE AGENCY BELIEVES TO BE RELIABLE, BUT THE AGENCY, THE CORPORATION, THE BOND TRUSTEE AND THE UNDERWRITER TAKE NO RESPONSIBILITY FOR THE ACCURACY THEREOF. NO REPRESENTATION IS MADE BY THE AGENCY, THE CORPORATION, THE BOND TRUSTEE OR THE UNDERWRITER 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 AGENCY, THE CORPORATION, THE BOND TRUSTEE OR THE UNDERWRITER TO DETERMINE WHETHER DTC IS OR WILL BE FINANCIALLY OR OTHERWISE CAPABLE OF FULFILLING ITS OBLIGATIONS. NEITHER THE AGENCY NOR THE BOND TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATIONS TO SUCH DTC PARTICIPANTS, INDIRECT PARTICIPANTS, OR THE PERSONS FOR WHOM THEY ACT AS NOMINEES WITH RESPECT TO THE PAYMENTS TO OR THE PROVIDING OF NOTICE FOR THE DTC PARTICIPANTS, THE INDIRECT PARTICIPANTS, OR THE BENEFICIAL OWNERS. PAYMENTS MADE TO DTC OR ITS NOMINEE SHALL SATISFY THE AGENCY'S OBLIGATION UNDER THE ACT AND THE TRUST AGREEMENT TO THE EXTENT OF SUCH PAYMENTS.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2016A BONDS

Master Indenture and Security Therefor

Principal of and interest and any premium on the Series 2016A Bonds will be payable from moneys paid by the Corporation pursuant to the Loan Agreement and by the Obligated Group pursuant to

Obligation No. 21. Payment of Obligation No. 21 will be the joint and several obligation of the Members of the Obligated Group under the Master Indenture. Pursuant to the Trust Agreement, the Agency has, for the benefit of the owners of the Series 2016A Bonds, assigned all of the Agency's right, title and interest in and to the Loan Agreement (subject to the reservation of certain rights of the Agency, including its rights to notices, payment of certain expenses and indemnity), all of the Agency's right, title and interest in and to Obligation No. 21, all of the Agency's rights under the Master Indenture as the owner of Obligation No. 21 and all moneys and securities in the Bond Fund and the Redemption Fund established under the Trust Agreement, to the Bond Trustee in trust.

Pursuant to the Master Indenture, as security for the payment of the amounts due on the Obligations issued under the Master Indenture: (i) the Corporation has granted the Mortgage to the Master Trustee and (ii) UVM Health Network, the Corporation and CVMC have pledged and granted, and any other future Members of the Obligated Group will pledge and grant, a security interest in Pledged Assets to the Master Trustee. The Pledged Assets consist of the Gross Receipts of the Members of the Obligated Group and all proceeds thereof.

"Gross Receipts" means for any period all Accounts and all revenues, income, receipts and other money (other than proceeds of borrowing) received in such period by or on behalf of any Member of the Obligated Group, including, but without limiting the generality thereof, (a) revenues derived from its operations, (b) gifts, grants, bequests, donations and contributions and the income therefrom, exclusive of any gifts, grants, bequests, donations and contributions to the extent specifically restricted by the donor to a particular purpose inconsistent with their use for the payment of Obligations, (c) proceeds derived from (i) insurance, except to the extent otherwise required by the provisions of the Master Indenture (ii) Accounts, (iii) securities and other investments, (iv) inventory and other tangible and intangible property, (v) medical or hospital insurance, indemnity or reimbursement programs or agreements and (vi) contract rights and other rights and assets, whether now or hereafter owned, held or possessed by each Member of the Obligated Group, and (d) rentals received from the leasing of real or tangible personal property. "Accounts" means any right to payment for goods sold or leased or for services rendered which is not evidenced by an instrument or chattel paper, whether or not it has been earned by performance.

The security interest in Pledged Assets has been perfected to the extent, and only to the extent, that such security interest may be perfected by filing financing statements under the Uniform Commercial Code of the State of Vermont (the "UCC"). Continuation statements with respect to such filings must be filed every five years to continue the perfection of such security interest. The security interest in Pledged Assets is subject to Permitted Liens that existed prior to or that may be created subsequent to the time the security interest in Pledged Assets attached and subject to the right of each Member of the Obligated Group to sell Accounts or incur Indebtedness secured by Accounts under certain circumstances, as described more fully in Appendix C. The security interest in Pledged Assets may not be enforceable against third parties unless Pledged Assets are transferred to the Master Trustee (which transfer Members of the Obligated Group are required to make only if requested by the Master Trustee after a default under the Master Indenture) and is subject to certain exceptions under the UCC. The enforcement of the security interest in Pledged Assets may be further limited by the following: (i) statutory liens, (ii) rights arising in favor of the United States of America or any agency thereof, (iii) present or future prohibitions against assignment in any federal or State statutes or regulations, (iv) constructive trusts, equitable liens or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction, (v) federal bankruptcy laws, State of Vermont receivership or fraudulent conveyance laws or similar laws affecting creditors' rights that may affect the enforceability of the Master Indenture or the security interest in Pledged Assets and (vi) rights of third parties in Pledged Assets not in the possession of the Master Trustee.

The actual realization of amounts to be derived upon the enforcement of any security interest securing the Series 2016A Bonds will depend upon the exercise of various remedies specified by the Loan Agreement, the Trust Agreement and the Master Indenture. These and other remedies may, in many

respects, require judicial action of a nature that is often subject to discretion and delay. Under existing law, the remedies specified by the Loan Agreement, the Trust Agreement and the Master Indenture may not be readily available or may be limited. A court may decide not to order the specific performance of the covenants contained in those documents. The various legal opinions to be delivered concurrently with the delivery of the Series 2016A Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings and decisions affecting remedies and by bankruptcy, fraudulent conveyance, reorganization and other laws affecting the enforcement of creditors' rights generally.

Pursuant to the Master Indenture, the Members of the Obligated Group are subject to covenants under the Master Indenture relating to maintenance of a Long-Term Debt Service Coverage Ratio and concerning, among other things, incurrence of Indebtedness, existence of liens on Property, consolidation and merger, disposition of assets, addition of Members to the Obligated Group and withdrawal of Members from the Obligated Group. See "SUMMARY OF THE MASTER INDENTURE – Particular Covenants" in Appendix C hereto.

THE MASTER INDENTURE PERMITS MEMBERS OF THE OBLIGATED GROUP TO ISSUE OR INCUR ADDITIONAL INDEBTEDNESS EVIDENCED BY OBLIGATIONS THAT WILL SHARE THE SECURITY FOR THE PRIOR OBLIGATIONS AND OBLIGATION NO. 21 ON A PARITY WITH THE PRIOR OBLIGATIONS AND OBLIGATION NO. 21. SUCH ADDITIONAL OBLIGATIONS WILL NOT BE SECURED BY THE MONEY OR INVESTMENTS IN ANY FUND OR ACCOUNT HELD BY THE BOND TRUSTEE FOR THE SECURITY OF THE SERIES 2016A BONDS.

The Mortgage

The Corporation has executed and delivered the Mortgage to the Master Trustee, which constitutes a mortgage on the Corporation's campus located at 111 Colchester Avenue, Burlington, Vermont. For a description of the Corporation's campus, see Appendix A – "FACILITIES – UVM Medical Center – A Member of the Obligated Group – The Medical Center Campus." The Mortgage secures the payments required to be made by the Corporation pursuant to the Obligations, including Obligation No. 21, issued under the Master Indenture. The distribution of proceeds from the enforcement or foreclosure of the Mortgage will be pro rata based on the outstanding principal amount of the Indebtedness secured by the Mortgage, thereby placing such Indebtedness on a parity with respect to foreclosure proceeds regardless of the order of priority of the liens granted under the Mortgage. The Members of the Obligated Group may issue additional Obligations which will be secured on a parity by the Mortgage.

Limited Obligations

The Series 2016A Bonds are limited obligations of the Agency. The Agency is not obligated to pay the principal of, or the premium, if any, or the interest on, the Series 2016A Bonds except from revenues and receipts derived in respect of Obligation No. 21 as described above, the Loan Agreement and the money attributable to proceeds of the Series 2016A Bonds and the income from the investment thereof and, under certain circumstances, proceeds of insurance, sale and condemnation awards and proceeds derived from the exercise of remedies. The Agency has no taxing power. THE SERIES 2016A BONDS DO NOT CONSTITUTE OR CREATE ANY DEBT, LIABILITY OR OBLIGATION OF THE STATE OF VERMONT OR ANY POLITICAL SUBDIVISION OR INSTRUMENTALITY THEREOF (OTHER THAN THE AGENCY) OR A PLEDGE OF THE FAITH AND CREDIT OF THE STATE OR ANY POLITICAL SUBDIVISION OR AGENCY OF THE STATE, AND NEITHER THE FAITH AND CREDIT NOR THE TAXING POWER OF THE STATE OR ANY POLITICAL SUBDIVISION OR ANY AGENCY THEREOF IS PLEDGED AS SECURITY FOR THE PAYMENT OF THE PRINCIPAL OF, OR PREMIUM, OR THE INTEREST ON THE SERIES 2016A BONDS.

SUBSTITUTION OF MASTER INDENTURE

The Master Indenture provides that each Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds shall surrender such Obligation to the Master Trustee and each Related Bond Trustee for Related Bonds shall, with the prior written consent of the bond insurer or credit facility provider, if any, for such Related Bonds, and with the consent of a majority of the Series 2016A Holders (so long as the Series 2016A Bonds are Outstanding) surrender any Obligation issued to secure such Related Bonds to the Master Trustee upon satisfaction of conditions set forth in the Master Indenture. The Corporation, as the Obligated Group Representative, has covenanted in Supplement No. 21 that, for so long as the Series 2016A Bonds remain outstanding, the Obligated Group will make no substitution of the Master Indenture without the consent of a majority of the Holders of the then Outstanding Series 2016A Bonds. See "SUMMARY OF THE MASTER INDENTURE – Replacement Master Indenture" in Appendix C hereto.

BONDHOLDERS' RISKS

Purchase of the Series 2016A Bonds involves a degree of risk. In order to identify risk factors and make an informed investment decision, potential investors should be thoroughly familiar with this entire Official Statement, including the Appendices hereto, in order to make a judgment as to whether the Series 2016A Bonds are an appropriate investment. Certain risks associated with the purchase of the Series 2016A Bonds are described below. Such lists of possible factors, while not setting forth all the factors which must be considered, contain some of the factors which should be considered prior to purchasing the Series 2016A Bonds. **THE FOLLOWING DISCUSSION OF RISK FACTORS IS NOT, AND IS NOT INTENDED TO BE, COMPREHENSIVE OR EXHAUSTIVE.** Prospective purchasers of the Series 2016A Bonds should give careful consideration to the matters referred to in the following summary. Such summary should not be considered exhaustive, but rather informational only.

The revenue and expenses of the Obligated Group are affected by the rapidly changing health care environment. These changes are a result of the implementation of national health reform and efforts by the federal and state governments, managed care organizations ("MCOs"), private insurance companies and business coalitions to reduce and contain health care costs, including, but not limited to, the costs of inpatient and outpatient care, physician fees, capital expenditures and the costs of graduate medical education. In addition to matters discussed elsewhere herein, the following factors may have a material effect on the operations of the Obligated Group to an extent that cannot be determined at this time.

General

The receipt of future revenues by the Obligated Group is subject to, among other factors, federal and state regulations and policies affecting the health care industry, the policies and practices of MCOs, private insurers and other third-party payors, and private purchasers of health care services. The effect on the Obligated Group of future changes in federal, state and private policies cannot be determined at this time.

Future revenues and expenses of the Obligated Group may be affected by events and economic conditions, which may include an inability to control expenses in periods of inflation, as well as other conditions such as demand for health care services; the capability of the management of the Obligated Group; the receipt of grants and contributions; referring physicians' and self-referred patients' confidence in the Obligated Group; and increased use of discounted or risk-based contracts with MCOs and other payors. Other factors that may affect revenues and expenses include the ability of the Obligated Group to provide services required by patients; the relationship of the Obligated Group with physicians; the success of the Obligated Group's strategic plans; the degree of cooperation among and competition with other providers in the Obligated Group's area; changes in levels of private philanthropy; malpractice claims and

other litigation; economic and demographic developments in the United States and in the service areas in which facilities of the Obligated Group are located; competition; changes in interest rates that affect investment results; and changes in rates, costs, third-party payments (including, without limitation, Medicare and Medicaid program payment) and governmental regulations concerning payment. All of the above referred-to factors could affect the Corporation's ability to make payments with respect to the Series 2016A Bonds.

Enforceability of Lien on Gross Receipts

The Loan Agreement provides that the Corporation shall make payments to the Trustee sufficient to pay the principal of and premium, if any, and interest on the Series 2016A Bonds as the same become due. The obligation of the Corporation to make such payments is secured by Obligation No. 21 issued under the Master Indenture which, in turn, is secured by, among other things, a security interest granted to the Master Trustee in the Gross Receipts of each Member of the Obligated Group and a mortgage on the Mortgaged Property. The lien on Gross Receipts may become subordinate to certain Permitted Liens under the Master Indenture. Gross Receipts paid by the Obligated Group to third parties in the ordinary course may no longer be subject to the lien of the Master Indenture.

To the extent that Gross Receipts are derived from payments by the federal or state government under the Medicare or Medicaid program, any right to receive such payments directly may be unenforceable. The Social Security Act and state regulations prohibit anyone other than the individual receiving care or the institution providing service from collecting Medicare and Medicaid payments directly from the federal or state government. In addition, Medicare and Medicaid receivables may be subject to provisions of the Assignment of Claims Act of 1940, which restricts the ability of a secured party to collect accounts directly from government agencies. With respect to receivables and Gross Receipts not subject to the Lien, the Master Trustee would occupy the position of an unsecured creditor. Counsel to the Obligated Group has not provided an opinion with regard to the enforceability of the Lien on Gross Receipts of the Obligated Group where such Gross Receipts are derived from the Medicare and Medicaid programs.

In the event of bankruptcy of a Member of the Obligated Group, transfers of property by the bankrupt entity, including the payment of debt or the transfer of any collateral, including receivables and Gross Receipts on or after the date which is ninety (90) days (or, in some circumstances, one year) prior to the commencement of the case in bankruptcy court may be subject to avoidance or recoupment as preferential transfers. Under certain circumstances a court may have the power to direct the use of Gross Receipts to meet expenses of the Members of the Obligated Group before paying debt service on the Series 2016A Bonds.

Pursuant to the Vermont Uniform Commercial Code, a security interest in the proceeds of Gross Receipts may not continue to be perfected if such proceeds are not paid over to the Master Trustee by a Member of the Obligated Group under certain circumstances. If any required payment is not made when due, the Members of the Obligated Group must transfer or pay over immediately to the Master Trustee any Gross Receipts with respect to which the security interest remains perfected pursuant to law. Any Gross Receipts thereafter received shall upon receipt by a Member of the Obligated Group be transferred to the Master Trustee without such Gross Receipts being commingled with other funds, in the form received (with necessary endorsements) up to an amount equal to the amount of the missed payment.

The value of the security interest in the Gross Receipts could be diluted by the incurrence of Additional Indebtedness secured equally and ratably with Obligation No 21, which secures the Series 2016A Bonds, as to the security interest in Gross Receipts or by the incurrence of debt secured on a basis senior to Obligation No. 21. See Appendix C – "SUMMARY OF THE LOAN AGREEMENT – Security for the Loan."

Enforceability of Master Indenture and Agreement

It is possible that the security interest granted by a Member of the Obligated Group and the joint and several obligation of each Member of the Obligated Group to make payments due under Obligations, including the Obligation No. 21, relating to bonds issued for the benefit of another Member of the Obligated Group, may be declared void in an action brought by third-party creditors pursuant to the Vermont fraudulent conveyance statutes or may be avoided by a Member of the Obligated Group or a trustee in bankruptcy in the event of the bankruptcy of the Member of the Obligated Group from which payment is requested. An obligation may be voided under the federal Bankruptcy Code or under the Vermont fraudulent conveyance statute if (i) the obligation was incurred without receipt by the obligor of "fair consideration" or "reasonably equivalent value," and (ii) the obligation renders the obligor "insolvent," or becomes so as a result of the obligations incurred, as such terms are defined under the applicable statute. Interpretation by the courts of the tests of "insolvency," "reasonably equivalent value" and "fair consideration" has resulted in a conflicting body of case law. For example, a Member of the Obligated Group's joint and several obligation under the Master Indenture to make all payments thereunder, including payments in respect of funds used for the benefit of any other Member of the Obligated Group, may be held to be a "transfer" which makes such Member of the Obligated Group "insolvent" if its liabilities exceed its assets. Also, one of the Members of the Obligated Group may be deemed to have received less than "reasonably equivalent value" for such obligation because none or only a portion of the proceeds of the indebtedness is to be used to finance projects occupied or used by such Member of the Obligated Group. While the Members of the Obligated Group may benefit generally from the projects financed from the Indebtedness incurred for the benefit of the other Members of the Obligated Group, the actual cash value of this benefit may be less than the joint and several obligation. The rights under the Vermont fraudulent conveyance statutes may be asserted for a period of up to four years from the incurring of the obligations or granting of security under the Master Indenture and the Loan Agreement.

In addition, there exists common law authority and authority under state statutes for the ability of state courts to terminate the existence of a not-for-profit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes or has taken some action which renders it unable to carry out such purposes. Such court action may arise on the court's own motion or pursuant to a petition of the state attorney general or such other persons who have interests different from those of the general public, pursuant to common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses. The enforceability of similar master trust indentures has been challenged in jurisdictions outside of Vermont. In the absence of clear legal precedent in this area, the extent to which the assets of any Member of the Obligated Group can be used to pay Obligations issued by others cannot be determined at this time.

Exercise of Remedies Under Master Indenture

"Events of Default" under the Master Indenture include the failure of the Obligated Group to make payments on any Obligation Outstanding under the Master Indenture (such as Obligation No. 21) and may include nonpayment related defaults under documents such as the Loan Agreement or the Mortgage. The Master Indenture provides that upon an "Event of Default" thereunder, the Master Trustee may in its discretion, by notice in writing to Members of the Obligated Group, declare the principal of all (but not less than all) Obligations Outstanding thereunder to be due and payable immediately and may exercise other remedies thereunder. However, the Master Trustee is not required to declare amounts under the Master Indenture to be due and payable immediately unless requested to do so by the holders of not less than 50% in aggregate principal amount of all Obligations then Outstanding under the Master Indenture. Consequently, upon the occurrence of an "Event of Default" under the Loan Agreement with respect to the Series 2016A Bonds and an acceleration of the maturity of the Series 2016A Bonds, the Master Trustee is not required to accelerate the maturity of all Obligations Outstanding under the Master

Indenture upon direction from the Trustee unless (i) the principal amount of the Series 2016A Bonds Outstanding is at least equal to 50% of the principal amount of all Obligations Outstanding under the Master Indenture, or (ii) the Trustee and all other holders of Obligations requesting such acceleration hold at least 50% of all Obligations Outstanding under the Master Indenture.

Obligation No. 21 is cross-defaulted and secured on a parity with all other Obligations under the Master Indenture. Further, an Event of Default under the Master Indenture or the Mortgage constitutes an Event of Default under the Loan Agreement. See Appendix C – "SUMMARY OF THE LOAN AGREEMENT – Defaults and Remedies."

Considerations Relating to Additional Debt

Subject to the coverage and other tests set forth therein, the Master Indenture permits the Obligated Group to incur Additional Indebtedness. Such indebtedness would increase the Obligated Group's debt service and repayment requirements and may adversely affect debt service coverage on the Series 2016A Bonds.

Realization of Value of Mortgaged Property

The Mortgaged Property is not comprised of general purpose buildings and would not generally be suitable for industrial or commercial use. Consequently, it would be difficult to find a buyer or lessee for the Mortgaged Property if it were necessary to foreclose on the Mortgaged Property. Thus, upon any default, it may not be possible to realize funds at least equal to the outstanding interest on and principal on the Series 2016A Bonds from a sale or lease of the Mortgaged Property. Furthermore, in order to operate the Mortgaged Property as health care facilities, a purchaser of the Mortgaged Property at a foreclosure sale would under present law have to obtain operating licenses from the applicable state regulatory agency, appropriate provider agreements from third party payors and a certificate of need ("CON") from the Green Mountain Care Board ("GMCB"). Further, the dollar value secured by the Mortgage is less than the aggregate par amount of all Obligations outstanding under the Master Indenture.

In addition, under applicable environmental law, in the event of any past or future releases of pollutants or contaminants on or near the Mortgaged Property, a lien superior to the lien of the Mortgage could attach to the Mortgaged Property to secure the costs of removing or otherwise treating such pollutants or contaminants. Such a lien would adversely affect the Master Trustee's ability to realize value from the disposition of the Mortgaged Property upon foreclosure. Furthermore, in determining whether to exercise any foreclosure rights with respect to the Mortgaged Property, the Master Trustee may have to take into account the potential liability of any owner of the Mortgaged Property, including an owner by foreclosure, for clean-up costs with respect to such pollutants and contaminants.

The value of the Mortgaged Property to Bondholders could be diluted by the incurrence of Additional Indebtedness secured equally and ratably with Obligation No. 21, which secures the Series 2016A Bonds as to the Mortgaged Property, or by the incurrence of debt secured on a basis senior to Obligation No. 21. See Appendix C – "SUMMARY OF THE LOAN AGREEMENT – Security for the Loan."

Effect of Bankruptcy

If any Member of the Obligated Group files for protection under the federal Bankruptcy Code, its revenues may not be subject to the security interests created under the Master Indenture. Property acquired after the date of filing of the bankruptcy, including newly created accounts receivable, will not be subject to the security interests created under the Master Indenture. The Member's property, including accounts receivable and cash collateral, also could be used for the benefit of the Member despite the security interest of the Trustee if the Bankruptcy Court finds that "adequate protection" of the security interest in the property exists or is given.

The commencement of a case under the federal Bankruptcy Code operates as an automatic stay of any act or proceeding to enforce a lien upon property of the affected Member of the Obligated Group. A patient care ombudsman could be appointed as an advocate for the welfare of patients. The Trustee may not be able to obtain relief from the automatic stay to realize upon security interests created under the Master Indenture as a result of concern for patient welfare or otherwise. Delay in the Trustee's ability to exercise remedies against collateral could impair recovery from the collateral securing the Series 2016A Bonds.

The commencement of a proceeding under the Bankruptcy Code can also adversely affect the business of the Obligated Group, including by increasing costs and by deterring recipients of health care services from utilizing the Members of the Obligated Group for such services. In addition, if a Member of the Obligated Group were to become insolvent or if reorganization under the Bankruptcy Code were to be perceived as being in doubt, accounts receivable could become more difficult or impossible to collect.

In a proceeding under the Bankruptcy Code, in particular if the indebtedness evidenced by the Obligation No. 21 were to be deemed not fully secured, payments made thereon in respect of the Series 2016A Bonds or other transfers of property within 90 days prior to the date of a bankruptcy case could be avoided as preferential transfers absence the presence of one of the Bankruptcy Code defenses to avoidance. To the extent avoided, the value of such payments or transfers could be recovered from the Trustee or from subsequent transferees and claims in respect of the Series 2016A Bonds could be disallowed pending recovery of the value of such payments or transfers.

In a Chapter 11 case, a Member of the Obligated Group could file a plan of reorganization that would adjust its debts and modify the rights of creditors generally, or any class of creditors, secured or unsecured. The plan, if confirmed by the court, binds all creditors and discharges all claims held by creditors who had notice or knowledge of the bankruptcy except as set forth in the plan. No plan may be confirmed unless, among numerous other conditions, the plan is determined to be in the best interest of creditors, is feasible and either has been accepted by each class of claims impaired thereunder, or the court has found sufficient grounds to confirm the plan over the objections of a dissenting class. To accept the plan, at least two-thirds in dollar amount and more than one-half in number of the allowed claims of the class that vote with respect to the plan must accept the plan. Even if the plan is not so accepted, it may still be confirmed if the court finds that the plan is "fair and equitable" with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly in favor of junior creditors. With respect to secured claims of holders of the Series 2016A Bonds, if certain legal requirements were satisfied, a plan could alter substantive rights such as the maturity date and interest rate of the Series 2016A Bonds.

Risks Affecting the Health Care Industry Generally

Future revenues and expenses of the Obligated Group will be affected by events and conditions relating generally to, among other things, demand for the services of the Obligated Group, the ability of the Obligated Group to provide the services required by patients, physicians' relationships with the Obligated Group, reimbursement rates under agreements with third party payors as well as the Medicare and Medicaid programs, research grant funding, management capabilities, the correctness of the design and success of the Obligated Group's strategic plans, the degree of cooperation among and competition with other hospitals in the Obligated Group's area, changes in private philanthropy, malpractice claims and other litigation, economic developments in the Obligated Group's service area, the Obligated Group's ability to control expenses and maintain relationships with health maintenance organizations ("HMOs"), sponsors of research, and other managed health care organizations and third-party payors, rates, costs, third-party reimbursement, legislation and government regulation. While the Obligated Group reasonably expects to generate sufficient revenues in the future to cover its expenses, third-party payments, regulation and unanticipated events and circumstances may occur that cause variations from this expectation, and the variations may be material.

Accordingly, there can be no assurance that the financial condition of the Obligated Group and/or utilization of the Obligated Group's facilities will not be adversely affected, and there can be no guarantee that there will be sufficient revenues to make payments with respect to the Series 2016A Bonds. The following general factors, among others, could affect the level of revenues to the Obligated Group or its financial condition or otherwise result in risks for Bondholders.

Impact of Market Turmoil and General Economic Factors

The disruption of the credit and financial markets since 2008 resulted in volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies. In response to this disruption of the credit and financial markets, federal legislation was enacted, including the Recovery Act and the Dodd-Frank Act (each defined below).

In February 2009, the American Recovery and Reinvestment Act of 2009 (the "Recovery Act") was enacted and included several provisions intended to provide financial relief to the health care sector by providing approximately $150 billion in new funds. The funds were used to, among other things, provide a temporary increase in Federal payments to fund state Medicaid programs and provided subsidies to the recently unemployed for health insurance premium costs. The Recovery Act and resulting regulations established a framework for the implementation of a nationally-based health information technology program. For more information regarding this program, see "—Regulatory Environment—The HITECH Act" below.

In July 2010, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") was enacted in an effort to stabilize the credit and financial markets. Regulatory action has been taken and is still being considered by various federal agencies and the Federal Reserve Board and foreign governments which are intended to increase the regulation of financial institutions and domestic and global credit and securities markets. The effects of these legislative, regulatory and other governmental actions, including the Dodd-Frank Act, upon the Obligated Group and, in particular upon its access to capital markets and its investment portfolios, cannot be predicted.

Nonprofit Health Care Environment

Each Member of the Obligated Group is a nonprofit corporation, exempt from federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code (the "Code"). As a nonprofit, tax-exempt organization, each Member of the Obligated Group is subject to federal, state and local laws, regulations, rulings and court decisions relating to its organization and operation, including its operation for charitable purposes. At the same time, the Obligated Group conducts large-scale, complex business transactions and is a major employer in the Vermont and northeastern New York areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex health care organization.

The operations and practices of nonprofit, tax-exempt hospitals are routinely challenged or criticized for inconsistency or inadequate compliance with the regulatory requirements for, and societal expectations of, nonprofit, tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the health care organizations. Areas that have come under examination include pricing practices, billing and collection practices, charitable care, methods of providing and reporting community benefit, executive compensation, exemption of property from real property taxation, private use of facilities financed with tax-exempt bonds and others. These challenges and questions have come from a variety of sources, including state attorneys general, the IRS, labor unions, Congress, state legislatures, and patients, and in a variety of forums, including hearings, audits and litigation. The challenges and examinations, and any resulting

legislation, regulations, judgments or penalties, could have a material adverse effect on the Obligated Group. These challenges or examinations include the following, among others:

Congressional Hearings. Senate and House committees have conducted several nationwide investigations of hospital billing and collection practices and prices charged to uninsured patients and have considered reforms to the nonprofit sector, including proposed reform in the area of tax-exempt health care organizations, as part of health care reform generally. See "—IRS Examination of Compensation Practices," "—IRS Community Benefit Initiative" and "—Challenges to Real Property Tax Exemption" below.

IRS Bond Examinations. IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds in the charitable organization sector with specific review of private use. A schedule to the revised Form 990 return (Schedule K), effective for the 2009 tax year and thereafter, is intended to address what the IRS believes is significant noncompliance with recordkeeping and record retention requirements. Schedule K also requires tax-exempt organizations to report on the investment and use of bond proceeds to address IRS concerns regarding post-issuance compliance with arbitrage rebate requirements and the private use of bond-financed facilities.

IRS Examination of Compensation Practices. In 2004, the IRS began a new program to measure compliance by tax-exempt organizations with requirements that they not pay excessive compensation and benefits to their officers and other insiders. In 2009, the IRS issued its Hospital Compliance Project Final Report (the "IRS Final Report") that examined tax-exempt hospitals' practices and procedures with regard to compensation and benefits paid to their officers and other defined "insiders." The IRS Final Report indicates that the IRS will continue to heavily scrutinize executive compensation arrangements, practices and procedures of tax-exempt hospitals and other tax-exempt organizations and, in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

IRS Community Benefit Initiative. The IRS has undertaken a community benefit initiative directed at hospitals. An IRS report on this initiative determined that a lack of uniformity in definitions of community benefit used by reporting hospitals, including those regarding uncompensated care and various types of community benefit, make it difficult for the IRS to assess whether any particular hospital is in compliance with current law. The revised Form 990 includes a new schedule, Schedule H, which hospitals and health systems must use to report their community benefit activities, including the cost of providing charity care and other tax-exemption related information.

New ACA Requirements for Tax-Exempt Status. As part of the ACA, Congress enacted Section 501(r) of the Code which imposes additional requirements for hospitals and other designated health care organizations to be treated as tax-exempt organizations. Under the new rules, in order to maintain their tax-exempt status hospitals must establish and publicize written financial assistance policies, conduct community health needs assessments at least once every three years and describe in their annual tax returns how they are addressing the needs identified in such assessments. Tax-exempt hospitals are also subject to new limitations on their collection activities and the amounts they can charge for emergency or other medically necessary care for individuals eligible for financial assistance. The hospitals operated by the Obligated Group (the "Hospitals") are subject to these new rules, and failure to comply can result in fines and the loss of a hospital's tax-exempt status. There have been no challenges to the tax-exempt status of the Hospitals, but there can be no assurance that a challenge will not occur in the future.

Challenges to Real Property Tax Exemption. Recently, the real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the grounds that the health care providers were not engaged in sufficient charitable activities as to warrant exemption from taxation as a charitable institution. For example, the Illinois Supreme Court upheld a decision relating to a local taxing authority's decision to deny a request for property tax exemption for a nonprofit hospital on the basis that the hospital had not proven with clear and convincing evidence that it

was operating within a charitable purpose under applicable Illinois law. Additionally, similar challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements. See "—Tax-Exempt Status and Other Tax Matters—Real Property Tax Exemption" below.

Indigent Care. Tax-exempt health care providers often treat large numbers of indigent patients who are unable to pay in full for their medical care. Typically, urban, inner-city hospitals and other health care providers may treat significant numbers of indigents. These hospitals and health care providers may be susceptible to economic and political changes that could increase the number of indigents or their responsibility for caring for this population. General economic conditions affect the number of employed individuals who have health coverage and the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, county, state and federal health care programs (including Medicare and Medicaid) may increase the frequency and net cost of indigent treatment by such hospitals and other providers. It also is possible that future legislation could require that tax-exempt hospitals and other providers maintain minimum levels of indigent care as a condition to federal income tax exemption or exemption from certain state or local taxes.

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

The foregoing are some examples of the challenges and examinations facing nonprofit health care organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations and may indicate an increasingly difficult operating environment for health care organizations, including the Members of the Obligated Group. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and health care providers, including the Obligated Group, and, in turn, its ability to make payments under the Master Indenture and the Series 2016A Bonds.

Health Care Reform

The changes in the health care industry brought about by the ACA will likely have both positive and negative effects, directly and indirectly, on the nation's hospitals and other health care providers, including the Obligated Group. For example, the projected increase in the number of individuals with health care insurance occurring as a consequence of Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the mandate for individuals to purchase insurance could result in lower levels of bad debt and increased utilization or profitable shifts in utilization patterns for hospitals. Substantial reductions in the rate of increase of Medicare "market basket" adjustments and in actual reductions in Medicare payments will likely result in a significant negative impact to the hospital industry overall. The legislation's cost-cutting provisions to the Medicare program include reduction in Medicare market basket updates to hospital reimbursement rates under the inpatient prospective payment system over the next ten years, as well as reductions to or elimination of Medicare reimbursement for certain patient readmissions and hospital-acquired conditions.

The ACA likely will affect some health care organizations differently from others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more federal health care dollars to integrated provider organizations and providers that demonstrate achievements in quality care. The ACA proposes a value-based purchasing system for hospitals under which a percentage of payments will be contingent on satisfaction of specified performance measures related to common and high-cost medical conditions, such as cardiac, surgical and pneumonia care. The ACA also funds various demonstration programs and pilot projects and other voluntary programs to evaluate and encourage new provider delivery models and payment structures, including "accountable care organizations" and bundled provider payments. The outcomes of these projects and programs, including the likelihood of their being made permanent or expanded, and their effect on health care organizations' revenues or financial performance, cannot be predicted. See also "—Patient Service Revenues—Medicare Program" below.

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

Some of the specific provisions of the ACA that may affect the Obligated Group's operations, financial performance or financial condition are described below.

Market Basket Reductions. Generally, Medicare payment rates to hospitals are adjusted annually based on a "market basket" update of estimated cost increases, which have averaged approximately 2-4% annually in recent years. The ACA provides for three types of annual reductions in the market basket. The first is a general reduction of a specified percentage in each federal fiscal year ("FFY") beginning in 2010 and extending through 2019, increasing from 0.10% to 0.75% each year.

The second type of reduction is a "productivity adjustment" based on national economic productivity statistics. This adjustment resulted in a 1% reduction in the market basket update for FFY 2012 and a .7% reduction in the market basket update for FFY 2013. CMS instituted a 0.5% reduction for FFY 2014, another 0.5% reduction for FFY 2015, and another 0.5% reduction for FFY 2016. It is anticipated that similar reductions may be imposed in future years.

The third type of reduction is in connection with Medicare's value-based purchasing program. Beginning in FFY 2013, Medicare inpatient payments to hospitals were reduced by 1%. For FFY 2015 the payments were reduced by 1.5%, and reductions will increase to 2% by FFY 2017. For each FFY, the total amount collected from these reductions is pooled and used to fund payments to hospitals that meet "value-based purchasing" standards for treatment of certain conditions. While the reductions may be partially offset or recovered in full if a hospital satisfies the specified quality metrics, the recovery amounts may be delayed.

The CMS's actuary projects that these combined general reductions and productivity adjustments to the market basket update will result in Medicare savings of approximately $112 billion.

Hospital Acquired Conditions Penalty. Beginning in FFY 2015, Medicare inpatient payments to hospitals that are in the top quartile nationally for frequency of certain "hospital-acquired conditions" are reduced by 1% for all discharges for the applicable FFY. In addition, the ACA provides that, as of July 1, 2011, CMS will no longer provide federal funding to states for any amounts expended by providers in treating so-called provider-preventable conditions. CMS has also directed states to submit amendments to their Medicaid state plans to require payment denials for the cost of treating such conditions, consistent with the prohibition on federal reimbursement.

Readmission Rate Penalty. The ACA required CMS to reduce Medicare inpatient payments to hospitals with excess readmission rates for certain medical conditions, beginning on October 1, 2012. For FFY 2015 and FFY 2016, a hospital's payments can be reduced by a maximum of 3%. In addition, the ACA allows for expansion of the conditions measured for readmission rate penalties beginning in FFY 2015.

DSH Funding. Beginning in FFY 2014, hospitals receiving supplemental disproportionate share hospital ("DSH") payments from Medicare (i.e., those hospitals that care for a disproportionate share of Medicare beneficiaries) had their DSH payments reduced by potentially 75% (offset however, by the reduced levels of uninsured requiring services). The base 25% is supplemented by additional payments based on the volume of uninsured and uncompensated care provided by each such hospital, and is anticipated to be partially offset by a higher proportion of covered patients as other provisions of the ACA go into effect. Separately, beginning in federal fiscal year 2018, Medicaid DSH allotments to each state also will be reduced, based on a methodology to be determined by DHHS, accounting for statewide reductions in uninsured and uncompensated care.

Payments to Medicare Advantage Plans. Hospitals also receive payments from health plans under the Medicare Advantage program. The ACA includes significant changes to federal payments to Medicare Advantage plans. Payments to plans were frozen for FFY 2011. Beginning in FFY 2012, federal payments to Medicare Advantage plans were tied to the level of fee-for-service spending in the applicable county, resulting in a reduction below the FFY 2011 level for certain Medicare Advantage plans. The revised payment methodology will be phased in through FFY 2016 and will be in full effect in all counties as of FFY 2017. Payment to plans also will be based on achievement of quality indicators. Medicare's new payment methodology could result in lower payments to plans, which could impact the plans' scope of coverage or cause plan sponsors to negotiate lower payments to providers.

Tax Exemption Requirements. The ACA also contains new requirements for tax-exempt hospitals. Under the ACA, each tax-exempt hospital facility is required to (i) conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the identified community needs, (ii) adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment without discrimination, (iii) limit charges to individuals who qualify for financial assistance under such tax-exempt hospital's financial assistance policy to no more than the amounts generally billed to individuals who have insurance covering such care and refrain from using "gross charges" when billing such individuals, and (iv) refrain from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under such tax-exempt hospital's financial assistance policy. In addition, the Treasury Department is required to review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require such hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

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 June 28, 2012 and June 25, 2015 decisions by the Supreme Court, which both largely upheld the ACA as constitutional. The 2012 decision 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 had the option but not the obligation to extend Medicaid coverage to the indigent adult population specified in the ACA. Although the Supreme Court's rulings

removed a significant source of uncertainty surrounding the implementation of federal health care reform, legislative repeal under a future Congress or Presidential administration remains a possibility. As the ACA's reductions in reimbursement to health care providers continue to take effect, the practical consequences of the ACA, as well as of other future federal and state actions to cut costs and change the health care delivery system, cannot be foreseen.

Management of the Obligated Group has analyzed the ACA and will continue to do so in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management of the Obligated Group cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

Patient Service Revenues

Medicare Program. Medicare is the federal health insurance system under which hospitals are paid for services provided to eligible elderly and disabled persons. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the states and The Joint Commission. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies and services. As the population ages, more people will become eligible for the Medicare program. Current projections indicate that demographic changes and continuation of current cost trends will exert significant and negative forces on the overall federal budget.

For each of the fiscal years ended September 30, 2015 and September 30, 2014, Medicare payments represented approximately 29.4% and 30.2%, respectively, of the Obligated Group's net patient service revenue. See Appendix A – "MANAGEMENT'S DISCUSSION AND ANALYSIS OF RECENT FINANCIAL PERFORMANCE OF THE OBLIGATED GROUP – Payer Mix – Medicare."

Hospital Inpatient Reimbursement. Hospitals are generally paid for inpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions known as diagnosis related groups ("DRGs"). The actual cost of care, including capital costs, may be more or less than the DRG rate. DRG rates are subject to adjustment by CMS and are subject to federal budget considerations. There is no guarantee that DRG rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

Hospital Outpatient Reimbursement. Hospitals are generally paid for outpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions known as ambulatory payment classifications ("APC"). The actual cost of care, including capital costs, may be more or less than the reimbursements. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

Physician Payments. Medicare pays for certain physician services based on a national fee schedule called the "resource-based-relative-value scale" ("RB-RVS"). The RB-RVS fee schedule establishes payment amounts for all physician services, including services of provider-based physicians, and is subject to annual updates. The Sustainable Growth Rate ("SGR"), which is a limit on the growth of Medicare payments for physician services, is linked to changes in the U.S. Gross Domestic Product over a ten-year period. SGR targets are compared to actual expenditures in order to determine subsequent physician fee schedule updates. Because it became apparent that rigorous implementation of the SGR would have produced significant reductions in Medicare's physician payments, beginning in 2003 Congress continuously delayed application of the SGR, leading ultimately to the replacement of the SGR in April 2015 through enactment of the Medicare Access and CHIP Reauthorization Act of 2015. That Act established a fixed 0.5% annual adjustment through calendar year 2019. For years 2020-2025, the

base rates will be maintained and physician compensation will be subject to adjustment under the Merit-Based Incentive Payment System ("MIPS"). Beginning in 2026, physicians who receive a significant portion of revenues through alternative payment models (that is, payments not fee-for-service based) will receive a 0.75% increase, while physicians who do not participate in these alternatives will receive an increase of 0.25%.

Under MIPS, physicians will be assigned a composite performance score based on measures of quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. A threshold performance score will be set annually by DHHS at the mean or median of all composite scores for a prior annual performance period. Performance exceeding the threshold will result in a positive adjustment, performance below the threshold will result in a negative adjustment, and performance at the threshold will result in no adjustment.

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

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

Medical Education Payments. Medicare currently pays for a portion of the costs of medical education at hospitals that have teaching programs. These payments are vulnerable to reduction or elimination. The direct and indirect medical education reimbursement programs have repeatedly emerged as targets in the legislative efforts to reduce the federal budget deficit.

Medicaid Program. Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain needy individuals and their dependents. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. Attempts to balance or reduce federal and state budgets will likely negatively affect Medicaid and other state health care program spending.

Historically Medicaid has reimbursed at rates below the cost of care. Therefore, increases in the overall proportion of Medicaid patients pose a risk. It is uncertain to what extent this risk may be mitigated if the increased Medicaid utilization replaces previously uncompensated patients.

Certain states selectively contract with general acute care hospitals to provide services to participants in the Medicaid program of the state and may not provide payment to hospitals that do not have such a contract. Payment under the contracts may not cover the cost of providing services or may be reduced by the states. Reductions in payments by state Medicaid programs or loss of such contracts could materially adversely affect the financial condition of the Obligated Group.

For the fiscal years ended September 30, 2015 and September 30, 2014, the Obligated Group received approximately 7.7% and 8.0%, respectively, of gross patient service revenues from state Medicaid programs. See Appendix A – "MANAGEMENT'S DISCUSSION AND ANALYSIS OF RECENT FINANCIAL PERFORMANCE OF THE OBLIGATED GROUP – Payer Mix – Medicaid."

Medicare and Medicaid Audits. Hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under these programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments in certain circumstances. New billing rules and reporting requirements for which there is no clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health programs.

Authorized by HIPAA (as defined below), the Medicare Integrity Program ("MIP") was established to deter fraud and abuse in the Medicare program. Funded separately from the general administrative contractor program, MIP allows CMS to enter into contracts with outside entities and insure the "integrity" of the Medicare program. These outside entities, Medicare zone program integrity contractors ("ZPICs") are contracted by CMS to review claims and medical charts, both on a prepayment and post-payment basis, conduct cost report audits and identify cases of suspected fraud. ZPICs have the authority to deny and recover payments as well as to refer cases to the Office of Inspector General of the DHHS (the "OIG"). CMS is also planning to enable ZPICs to compile claims data from multiple sources in order to analyze the complete claims histories of Medicare beneficiaries for inconsistencies.

CMS also enlists recovery audit contractors ("RACs") to conduct periodic annual audits of Medicare payments to search for potentially improper Medicare payments from prior years that were not detected through CMS's routine program integrity efforts. The RACs are private contractors, paid on a contingency fee basis, and use their own software and review processes. Although required to identify both overpayments and underpayments, RACs have in practice collected significantly more in overpayments from health care providers in proportion to the underpayments to the providers. Under the ACA, recovery audits were expanded to include Medicaid by requiring states to contract with RACs to conduct those audits.

In addition, CMS has instituted a Medicaid Integrity Program, modeled on MIP. Medicaid Integrity Program contractors assist state Medicaid agencies by analyzing Medicaid claims data to identify high-risk areas and potential vulnerabilities and conducting post-payment field audits and desk reviews audits of Medicaid provider payments.

Audits may result in reduced reimbursement or repayment obligations related to past alleged overpayments and may also delay Medicare or Medicaid payments to health care providers pending resolution of the appeals process. The ACA explicitly gives DHHS the authority to suspend Medicare and Medicaid payments to a health care provider or supplier during a pending investigation of fraud. The ACA also amended certain provisions of the FCA (as defined below) to include retention of overpayments as a violation. It also added provisions respecting the timing of the obligation to identify, report and reimburse overpayments. See "—Regulatory Environment—False Claims Act" below. The effect of these changes on existing programs and systems of the Obligated Group cannot be predicted.

State and Local Budgets. The State of Vermont has incurred financial challenges, including erosion of general fund tax revenues, falling real estate values, slowing economic growth, and higher unemployment, each of which may continue to worsen or resist improvement over the coming years.

The financial challenges facing Vermont may negatively affect hospitals in a number of ways, including elimination or reduction of health care safety net programs (causing a greater number of indigent, uninsured or underinsured patients) and reductions in Medicaid reimbursement rates. The financial challenges may also result in a greater number of indigent, uninsured or underinsured patients who are unable to pay for their care or gain access to primary care facilities and a greater number of individuals who qualify for Medicaid.

Health Plans and Managed Care. Most private health insurance coverage is provided by various types of "managed care" plans, including HMOs and preferred provider organizations ("PPOs") that generally use discounts and other economic incentives to reduce or limit the cost and utilization of health care services. Medicare and Medicaid also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

In many markets, managed care plans have replaced indemnity insurance as the primary source of non-governmental payment for hospital services, and hospitals must be capable of attracting and maintaining managed care business, often on a regional basis. Regional coverage and aggressive pricing may be required. However, it is also essential that contracting hospitals be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment.

Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis or, for institutional care, on a fixed rate per day of care, which, in each case, usually is discounted from the usual and customary charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider's ability to manage this component of revenue and cost.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital's actual costs of care, or if utilization by enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly.

Often, HMO contracts are enforceable for a stated term, regardless of hospital losses and may require hospitals to care for enrollees, regardless of whether the HMO is able to pay the hospital. State law requires that hospitals hold enrollees harmless in the event the HMO is not able to pay the hospital. Members of the Obligated Group from time to time may have disputes with HMOs, PPOs and other managed care payors concerning payment and contract interpretation issues. Such disputes may result in mediation, arbitration or litigation. Management of the Obligated Group expects that these types of issues ultimately will be resolved.

Defined broadly, for the fiscal year ended September 30, 2015, commercial payor payments (excluding capitated Medicare and Medicaid contracts) constituted approximately 57.2% of the net patient service revenues of the Obligated Group, but there is no assurance that the Obligated Group will maintain managed care contracts or obtain other similar contracts in the future. Appendix A – "MANAGEMENT'S DISCUSSION AND ANALYSIS OF RECENT FINANCIAL PERFORMANCE OF THE OBLIGATED GROUP – Payer Mix – Medicaid."

Failure to maintain contracts could have the effect of reducing the Obligated Group's market share and net patient services revenues. Conversely, participation may result in lower net income to the Obligated Group if it is unable to contain adequately its costs. Thus, managed care poses one of the most significant business risks (and opportunities) the Obligated Group faces.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures. Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and health care providers. 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, the members of their medical staffs and other providers 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 or a health care provider negatively may adversely affect its reputation and financial condition.

Regulatory Environment

"Fraud" and "False Claims." Health care "fraud and abuse" laws have been enacted at the federal and state levels to regulate broadly the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to the beneficiaries. Under these laws, hospitals and others can be penalized for a wide variety of conduct, including: submitting claims for services that are not provided; billing in a manner that does not comply with government requirements or includes inaccurate billing information; billing for services deemed to be medically unnecessary; or billing accompanied by an illegal inducement to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties, and suspension of Medicare/Medicaid payments. Fraud and abuse cases may be prosecuted by one or more government entities and private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation.

Laws governing fraud and abuse may apply to a hospital and to nearly all individuals and entities with which a hospital does business. Fraud investigations, settlements, prosecutions and related publicity can have a material adverse effect on hospitals. See "Enforcement Activity" below. Major elements of these often highly technical laws and regulations are generally summarized below.

The Secretary of DHHS may exclude a provider's participation in Medicare and Medicaid, as well as suspend payments to a provider pending an investigation or prosecution of a credible allegation of fraud against the provider.

False Claims Act. The federal False Claims Act ("FCA") makes it illegal to submit or present a false, fictitious or fraudulent claim for payment or approval for payment for which the federal government provides, or reimburses at least some portion of, the requested money or property. Pursuant to the ACA, failure to report and return to a federal health care program a known overpayment within 60 days of having identified the overpayment or, for cost-reporting entities, the date (if later) on which a hospital cost report is due can give rise to an FCA claim. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," can share in the damages recovered by the government or recover independently if the government does not participate. The FCA has become one of the government's primary weapons against health care fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital.

Anti-Kickback Law. The federal "Anti-Kickback Law" is a criminal statute that prohibits anyone from soliciting, receiving, offering or paying any remuneration, directly or indirectly, overtly or covertly,

in cash or in kind, in return for a referral (or to induce a referral) for any item or service that is paid by any federal or state health care program. The Anti-Kickback Law applies to many common health care transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, medical director agreements, physician recruitment agreements, physician office leases and other transactions. The ACA amended the Anti-Kickback Law to provide that a claim that includes items or services resulting from a violation of the Anti-Kickback Law now constitutes a false or fraudulent claim for purposes of the FCA.

Violation or alleged violation of the Anti-Kickback Law most often results in settlements that require multi-million dollar payments and mandatory compliance agreements that typically include costly audit requirements. The Anti-Kickback Law can be prosecuted either criminally or civilly. Violation is a felony, subject to a fine of up to $25,000 for each act (which may be each item or each bill sent to a federal program), imprisonment and exclusion from the Medicare and Medicaid programs. In addition, civil monetary penalties of $10,000 per item or service in noncompliance (which may be each item or each bill sent to a federal program) or an "assessment" of three times the amount claimed may be imposed. The IRS has taken the position that hospitals which are in violation of Anti-Kickback Law may also be subject to revocation of their tax-exempt status.

Stark Referral Law. The federal "Stark" statute prohibits the referral by a physician of Medicare and Medicaid patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and radiation and other imaging services) to entities with which the referring physician has a direct or indirect financial relationship. It also prohibits a hospital furnishing the designated services from billing Medicare, or any other payor or individual, for services performed pursuant to a prohibited referral. The government does not need to prove that the entity knew that the referral was prohibited to establish a Stark violation. If certain substantive and technical requirements are not met, many ordinary business practices and economically desirable arrangements between hospitals and physicians will likely constitute "financial relationships" within the meaning of the Stark statute, thus triggering the prohibition on referrals and billing. Most providers of designated health services with physician relationships have some exposure to liability under the Stark statute.

Medicare may deny payment for all services related to a prohibited referral, and a hospital that has billed for prohibited services is obligated to notify and refund the amounts collected from the Medicare program. For example, if an office lease between a hospital and a large group of heart surgeons is found to violate Stark, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease; a potentially significant amount. The government may also seek substantial civil monetary penalties, and in some cases, a hospital may be liable for fines up to three times the amount of any monetary penalty, and be excluded from the Medicare and Medicaid programs. Potential repayments to CMS, settlements, fines or exclusion for a Stark violation or alleged violation could have a material adverse impact on a hospital.

Civil Monetary Penalties Law. The federal Civil Monetary Penalties Law ("CMPL") provides for administrative sanctions, including civil money penalties and treble damages, against health care providers for a broad range of billing and other financial abuses. For example, a health care provider is liable under the CMPL if it knowingly presents, or causes to be presented, improper claims for reimbursement under Medicare, Medicaid and other federal health care programs or if it gives benefits or other inducements to Medicare or Medicaid beneficiaries that the provider knows or should know are likely to induce the beneficiaries to choose the provider for their care. In addition, a hospital that participates in arrangements (known as "gainsharing") under which a physician is paid to limit or reduce services to Medicare fee-for-service beneficiaries would be subject to CMPL penalties. The ACA added new exceptions to the CMPL permitting, among other things, arrangements that promote access to care and pose a low risk of harm to patients and the federal health care programs.

Health care providers may be found liable under the CMPL even when they did not have actual knowledge of the impropriety of their action. It is sufficient to knowingly undertake the action. Ignorance of the CMPL is no defense. The imposition of civil money penalties on a health care provider could have a material adverse impact on the provider's financial condition.

OIG Compliance Guidance. The OIG has encouraged all health care providers to adopt and implement programs to promote compliance with federal and state laws, including the False Claims Acts, the Anti-Kickback Law and the Stark Law. The OIG's Compliance Program Guidance ("CPG") and Supplemental Compliance Program Guidance provide recommendations to hospitals for adopting and implementing effective programs to promote compliance with applicable federal and state law and health plan program requirements. The CPG also discusses significant risk areas for hospitals. The ACA requires the establishment of a compliance program as a condition of enrollment under the Medicare and Medicaid programs. In implementing the ACA, the OIG solicited comments from the industry regarding the core elements of industry-specific compliance programs and is expected to do further rulemaking on compliance plan requirements. The OIG will consider the existence of an effective compliance program that pre-dated any governmental investigation when addressing the appropriateness of administrative penalties. However, the presence of a compliance program is not an assurance that a health care provider will not be investigated by one or more federal or state agencies that enforce health care fraud and abuse laws or that it will not be required to make repayments to various health care insurers (including the Medicare and/or Medicaid programs). Hospitals are also required to create a Medicaid Compliance Plan and to educate staff, agents and contractors about state and federal anti-fraud and abuse laws.

State "Fraud" and "False Claims" Laws. Health care providers are also subject to state laws related to false claims (similar to the FCA or that are generally applicable false claims laws), anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback or fraud laws), and physician referral (similar to Stark). These prohibitions while similar in public policy and scope to the federal laws have not in all instances been avidly enforced to date. However, in the future they could pose the possibility of a material adverse impact on a hospital for the same reasons as the federal statutes. See "—False Claims Act," "—Anti-Kickback Law" and "—Stark Referral Law" above.

Antitrust. Antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, as well as other areas of activity. The application of the federal and state antitrust laws to health care is evolving (especially as the ACA is implemented), and therefore not always clear. Currently, the most common areas of potential liability are joint action among providers with respect to payor contracting and medical staff credentialing disputes. From time to time, the Obligated Group is or may be involved with all of these types of activities, and the Obligated Group cannot predict when or to what extent liability, if any, may arise. Liability in any of these or other trade regulation areas may be substantial, depending upon the facts and circumstances of each case.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") adds additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds, or other assets of a health care benefit program. A health care provider convicted of health care fraud could be subject to mandatory exclusion from Medicare.

HIPAA addresses the confidentiality of individuals' health information. Disclosure of certain broadly defined, protected health information is prohibited unless expressly permitted under the provisions of HIPAA and applicable regulations or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability.

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. The penalties range from $50,000 to $250,000 and/or imprisonment for up to 10 years if the information was obtained or used with the intent to sell, transfer or use for commercial advantage, personal gain or malicious harm.

The Recovery Act includes broad, sweeping changes to the HIPAA provisions regarding confidentiality of patient medical records. In general, the Recovery Act increases penalties for violations of patient medical record confidentiality and strengthens enforcement and oversight.

The HITECH Act. Provisions in the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the Recovery Act, increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable health information, and (iv) restricts covered entities' marketing communications.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for demonstrating the "meaningful use" of certified electronic health record ("EHR") technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by CMS for using health information technology and by reporting on specified clinical quality measures. Beginning in 2015, hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced.

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

International Classification of Diseases, 10th Revision Coding System. In 2009, CMS published the final rule adopting the International Classification of Disease, 10th Revision coding system ("ICD-10"). ICD-10 provides a common approach to the classification of diseases and other health problems, allowing the United States to align with other nations to better share medical information, diagnosis, and treatment codes. In order to implement the ICD-10, staff will need to be retrained, processes redesigned,

and computer applications modified as the current available codes and digit size will dramatically increase. Additionally, there is a potential for temporary coding and payment backlog, as well as potential increases in claims errors. Products and services will be developed by outside software vendors, clearinghouses and third-party billing companies to support and enable timely, complete and successful implementation of ICD-10. Health care organizations were required to implement ICD-10 no later than October 1, 2015.

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

Enforcement Affecting Academic Research. In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also stepped up enforcement of laws and regulations governing the conduct of clinical trials at hospitals. DHHS elevated and strengthened its Office of Human Research Protection, one of the agencies with responsibility for monitoring federally funded research. In addition, the National Institutes of Health ("NIH") significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. Moreover, the OIG has included several enforcement initiatives related to reimbursement for experimental drugs and devices (including kickback concerns) and has issued compliance program guidance directed at recipients of extramural research awards from the NIH and other agencies of the U.S. Public Health Service. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs, and errors in billing of the Medicare program for care provided to patients enrolled in clinical trials that is not eligible for Medicare reimbursement can subject hospitals to sanctions as well as repayment obligations.

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

Compliance with Conditions of Participation. CMS, in its role of monitoring participating providers' compliance with conditions of participation in the Medicare program, may determine that a provider is not in compliance with its conditions of participation. In that event, a notice of termination of participation may be issued or other sanctions potentially could be imposed.

EMTALA. The Emergency Medical Treatment and Active Labor Act ("EMTALA") is a federal civil statute that requires hospitals to treat or conduct a medical screening for emergency conditions and to stabilize a patient's emergency medical condition before releasing, discharging or transferring the patient. A hospital that violates EMTALA is subject to civil penalties of up to $50,000 per offense and exclusion from the Medicare and Medicaid programs. In addition, the hospital may be liable for any claim by an individual who has suffered harm as a result of a violation.

Licensing, Surveys, Investigations and Audits. Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses or accreditations could reduce hospital utilization or revenues, or a hospital's ability to operate all or a portion of its facilities.

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

Health facilities may be subject to requirements related to investigating and remedying hazardous substances located on their property, including substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with the environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and increase their cost; may result in legal liability, damages, injunctions or fines; and may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance.

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

Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and similar payments or to recover higher damages, assessments or penalties by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business of a hospital, regardless of outcome.

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

Business Relationships and Other Business Matters

Affiliation, Merger, Acquisition and Divestiture. As part of its ongoing planning and property management functions, the Members of the Obligated Group review the use, compatibility and financial

viability of many of their operations, and from time to time, may pursue changes in the use, or disposition, of their facilities. Likewise, any Member of the Obligated may receive offers from, or conduct discussions with, third parties about the potential acquisition of operations or properties that may become part of one or more of the Members of the Obligated Group in the future, or about the potential sale of some of the operations and properties of the Members of the Obligated Group. Discussions with respect to affiliation, merger, acquisition, disposition, or change of use, including those that may affect the Members of the Obligated Group, are held on an intermittent, and usually confidential, basis. As a result, it is possible that the assets currently owned by the Members of the Obligated Group may change from time to time, subject to the provisions in the financing documents that apply to merger, sale, disposition or purchase of assets. The Members of the Obligated Group evaluate affiliation opportunities as they arise. Any affiliation or other similar transaction would be completed in compliance with the covenants in the Master Indenture.

Integrated Delivery Systems. Health facilities and health care systems often own, control or have affiliations with physician groups and independent practice associations. Generally, the sponsoring health care facility or health care system is the primary capital and funding source for the alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits. As separate operating units, integrated physician practices and medical foundations sometimes operate at a loss and require subsidy from the related hospital or health system.

These types of alliances are likely to become increasingly important to the success of hospitals in the future as a result of changes to the health care delivery and reimbursement systems that are intended to restrain the rate of increases of health care costs, encourage coordinated care, promote collective provider accountability and improve clinical outcomes. The ACA authorizes several alternative payment programs for Medicare that promotes, reward or necessitate integration among hospitals, physicians and other providers.

Whether these programs will achieve their objectives and be expanded or mandated as conditions of Medicare participation cannot be predicted. However, Congress and CMS have clearly emphasized continuing the trend away from the fee-for-service reimbursement model, which began in the 1980's with the introduction of the prospective payment system for inpatient care, and toward an episode-based payment model that rewards use of evidence-based protocols, quality and satisfaction in patient outcomes, efficiency in using resources, and the ability to measure and report clinical performance. This shift is likely to favor integrated delivery systems, which may be better able than stand-alone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. Changes to the reimbursement methods and payment requirements of Medicare, which is the dominant purchaser of medical services, are likely to prompt equivalent changes in the commercial sector, because commercial payors frequently follow Medicare's lead in adopting payment policies.

While payment trends may stimulate the growth of integrated delivery systems, these systems carry with them the potential for legal or regulatory risks. Many of the risks discussed in "—Regulatory Environment" above, may be heightened in an integrated delivery system. The foregoing laws were not designed to accommodate coordinated action among hospitals, physicians and other health care providers to set standards, reduce costs and share savings, among other things. Although CMS and the agencies that enforce these laws are expected to institute new regulatory exceptions, safe harbors or waivers that will enable providers to participate in payment reform programs, there can be no assurance that the regulations will be forthcoming or that any regulations or guidance issued will sufficiently clarify the scope of permissible activity. State law prohibitions, such as the bar on the corporate practice of medicine, or state law requirements, such as insurance laws regarding licensure and minimum financial reserve holdings of risk-bearing organizations, may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems. Tax-exempt hospitals also face the risk in affiliating with for-profit entities that the IRS will determine that compensation practices or business

arrangements result in private benefit or private use or generate unrelated business income for the hospitals.

In addition, integrated delivery systems present business challenges and risks. Inability to attract or retain participating physicians may negatively affect managed care, contracting and utilization. The technological and administrative infrastructure necessary both to develop and operate integrated delivery systems and to implement new payment arrangements in response to changes in Medicare and other payor reimbursement is costly. Hospitals may not achieve savings sufficient to offset the substantial costs of creating and maintaining this infrastructure.

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

Physician Supply. Sufficient community-based physician supply is important to hospitals. CMS annually reviews overall physician reimbursement formulas for Medicare and Medicaid. Changes to physician compensation under these programs could lead to physicians ceasing to accept Medicare or Medicaid patients. Regional differences in reimbursement by commercial and governmental payors, along with variations in the costs of living, may cause physicians to avoid locating their practices in communities with low reimbursement or high living costs. Hospitals may be required to invest additional resources in recruiting and retaining physicians, or may be compelled to affiliate with, and provide support to, physicians in order to continue serving the growing population base and maintain market share.

Competition Among Health Care Providers. Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, HMOs, inpatient and outpatient health care facilities, long-term care and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and revenues of hospitals. Existing and potential competitors may not be subject to various restrictions applicable to hospitals, and competition, in the future, may arise from new sources not currently anticipated or prevalent.

Specialty facilities or ventures that attract an important segment of an existing hospital's admitting specialists and services that generate significant revenue may be particularly damaging. For example, some large hospitals may have significant dependence on heart surgery or orthopedic programs producing revenue streams that cover significant fixed overhead costs. If a significant component of such a hospital's heart surgeons or orthopedists develop their own specialty hospital or surgery center (alone or in conjunction with a growing number of specialty hospital operators and promoters), taking with them their patient base, the hospital could experience a rapid and dramatic decline in net revenues that is not proportionate to the number of patient admissions or patient days lost. It is also possible that the competing specialty entity, as a for-profit venture, would not accept indigent patients or other payors and government programs, leaving low-pay patient populations in the full-service hospital. In certain cases, such an event could be materially adverse to the hospital. A variety of proposals has been advanced recently to permanently prohibit such investments. Nonetheless, specialty hospitals continue to represent a significant competitive challenge for full-service hospitals.

Freestanding ambulatory surgery centers may attract away significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient services, currently among the most profitable for hospitals, may be lost to competitors who can provide these services in an alternative, less

costly setting. Full-service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in a decline in operating income. Competing ambulatory surgery centers, more likely a for-profit business, may not accept indigent patients or low paying programs and would leave these populations to receive services in the full-service hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient health care delivery may reduce utilization and revenues of hospitals in the future or otherwise lead to new avenues of competition. In some cases, hospital investment in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment or clinical practice brought about by new technology or new pharmacology.

Action by Purchasers of Hospital Services and Consumers. Major purchasers of hospital services could take action to restrain hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals' revenues may be negatively affected. In addition, consumers and groups on behalf of consumers are increasing pressure on hospitals and health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

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

Wage and Hour Class Actions and Litigation. Federal law and many states impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years there has been a proliferation of lawsuits over these "wage and hour" issues, often in the form of large, sometimes multi-state, class actions. For large employers, such as hospitals, such class actions can involve multi-million dollar claims, judgments and settlements. A major class action decided or settled adversely to the Obligated Group could have a material adverse impact on its financial condition and results of operations.

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

Health Care Worker Classification. Health care providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent

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

Staffing. From time to time, the health care industry suffers from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care technicians. In addition, aging medical staffs and difficulties in recruiting individuals to the medical profession are predicted to result in physician shortages. A significant factor underlying this trend includes a decrease in the number of persons entering those professions. This is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of hospital-specific shortages. Competition for physicians and other health care professionals, coupled with increased recruiting and retention costs may increase hospital operating costs, possibly significantly. This trend could have a material adverse impact on the financial conditions and results of operations of hospitals. This scarcity may further be intensified if utilization of health care services increases as a consequence of the ACA's expansion of the number of insured consumers.

Professional Liability Claims and General Liability Insurance. In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in health care nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against health care providers. Insurance does not provide coverage for judgments for punitive damages.

Beginning in 2008, CMS refused to reimburse hospitals for medical costs arising from certain "never events," which include specific preventable medical errors. Certain private insurers and HMOs followed suit. DPH has also promulgated regulations concerning "serious reportable events," for more information see "—Health Care Reform—Hospital Acquired Conditions Penalty." The occurrence of "never events" or "serious reportable events" is more likely to be publicized and may negatively affect a hospital's reputation, reducing future utilization and potentially increasing the possibility of liability claims.

Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as an employer or as a result of medical staff or provider network peer review or the denial of medical staff or provider network privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims or business disputes are not covered by insurance or other sources and may, in whole or in part, be a liability of the Obligated Group if determined or settled adversely.

Professional malpractice litigation insurance assessments and premiums paid by the Obligated Group could increase. The Hospitals are members of VMC Indemnity Company, Ltd., a captive insurer formed by the Corporation to insure against medical malpractice claims. See "Appendix A – ADDITIONAL INFORMATION – Insurance."

Information Technology. The ability to adequately price and bill health care services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. An ongoing commitment of significant resources is required to maintain, protect and enhance existing information systems and to develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future.

Electronic media are also increasingly being used in clinical operations, including the conversion from paper to electronic medical records, computerization of order entry functions and the implementation of clinical decision-support software. The reliance on information technology for these purposes imposes new expectations on physicians and other workforce members to be adept in using and managing electronic systems. It also introduces risks related to patient safety, and to the privacy, accessibility and preservation of health information. See "—Regulatory Environment—HIPAA" above. Technology malfunctions or failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information, as well as in disputes with patients, physicians and other health care professionals. Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by health care providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on hospitals and health care providers.

Cybersecurity Risks. Despite the implementation of network security measures by the Obligated Group, its information technology systems may be vulnerable to breaches, hacker attacks, computer viruses, physical or electronic break-ins and other similar events or issues. Such events or issues could lead to the inadvertent disclosure of protected health information or other confidential information or could have an adverse effect on the ability of the Obligated Group to provide health care services.

Tax-Exempt Status and Other Tax Matters

Maintenance of the Tax-Exempt Status of Benefiting Affiliates. The tax-exempt status of the Series 2016A Bonds depends upon maintenance by each Member of the Obligated Group of its status as an organization described in Section 501(c)(3) of the Code. The maintenance of that status is contingent on compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and other permissible purposes and their avoidance of transactions that may cause their earnings or assets to inure to the benefit of private individuals. As these general principles were developed primarily for public charities that do not conduct large-scale technical operations and business activities, they often do not adequately address the myriad operations and transactions entered into by a modern health care organization. Although traditional activities of health care providers, such as medical office building leases, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities or categories of activities have not been fully addressed in any official opinion, interpretation or policy of the IRS.

The ACA also contains new requirements for tax-exempt hospitals. Under the ACA, each tax-exempt hospital facility is required to (i) conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the identified community needs, (ii) adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment without discrimination, (iii) limit charges to individuals who qualify for financial assistance under the tax-exempt hospital's financial assistance policy to no more than the amounts generally billed to individuals who have insurance covering that care and refrain from using "gross charges" when billing those individuals, and (iv) refrain from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under the tax-exempt hospital's financial assistance policy. In addition, the Treasury Department is required to review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

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

If the IRS were to find that a Member of the Obligated Group has participated in activities in violation of certain regulations or rulings, the tax-exempt status of that Member of the Obligated Group could be jeopardized. Although the IRS has not frequently revoked the 501(c) (3) tax-exempt status of nonprofit health care corporations, it could do so in the future. Loss of tax-exempt status by a Member of the Obligated Group potentially could result in loss of tax exemption of the Series 2016A Bonds and of other tax-exempt debt issued for the benefit of the Obligated Group and defaults in covenants regarding the Series 2016A Bonds and other related tax-exempt debt and obligations likely would be triggered. Loss of tax-exempt status also could result in substantial tax liabilities on the Obligated Group's income. For these reasons, loss of tax-exempt status of a Member of the Obligated Group could have a material adverse effect on the financial condition of the Obligated Group.

In some cases, the IRS has imposed substantial monetary penalties on tax-exempt hospitals in lieu of revoking their tax-exempt status. In those cases, the IRS and the tax- exempt hospitals entered into settlement agreements requiring the hospital to make substantial payments to the IRS.

In lieu of revocation of tax-exempt status, the IRS may impose penalty excise taxes on certain "excess benefit transactions" involving 501(c)(3) organizations and "disqualified persons." An excess benefit transaction is one in which a disqualified person or entity receives more than fair market value from the exempt organization, pays the exempt organization less than fair market value for property or services, or shares the net revenues of the tax-exempt entity. A disqualified person is a person (an individual or an entity) who is in a position to exercise substantial influence over the affairs of the exempt organization during the five years preceding an excess benefit transaction. The statute imposes excise taxes on the disqualified person and any "organization manager" who knowingly participates in an excess benefit transaction. These rules do not penalize the exempt organization itself, so there would be no direct impact on the Obligated Group or the tax status of the Series 2016A Bonds if an excess benefit transaction were subject to IRS enforcement, pursuant to these "intermediate sanctions" rules.

Real Property Tax Exemption. State, county and local taxing authorities undertake audits and reviews of the operations of tax-exempt health care providers with respect to their real property tax exemptions. In some cases, particularly where authorities are dissatisfied with the level of charitable activity provided by a nonprofit organization, the real property tax-exempt status of the health care providers has been questioned. The majority of the Obligated Group's real property is currently treated as exempt from real property taxation. Although the Obligated Group's real property tax exemptions with respect to its core hospital facilities have not, to the knowledge of management, been under challenge or investigation, an audit could lead to a challenge that could adversely affect the Obligated Group's real property tax exemptions.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of nonprofit corporations. There can be no assurance that future changes in the laws and regulations of state or local governments will not materially adversely affect the financial condition of the Obligated Group by requiring payment of income, local property or other taxes. See also "—Nonprofit Health Care Environment—IRS Community Benefit Initiative" and "—Challenges to Real Property Tax Exemption" above.

Maintenance of Tax-Exempt Status of Interest on the Series 2016A Bonds. The Code imposes a number of requirements that must be satisfied for interest on state and local obligations, such as the Series 2016A Bonds, to be excludable from gross income for federal income tax purposes. These requirements include limitations on the use of bond proceeds, limitations on the investment earnings of bond proceeds

prior to expenditure, a requirement that certain investment earnings on bond proceeds be paid periodically to the United States Treasury, and a requirement that issuers file an information report with the IRS. The Obligated Group has covenanted in certain of the documents referred to herein that it will comply with such requirements. Future failure by the Obligated Group to comply with the requirements stated in the Code and related regulations, rulings and policies may result in the treatment of interest on the Series 2016A Bonds as taxable, retroactively to the date of issuance.

IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds, including the use of bond proceeds, in the charitable organization sector, with specific reviews of private use.

In addition, under its compliance check program initiated in 2007, the IRS has from time to time sent post-issuance compliance questionnaires to several hundred nonprofit corporations that have borrowed on a tax-exempt basis regarding their post-issuance compliance with various requirements for maintaining the federal tax exemption of interest on their bonds. The questionnaire includes questions relating to the borrower's (i) record retention, which the IRS has particularly emphasized, (ii) qualified use of bond-financed property, (iii) arbitrage yield restriction and rebate requirements, (iv) debt management policies, and (v) voluntary compliance and education. IRS representatives indicate that questionnaires will be sent to additional nonprofit organizations.

Effective with the 2009 tax year, tax-exempt organizations must also complete new schedules to IRS Form 990-Return of Organizations Exempt From Income Tax, which create additional reporting responsibilities. On Schedule H, hospitals and health systems must report how they provide community benefit and specify certain billing and collection practices. Schedule K requires detailed information related to all outstanding bond issues of tax-exempt borrowers, including information regarding operating, management and research contracts as well as private use compliance. Tax-exempt organizations must also complete Schedule J, which requires reporting of compensation information for the organizations' officers, directors, trustees, key employees, and other highly compensated employees.

There can be no assurance that responses by the Obligated Group to a questionnaire or Form 990 will not lead to an IRS review that could adversely affect the market value of the Series 2016A Bonds or of other outstanding tax-exempt indebtedness issued for the benefit of the Obligated Group. Additionally, the Series 2016A Bonds or such other tax-exempt obligations may, from time to time, be subject to examinations or audits by the IRS.

Management of the Obligated Group believes that the Series 2016A Bonds properly comply with the tax laws. In addition, Bond Counsel will render an opinion with respect to the tax-exempt status of the Series 2016A Bonds, as described under the caption "—Tax-Exempt Status and Other Tax Matters" herein. No ruling with respect to the Series 2016A Bonds has been or will be sought from the IRS, however, and the opinions of counsel are not binding on the IRS or the courts. There can be no assurance that an examination of the Series 2016A Bonds will not adversely affect the Series 2016A Bonds or the market value of the Series 2016A Bonds. See "—Tax-Exempt Status and Other Tax Matters" herein.

Proposed Legislation Regarding Limitations or Elimination of Tax-Exempt Status of Interest on the Series 2016A Bonds. Tax legislation (either proposed or future), administrative actions taken by tax authorities, or court decisions, whether at the federal or state level, may adversely affect the tax-exempt status of interest on the Series 2016A Bonds under federal or state law or otherwise prevent beneficial owners of the Series 2016A Bonds from realizing the full current benefit of the tax status of such interest and could affect the market prices or marketability of the Series 2016A Bonds.

Prospective investors should consult with their tax advisors on the foregoing matters as they consider an investment in the Series 2016A Bonds.

Limitations on Contractual and Other Arrangements Imposed by the Internal Revenue Code. As a tax-exempt organization, each Member of the Obligated Group is limited with respect to its use of practice income guarantees, reduced rent on medical office space, low interest loans, joint venture programs and other means of recruiting and retaining physicians. Uncertainty in this area has been reduced somewhat by the issuance by the IRS of guidelines on permissible physician recruitment practices. The IRS scrutinizes a broad variety of contractual relationships commonly entered into by hospitals and has issued a detailed audit guide suggesting that field agents scrutinize numerous activities of the hospitals in an effort to determine whether any action should be taken with respect to limitations on or revocation of their tax-exempt status or assessment of additional tax. Any suspension, limitation, or revocation of a Member of the Obligated Group's tax-exempt status or assessment of significant tax liability would have a materially adverse effect on the Obligated Group and might lead to loss of tax exemption of interest on the Series 2016A Bonds.

New York and Vermont Regulatory Environment

Vermont has a CON law that requires review and approval of capital expenditures by hospitals in excess of $3 million, new equipment purchases in excess of $1 million, and any new health care service with annual operating costs in excess of $500,000. Vermont also requires annual review and approval of hospital budgets. The primary regulatory body since 2011 has been the Green Mountain Care Board, a five-member independent body appointed by the Governor. The Green Mountain Care Board has used its hospital budget approval authority as one of its key tools to contain the growth of health care costs, including capping the growth in hospitals' net patient revenues at 3.7 percent in 2015. The Green Mountain Care Board is currently in discussions with the U.S. Centers for Medicare and Medicaid Services ("CMS") for an "all-payer waiver" that would create an all-payer system in Vermont. An all-payer system in Vermont would provide the Green Mountain Care Board with oversight over all payers, including Medicare, Medicaid and insurance companies. Although the discussions with CMS are on-going and the Green Mountain Care Board would like to implement an all-payer system by January 1, 2017, the discussions are still preliminary, and whether the Green Mountain Care Board will be able to obtain agreement with CMS or implement an all-payer system and how such a system would impact the Corporation cannot be determined at this time.

The Green Mountain Care Board is also responsible under Act 48 and succeeding legislation for coordinating and implementing payment and delivery system reform. That work has been supported by a State Innovation Model ("SIM") grant of $45 million awarded to Vermont in 2013 by the Center for Medicare and Medicaid Innovation within CMS (now known as the CMS Innovation Center) to test payment reform models, with a particular focus on moving the majority of Vermonters' health care away from fee-for-service payments to value-based payments.

Health care providers and facilities are also highly regulated in New York. Although New York does not require review or approval of hospital operating budgets, it has a CON law that requires review and approval by the New York State Department of Health of new hospital projects and services. The Department of Health also has broad regulatory oversight of hospital operations and services.

Currently, New York is implementing a health reform initiative under a waiver agreement with CMS that will allow the state to reinvest $8 billion of savings generated by the state's Medicaid program with the objectives of preserving access to essential safety-net providers and reducing avoidable hospital admissions through the Delivery System Reform Incentive Payment ("DSRIP") program. To qualify for DSRIP funding, New York hospitals must meet certain eligibility criteria. UVM Health Network's New York affiliated hospitals, CVPH and ECH, both meet these eligibility criteria and are seeking to participate in the DSRIP programs through Adirondack ACO, an accountable care organization established by UVM Health Network, and Adirondack Health Institute, a non-profit organization established by CVPH and other New York providers to engage in population health management initiatives.

Other Risk Factors

Investments. The Obligated Group has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments and those fluctuations may be and historically have been at times material. For a discussion of these investments, see "Appendix B – note 3 to the Consolidated Financial Statements."

Other Future Risks. In the future, the following factors, among others, may adversely affect the operations of health care providers, including the Obligated Group, or the market value of health care revenue bonds, including the Series 2016A Bonds, to an extent that cannot be determined at this time:

(a) Adoption of legislation or implementation of regulations that would modify national or state health programs or that would establish national, statewide or otherwise regulated rates applicable to hospitals and other health care providers;

(b) Reduced demand for the services of the Obligated Group that might result from decreases in population or loss of market share to competitors;

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

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

(e) Cost and availability of any insurance, such as professional liability, fire, automobile and general comprehensive liability coverages, which health care facilities of a similar size and type generally carry;

(f) The occurrence of a natural or man-made disaster, a pandemic or an epidemic that could damage Obligated Group's facilities, interrupt utility service to such facilities, result in an abnormally high demand for health care services or otherwise impair the Obligated Group's operations and the generation of revenues from such facilities. The Obligated Group's facilities are covered by general property insurance in an amount that management considers generally sufficient to provide for the replacement of such facilities in the event of most natural disasters; and

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

(h) The continued ability of VMC Indemnity Company, Ltd. to provide sufficient amounts of general and professional liability coverage to the Corporation. See "Appendix A – ADDITIONAL INFORMATION – Insurance."

TAX EXEMPTION

Opinion of Bond Counsel

In the opinion of Sidley Austin LLP, New York, New York, Bond Counsel, based on current law, and assuming compliance by the Corporation and the Agency with certain requirements of the Internal Revenue Code of 1986, as amended (the "Code"), and covenants of the Trust Agreement and the Loan Agreement regarding the use, expenditure and investment of proceeds of the Series 2016A Bonds and the timely payment of certain investment earnings to the U.S. Treasury, interest on the Series 2016A Bonds is not includable in the gross income of the owners of the Series 2016A Bonds for federal income tax

purposes. The form of the opinion to be delivered by Bond Counsel is set forth in Appendix D to this Official Statement. Failure by the Corporation or the Agency to comply with their respective covenants to comply with the provisions of the Code regarding the use, expenditure and investment of proceeds of the Series 2016A Bonds and the timely payment of certain investment earnings to the Treasury of the United States may cause interest on the Series 2016A Bonds to become included in gross income for federal income tax purposes retroactive to their date of issuance. The covenant of the Agency described above does not require the Agency to make any financial contribution for which it does not receive funds from the Corporation. The opinion with respect to the exclusion from gross income of the interest on the Series 2016A Bonds for federal income tax purposes may not be relied upon to the extent that such exclusion is adversely affected as a result of any action taken or not taken in reliance upon the opinion or advice of counsel other than Bond Counsel.

Interest on the Series 2016A Bonds will not be treated as an item of tax preference for purposes of the federal individual or corporate alternative minimum tax. The Code contains provisions (some of which are noted below) that could result in tax consequences upon which Sidley Austin LLP renders no opinion as a result of ownership of such Series 2016A Bonds or the inclusion in certain computations (including without limitation, those related to the corporate alternative minimum tax) of interest that is excluded from gross income. Interest on the Series 2016A Bonds owned by a corporation will be included in the calculation of the corporation's federal alternative minimum tax liability.

Bond Counsel's opinion relies upon certain representations made by the Corporation with respect to certain material facts within the knowledge of the Corporation, which facts Bond Counsel has not verified, and upon the opinion of Dinse, Knapp & McAndrew, P.C., Burlington, Vermont, counsel to the Corporation, that the Corporation is an organization described in Section 501(c)(3) of the Code and exempt from tax under Section 501(a) of the Code, or corresponding provisions of prior law and that, to such counsel's knowledge, the Corporation has done nothing to impair such status or cause the use of property financed or refinanced with the proceeds of the Series 2016A Bonds to constitute an unrelated trade or business under Section 513(a) of the Code in excess of any allowable amount permitted under Section 145(a) of the Code. The tax exemption of interest on the Series 2016A Bonds is dependent upon, among other things, the Corporation's status as a "Section 501(c)(3) organization" and, therefore, the conclusion of Bond Counsel that such interest is excludable from gross income for federal income tax purposes is dependent, in part, upon such opinion of Dinse, Knapp & McAndrew, P.C.

Original Issue Discount

The excess, if any, of the amount payable at maturity of any maturity of the Series 2016A Bonds purchased as part of the initial public offering over the issue price thereof constitutes original issue discount. The amount of original issue discount that has accrued and is properly allocable to an owner of any maturity of the Series 2016A Bonds with original issue discount (a "Discount Bond") will be excluded from gross income for federal income tax purposes to the same extent as interest on the Series 2016A Bonds. In general, the issue price of a maturity of the Series 2016A Bonds is the first price at which a substantial amount of Series 2016A Bonds of that maturity was sold (excluding sales to bond houses, brokers or similar persons or organizations acting in the capacity of underwriters, placement agents, or wholesalers) and the amount of original issue discount accrues in accordance with a constant yield method based on the compounding of interest. A purchaser's adjusted basis in a Discount Bond is to be increased by the amount of such accruing discount for purposes of determining taxable gain or loss on the sale or other disposition of such Discount Bonds for federal income tax purposes. A portion of the original issue discount that accrues in each year to an owner of a Discount Bond which owner is a corporation will be included in the calculation of the corporation's federal alternative minimum tax liability. In addition, original issue discount that accrues in each year to an owner of a Discount Bond is included in the calculation of the distribution requirements of certain regulated investment companies and may result in some of the collateral federal income tax consequences discussed herein. Consequently, an owner of a Discount Bond should be aware that the accrual of original issue discount in each year may

result in an alternative minimum tax liability, additional distribution requirements or other collateral federal income tax consequences although the owner of such Discount Bond has not received cash attributable to such original issue discount in such year.

The accrual of original issue discount and its effect on the redemption, sale or other disposition of a Discount Bond that is not purchased in the initial offering at the first price at which a substantial amount of such Bond is sold to the public may be determined according to rules that differ from those described above. An owner of a Discount Bond should consult his tax advisors with respect to the determination for federal income tax purposes of the amount of original issue discount with respect to such Discount Bond and with respect to state and local tax consequences of owning and disposing of such Discount Bond.

Bond Premium

The excess, if any, of the tax basis of a maturity of the Series 2016A Bonds purchased as part of the initial public offering to a purchaser (other than a purchaser who holds such Series 2016A Bonds as inventory, stock in trade or for sale to customers in the ordinary course of business) over the amount payable at maturity is "bond premium." Bond premium is amortized over the respective terms of the Series 2016A Bonds with bond premium (the "Premium Bonds") for federal income tax purposes (or, in the case of a Series 2016A Bond with bond premium callable prior to its stated maturity, the amortization period and yield may be required to be determined on the basis of an earlier call date that results in the lowest yield on such Series 2016A Bond). Owners of the Premium Bonds are required to decrease their adjusted basis in such Premium Bonds by the amount of amortizable bond premium attributable to each taxable year such Premium Bonds are held. The amortizable bond premium attributable to a taxable year is not deductible for federal income tax purposes; however, bond premium is treated as an offset to qualified stated interest received on such Premium Bonds. Owners of the Premium Bonds should consult their tax advisors with respect to the determination for federal income tax purposes of the treatment of bond premium upon sale or other disposition of Premium Bonds and with respect to the state and local tax consequences of owning and disposing of Premium Bonds.

Backup Withholding

Interest paid on tax-exempt obligations will be subject to information reporting in a manner similar to interest paid on taxable obligations. Although such reporting requirement does not, in and of itself, affect the excludability of interest on the Series 2016A Bonds from gross income for federal income tax purposes, such reporting requirement causes the payment of interest on the Series 2016A Bonds to be subject to backup withholding if such interest is paid to beneficial owners who (a) are not "exempt recipients," and (b) either fail to provide certain identifying information (such as the beneficial owner's taxpayer identification number) in the required manner or have been identified by the IRS as having failed to report all interest and dividends required to be shown on their income tax returns. Generally, individuals are not exempt recipients, whereas corporations and certain other entities generally are exempt recipients. Amounts withheld under the backup withholding rules from a payment to a beneficial owner would be allowed as a refund or a credit against such beneficial owner's federal income tax liability provided the required information is furnished to the IRS.

Other Tax Consequences

Ownership of tax-exempt obligations may result in collateral federal income tax consequences to certain taxpayers, including, without limitation, financial institutions, property and casualty insurance companies, certain foreign corporations doing business in the United States, certain S Corporations with excess passive income, individual recipients of Social Security or Railroad Retirement benefits, taxpayers who may be deemed to have incurred or continued indebtedness to purchase or carry tax-exempt obligations, and taxpayers who may be eligible for the earned income credit. Prospective purchasers of

the Series 2016A Bonds should consult their tax advisors as to the applicability of any such collateral consequences.

The Act provides that the bonds of the Agency, including the Series 2016A Bonds, and the income therefrom shall at all times be exempt from taxation in the State of Vermont, except for transfer and estate taxes.

Future Developments

Future or pending legislative proposals, if enacted, regulations, rulings or court decisions may cause interest on the Series 2016A Bonds to be subject, directly or indirectly, to federal income taxation or to be subject, directly or indirectly, to State or local income taxation, or otherwise prevent beneficial owners from realizing the full current benefit of the tax status of such interest. Legislative or regulatory actions and future or pending proposals may also affect the economic value of the federal or state tax exemption or the market value of the Series 2016A Bonds. Prospective purchasers of the Series 2016A Bonds should consult their tax advisors regarding any future, pending or proposed federal or state tax legislation, regulations, rulings or litigation, as to which Bond Counsel expresses no opinion.

For example, various proposals have been made in Congress and by the President that would subject interest on bonds that is otherwise excludable from gross income for federal income tax purposes, including interest on the Series 2016A Bonds, to federal income tax payable by certain bondholders with adjusted gross income in excess of specified thresholds. Prospective purchasers should consult their tax advisors as to the effect of such proposals on their individual situations.

LEGALITY OF SERIES 2016A BONDS FOR INVESTMENT AND DEPOSIT

The Act provides that the bonds of the Agency, including the Series 2016A Bonds, are securities in which all public officers and bodies of the State and all municipalities and municipal subdivisions, all insurance companies and associations, all savings banks and savings institutions, including savings and loan associations, administrators, guardians, executors, trustees, committees and other fiduciaries in the State may properly and legally invest funds in their control.

NEGOTIABLE INSTRUMENTS

Pursuant to the Act, the Series 2016A Bonds are negotiable instruments, subject only to the provisions for registration of the Series 2016A Bonds.

STATE OF VERMONT NOT LIABLE ON SERIES 2016A BONDS

The State is not liable for the payment of the principal of or interest on the Series 2016A Bonds, or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the Agency, and none of the Series 2016A Bonds nor any of the Agency's agreements or obligations shall be construed to constitute an indebtedness of the State within the meaning of any constitutional or statutory provisions whatsoever, nor shall the Series 2016A Bonds directly or indirectly or continently obligate the State or any municipality or political subdivision thereof to levy or to pledge any form of taxation whatsoever therefor or to make any appropriation for their payment.

PLEDGE OF STATE NOT TO AFFECT RIGHTS OF BONDHOLDERS

Under the Act, the State does pledge to and agree with the holders of the Series 2016A Bonds that the State will not limit or alter the rights vested in the Agency until the Series 2016A Bonds, together with interest thereon, with interest on any unpaid installment of interest, and all costs and expenses incurred by the Agency in connection with the facilities or in connection with any action or proceedings by or on behalf of the bondholders, are fully met and discharged.

LEGAL MATTERS

The Series 2016A Bonds and the proceedings pursuant to which they are issued are subject to the approving opinion as to legality, validity and tax status of Sidley Austin LLP, New York, New York, Bond Counsel. The proposed form of the opinion of Bond Counsel is attached hereto as Appendix D. Certain legal matters pertaining to the Corporation will be passed upon by its counsel, Dinse, Knapp & McAndrew, P.C. Certain legal matters pertaining to the Agency will be passed upon by its counsel, Deppman & Foley, P.C. Certain legal matters will be passed upon for the Underwriter by its counsel, Ropes & Gray, LLP, Boston, Massachusetts.

FINANCIAL ADVISORS

The firm of Public Financial Management, Inc. has been retained by the Agency as its financial advisor in connection with the issuance of the Series 2016A Bonds.

Ponder & Co. ("Ponder") is serving as financial advisor to UVM Health Network, including the Corporation, CVMC and other affiliates, in connection with the issuance of the Series 2016A Bonds. Ponder is not obligated to undertake, and has not undertaken, either to make an independent verification of or to assume responsibility for, the accuracy, completeness or fairness of the information contained in this Preliminary Official Statement. Ponder is an independent financial advisory firm and is not engaged in the business of underwriting, trading or distributing securities.

LITIGATION

The Agency

There is not now pending any litigation against the Agency restraining or enjoining the issuance or delivery of the Series 2016A Bonds or questioning or affecting the validity of the Series 2016A Bonds or the proceedings and authority under which they are to be issued. Neither the creation, organization or existence of the Agency, nor the title of the present members or other officers of the Agency to their respective offices is being contested. There is no litigation pending which in any manner questions the right of the Agency to make the loan to the Corporation in accordance with the provisions of the Act, the Trust Agreement and the Loan Agreement.

The Obligated Group

There is not now pending any litigation contesting the plan of financing or the ability of any Member of the Obligated Group to enter into and perform its obligations under the Loan Agreement or the ability of each of UVM Health Network, the Corporation and CVMC to enter into and perform its obligations under the Master Indenture or to issue Obligation No. 21. No litigation or proceedings are pending or, to the knowledge of any Member of the Obligated Group, threatened against any Member of the Obligated Group except (a) litigation and proceedings involving claims for hospital professional liability in which the probable recoveries and estimated costs and expenses of defense will be entirely within the applicable insurance policy limits (subject to applicable deductibles) for the Corporation and (b) litigation and proceedings other than those described in (a) which if adversely determined would not materially adversely affect the financial condition or results of operations of any Member of the Obligated Group.

INDEPENDENT ACCOUNTANTS

The consolidated financial statements of The University of Vermont Health Network, Inc. and Subsidiaries (formerly known as Fletcher Allen Partners, Inc. and Subsidiaries) as of September 30, 2015 and 2014 and for the years then ended, included in Appendix B to this Official Statement, have been

audited by PricewaterhouseCoopers LLP, independent accountants, as stated in their report appearing in Appendix B herein.

UNDERWRITING

Under the bond purchase contract entered into between the Agency and Citigroup Global Markets Inc. (the "Underwriter"), and approved by the Corporation, the Series 2016A Bonds are being purchased at an aggregate purchase price equal to $ 202,596,511.88 (representing the principal amount of the Series 2016A Bonds, plus a net original issue premium of $27,456,137.20 and less an Underwriter's discount of $1,234,625.32). The bond purchase contract provides that the Underwriter will purchase all of the Series 2016A Bonds, if any are purchased. The obligation of the Underwriter to accept delivery of the Series 2016A Bonds is subject to various conditions contained in the bond purchase contract.

The Underwriter intends to offer the Series 2016A Bonds to the public initially at the offering prices set forth on the inside cover page of this Official Statement, which prices may subsequently change without any requirement of prior notice. The Underwriter reserves the right to join with dealers and other underwriters in offering the Series 2016A Bonds to the public. The Underwriter may offer and sell Series 2016A Bonds to certain dealers (including dealers depositing Series 2016A Bonds into investment trusts) at prices lower than the public offering price.

Each Member of the Obligated Group has agreed to indemnify the Underwriter and the Agency and any person who controls any Underwriter or the Agency and any member, officer, official or employee, agent or attorney (including Bond Counsel) of any Underwriter or the Agency against certain liabilities arising out of certain incorrect information contained in or omitted from this Official Statement.

The Underwriter and its 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 Underwriter and its affiliates have, from time to time, performed, and may in the future perform, various investment banking services for the Agency for which they received or will receive customary fees and expenses.

In the ordinary course of their various business activities, the Underwriter and its 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 Agency and the Members of the Obligated Group.

The Underwriter has entered into a retail distribution agreement with each of TMC Bonds L.L.C. ("TMC") and UBS Financial Services Inc. ("UBSFS"). Under these distribution agreements, the Underwriter may distribute municipal securities to retail investors through the financial advisor network of UBSFS and the electronic primary offering platform of TMC. As part of this arrangement, the Underwriter may compensate TMC (and TMC may compensate its electronic platform member firms) and UBSFS for their selling efforts with respect to the Bonds.

RATINGS

Standard & Poor's Ratings Services, a Standard & Poor's Financial Services LLC company ("S&P"), Moody's Investors Service ("Moody's") and Fitch Ratings ("Fitch") have assigned their municipal bond ratings of A-, A3 and A- respectively, to the Series 2016A Bonds. A securities rating is not a recommendation to buy, sell or hold securities and may be subject to revision or withdrawal at any time. Such ratings reflect only the view of such organizations and an explanation of the significance of

such ratings may only be obtained from such rating agencies. There is no assurance such ratings will continue for any given period of time or that such ratings will not be revised downward or withdrawn entirely by the rating agency providing the same, if in the judgment of such rating agency, circumstances so warrant. Any such downward revision or withdrawal of any such rating may have an adverse effect on the market price of the Series 2016A Bonds.

VERIFICATION OF MATHEMATICAL CALCULATIONS

The arithmetical accuracy of certain computations included in the schedules provided by the Obligated Group relating to (a) computation of anticipated receipts of principal and interest on Defeasance Obligations and any initial cash deposit and the anticipated payments of principal and interest to redeem the Refunded Bonds, and (b) computation of the yields on the Series 2016A Bonds and the Defeasance Obligations was verified by Causey Demgen & Moore P.C. (the "Verification Agent"). Such computations were based solely upon information supplied by the Obligated Group. The Verification Agent has restricted its procedures to verifying the arithmetical accuracy of certain computations and has not made any study or evaluation of the information upon which the computations are based and, accordingly, has not expressed an opinion on the data used, the reasonableness of the assumptions reflected in its report, or the achievability of future events.

CONTINUING DISCLOSURE

The Obligated Group has covenanted in the Loan Agreement for the benefit of holders and beneficial owners of the Series 2016A Bonds to provide certain financial, operating and statistical data relating to the Obligated Group (the "Annual Report") not later than 180 days after the end of its fiscal year, to provide its unaudited quarterly financial statements not later than 60 days after the end of each of the quarters of each of its fiscal years, and to provide to notices of the occurrence of certain enumerated events. The Annual Reports and the notices of enumerated events will be filed by or on behalf of the Obligated Group with the Municipal Securities Rulemaking Board, through its Electronic Municipal Market Access System ("EMMA"). These covenants have been made in order to assist the Underwriter in complying with Securities and Exchange Commission Rule 15c2-12(b)(5) (the "Rule") Failure to comply with these covenants is not an event of default under the Loan Agreement and will not result in acceleration of the Series 2016A Bonds. See "SUMMARY OF THE LOAN AGREEMENT — Secondary Market Disclosure" in Appendix C to this Official Statement.

In the past five years, each Member of the Obligated Group has complied in all material respects with its previous undertakings to provide continuing disclosure in connection with the Rule. While the Obligated Group timely filed its annual reports, the annual reports for 2012–2014 did not contain certain utilization and physician activity information, and the annual reports for 2010–2014 did not contain certain physician market share information. The omitted information is unavailable due to the passage of time and changes in record-keeping practices. Additionally, in five instances, the Obligated Group did not timely file notices relating to changes in the ratings of bond insurers, which rating change notices have since been filed with EMMA.

MISCELLANEOUS

Reference is hereby made to Appendix C to this Official Statement for information relating to the Trust Agreement, the Loan Agreement and the Master Indenture, which Appendix should be reviewed by prospective purchasers of the Series 2016A Bonds.

The Corporation has reviewed the information contained herein which describes it, its respective facilities and business, and the plan of finance and has approved all such information for use within this Official Statement. The Agency has reviewed the information contained herein which relates to it and has

approved such information for use in this Official Statement. Information herein regarding DTC has been provided by DTC.

The references herein to the Act, the Trust Agreement, the Loan Agreement, Obligation No. 21 and the Master Indenture are summaries of certain provisions thereof and do not purport to be complete. Reference is made to such Act and documents for full and complete statements of such and all other provisions thereof. Neither any advertisement for the Series 2016A Bonds nor this Official Statement is to be construed as constituting a contract or agreement between the Agency or any Member of the Obligated Group and purchasers or owners of, or owners of beneficial interests in, the Series 2016A Bonds. So far as any statements are made in this Official Statement involving projections, forecasts, estimates and other statements involving matters of opinion, whether or not expressly so stated, they are intended merely as such and not as representations of fact.

The Corporation has agreed to indemnify the Agency and any person who controls the Agency and any member, officer, official or employee of the Agency against certain liabilities.

The execution and delivery of this Official Statement by the Executive Director of the Agency has been duly authorized by the Agency, and the approval of this Official Statement by the Corporation has been duly authorized by the Corporation.

VERMONT EDUCATIONAL AND HEALTH
BUILDINGS FINANCING AGENCY

By: */s/ Robert Giroux*
Robert Giroux
Executive Director

Approved:

THE UNIVERSITY OF VERMONT MEDICAL CENTER INC.,
as Obligated Group Representative

By: */s/ Todd Keating*
Todd Keating
Authorized Representative

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APPENDIX A

Information Concerning

THE
University of Vermont
HEALTH NETWORK

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INTRODUCTION

The information in this Appendix A is presented in connection with the issuance of the Vermont Educational and Health Buildings Finance Agency's Revenue Bonds, (University of Vermont Medical Center Project) Series 2016A (the "Bonds"). Unless otherwise specified, all financial and statistical data refer to the fiscal year ended September 30 and the source for all information is Network records.

The University of Vermont Health Network Inc. ("UVM Health Network" or the "Network"), a Vermont non-profit corporation, is the parent corporation of a two-state, four-hospital, non-profit integrated health delivery system that serves a population of approximately one million people in Vermont and northeastern New York (the "System"). The System includes: The University of Vermont Medical Center Inc. ("UVM Medical Center"), a Vermont non-profit corporation that owns and operates an academic medical center and the primary teaching hospital affiliated with the College of Medicine of the University of Vermont and State Agricultural College (the "University") (620 licensed beds/447 staffed beds); Central Vermont Medical Center, Inc. ("CVMC"), a Vermont non-profit corporation that owns and operates a community hospital in Berlin, Vermont (122 licensed beds/78 staffed beds); and Community Providers, Inc. ("CPI") the parent corporation of Champlain Valley Physicians' Hospital Medical Center ("CVPH"), a New York non-profit corporation that owns and operates a community hospital in Plattsburgh, New York (300 licensed beds/215 staffed beds), and Elizabethtown Community Hospital ("ECH"), a New York non-profit corporation that owns and operates a critical access hospital in Elizabethtown, New York (25 licensed beds/23 staffed beds). Unless otherwise specified, references to licensed and staffed beds include bassinets.

UVM Health Network's mission is to improve the health of people in the communities it serves by providing the best possible patient care and delivering a consistently high quality patient and family experience across the System, investing in the development of System personnel and partnering with community organizations and other healthcare providers to create social and physician environments that promote health and wellbeing for all. It is committed to the development of an integrated health delivery system that provides high-value health care to the region it serves and enhances its academic mission. The Network's vision is to be a model for the delivery of academic health care in a rural region.

UVM Medical Center has gained a national reputation for its services and in 2015 was ranked 16th overall among university hospitals that participate in the University Health Consortium ("UHC") Quality and Accountability Study, 8th for ambulatory care performance, and 2nd for supply chain performance and its Professional Billing Department was ranked in the top ten of the UHC/Association of American Medical Colleges Faculty Practice Solutions Center survey.

UVM Health Network, UVM Medical Center and CVMC are the current members of the obligated group (the "Obligated Group") established under the Master Trust Indenture dated as of January 1, 1993, as Amended and Restated on March 1, 2004 (the "Master Trust Indenture" and, together with all such supplements and amendments thereto as therein permitted, the "Master Indenture') . Each of UVM Health Network, UVM Medical Center and CVMC are referred to as a "Member of the Obligated Group". All of UVM Medical Center, CVMC, CPI, CVPH and ECH are referred to as an "Affiliate" and collectively as the "Affiliates." The Affiliates that are not Members of the Obligated Group are referred to as "Non-Obligated Affiliates." NEITHER THE ASSETS NOR REVENUES OF CPI, CVPH OR ECH ARE PLEDGED TO SECURE OR AVAILABLE TO MAKE PAYMENTS ON THE BONDS. ADDITIONALLY, THE UNIVERSITY IS NOT LIABLE FOR PAYMENT ON THE BONDS AND NONE OF THE ASSETS OR REVENUES OF THE UNIVERSITY IS PLEDGED TO SECURE OR AVAILABLE TO MAKE PAYMENTS ON THE BONDS.

APPENDIX A

Unless otherwise stated, all references herein to years refer to the fiscal year ending September 30. The Obligated Group had consolidated revenues of $1.318 billion for 2015, and consolidated unrestricted net assets of $718 million as of September 30, 2015, reflecting 80.06% of the System's consolidated revenues of $1.646 billion for 2015 and 90.59% of the System's consolidated net unrestricted assets of $792 million as of September 30, 2015. The Obligated Group had an average total of approximately 7,560 full-time equivalent ("FTE") employees, including 602 FTE of employed physicians, in 2015. The System had a total of approximately 9,548 FTE employees, including 674 FTE employed physicians, in FY 2015.

ORGANIZATIONAL STRUCTURE AND AFFILIATIONS

Corporate Organization

UVM Health Network is the sole corporate member of UVM Medical Center, CVMC, and CPI. CPI is a New York non-profit corporation that is the parent and sole corporate member of CVPH and ECH. UVM Health Network holds reserved powers with respect to UVM Medical Center, CVMC, CPI, CVH and ECH. See "GOVERNANCE AND MANAGEMENT – Reserved Powers," below. UVM Medical Center is also the sole corporate member of The University of Vermont Medical Group Inc. ("UVM Medical Group"), a Vermont non-profit corporation that serves as the clinical practice group for the medical faculty, and with the University, dually employs all the clinical faculty of the University's College of Medicine. See "PHYSICIAN NETWORK – UVM Medical Group," below. UVM Medical Center and the University jointly hold reserved powers with respect to UVM Medical Group.

The Network was organized in 2011 under the name "Fletcher Allen Partners, Inc." to provide a structure for the affiliation of UVM Medical Center (then named "Fletcher Allen Health Care, Inc.") and CVMC. That affiliation became effective on September 30, 2011.

Effective January 1, 2013, CPI and its affiliated New York hospitals (CVPH and ECH) joined the System. A Certificate of Need ("CON") issued by the New York State Department of Health recognizes the Network and CPI as the joint operators of CVPH and ECH. The New York State Department of Health has also determined that CPI, CVPH and ECH may join the Obligated Group in the future without further regulatory approvals. It is anticipated that they will join the Obligated Group in 2016, subject to satisfaction of various administrative requirements.

Effective November 12, 2014, the Network changed its corporate name to "The University of Vermont Health Network Inc." and UVM Medical Center changed its name to "The University of Vermont Medical Center Inc." as part of a system-wide branding program. The University has granted a license to UVM Health Network and its affiliated hospitals, including UVM Medical Center, to use the "University of Vermont" name pursuant to a License Agreement that is part of the Affiliation Agreement described below in "Network Overview - Affiliation with UVM; Education and Research".

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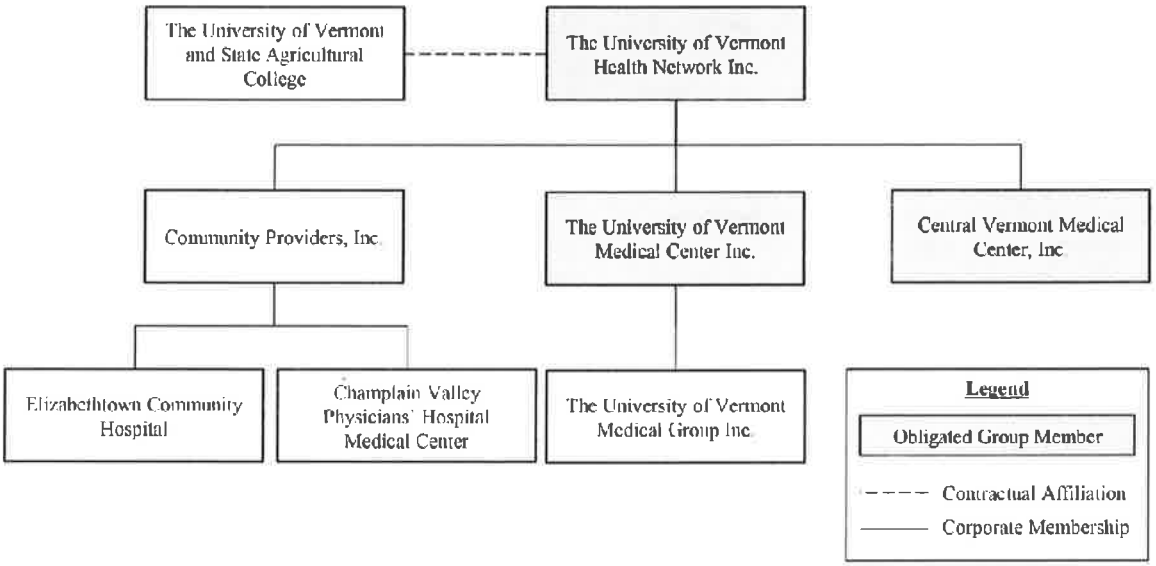
The corporate organization of the System is illustrated by the chart below:

Principal Affiliates of the System
(Members of Obligated Group shaded gray)



This chart does not show affiliates controlled by UVM Medical Center that are separately formed to hold or operate ancillary activites.

System Overview

The four hospitals that comprise the System cover a service area in Vermont and the six northeastern counties of New York as shown below:

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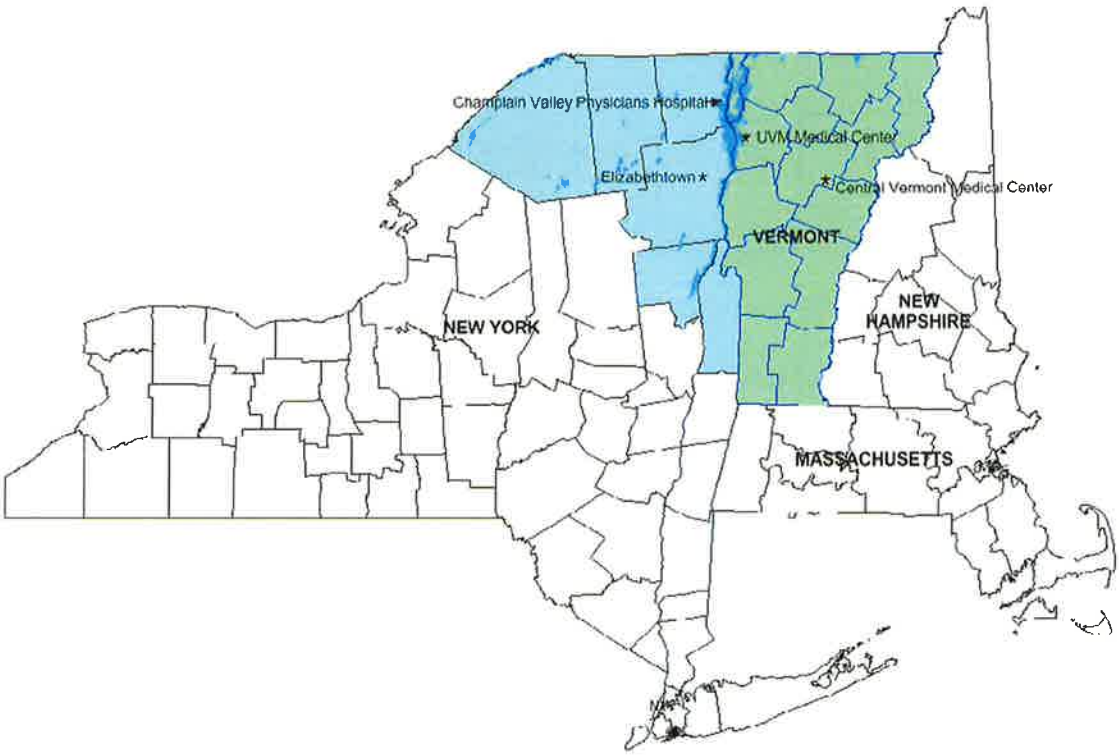
APPENDIX A

System Service Area



UVM Health Network's objective is to provide a highly-integrated, academic health care system that will improve quality, increase efficiencies, lower the costs of health care delivery, improve access to health care services, and advance medical education and research in the broad rural region served by System hospitals. In pursuit of this objective, the Network engages in coordinated regional planning, consistent with the goals of health reform, that seeks to align the missions, clinical services and economic interests of System hospitals and the University's College of Medicine and College of Nursing and Health Sciences.

All System hospitals are licensed by their respective state licensing agencies and are accredited by The Joint Commission. The System provides hospital and physician services that range from routine primary care to highly-specialized tertiary and quaternary services. See "HEALTH CARE SERVICES," below.

Potential Expansion of the System

The Network has signed a membership agreement dated October 7, 2015 with Alice Hyde Medical Center ("Alice Hyde") of Malone, New York, which operates an acute care hospital with 76 licensed beds, of which 42 are typically staffed, and a long-term care facility with 135 skilled nursing beds and 30 assisted living beds. The membership agreement provides for Alice Hyde to become an Affiliate of the Network, subject to receipt of regulatory approvals anticipated during the first quarter of 2016. The Network has also entered into two separate non-binding letters of intent with potential new Affiliates in New York: (i) Moses-Ludington Hospital ("MLH"), a critical access hospital in Ticonderoga, New York, and its parent organization Inter-Lakes Health, Inc. ("ILH") and (ii) St. Lawrence Health System, Inc. ("SLHS") and its affiliated hospitals, Canton-Potsdam Hospital in Potsdam, New York (with 94 licensed beds, and Gouverneur Hospital in Gouverneur, New York (a 25-bed critical access hospital). These two potential affiliations are subject to further review, regulatory approvals and certain other conditions.

In addition, the Network has signed a Collaboration Agreement, dated July 16, 2015 (the "Collaboration Agreement"), with Hudson Headwaters Health Network ("HHHN"), a federally qualified health center with a non-profit system of community health centers in 15 communities spread across six counties in northeastern New York State employing approximately 75 physicians and 80 mid-level providers. The Collaboration Agreement provides for joint planning and co-branding in the development of new primary practice locations and facilities in northeastern New York State, joint recruitment of additional primary care physicians, and the provision of a $750,000 community benefit grant to HHHN by the Network to expand primary care capacity in the region. In connection with the Collaboration Agreement, HHHN also acquired a 50% ownership interest in Adirondacks ACO, LLC ("Adirondacks ACO"), the entity established by UVM Health Network to engage in population health management initiatives in northeastern New York. The other 50% ownership interest is held by CVPH.

The Network continuously evaluates and engages in conversations regarding opportunities for strategic alliances and affiliations with health systems, hospitals, physicians, physician groups and others. Management cannot predict whether or when it will enter into any such affiliation or other transaction.

Affiliation with the University; Education and Research

UVM Medical Center has an affiliation with the University under an Affiliation Agreement dating back to January 1, 1995 (the "Affiliation Agreement"). The Affiliation Agreement was amended and restated as of June 19, 2014 for a five-year term ending June 18, 2019. UVM Medical Center also has related clinical affiliation agreements with the University on behalf of its College of Medicine (the "College of Medicine") and its College of Nursing and Health Sciences. Under these agreements, UVM Medical Center is designated as the primary teaching site for UVM's medical, nursing and allied health students, and UVM Medical Group is designated as the clinical practice organization for faculty of the College of Medicine.

The Affiliation Agreement obligates UVM Medical Center to meet its physician staffing needs through physicians employed by UVM Medical Group and eligible to hold appointments in the College of Medicine, and provides that the chairs of academic departments in the College of Medicine will be appointed by UVM Medical Center as the health care service leaders of the corresponding clinical services at UVM Medical Center. The Affiliation Agreement also expresses the joint commitment of UVM Medical Center and the University to maintain a high-quality academic medical center. Approximately 80% of medical staff members are employed by the UVM Medical Group; the remaining 20% are non-employed community physicians.

Under the Affiliation Agreement, UVM Medical Center agrees to make base annual academic support payments to the University for the benefit of the College of Medicine, which were in the amount of $7.5 million for 2015, increasing by an inflation index in each subsequent year of the Affiliation Agreement. The Affiliation Agreement also provides for percentage increases in the base academic support payment upon the addition of new affiliated hospitals of the System equal to the percentage increase in the Network's net patient revenues, and requires UVM Medical Center to make a supplemental annual payment of $2.0 million each year.

UVM Medical Group is required by its bylaws to operate in accordance with the Affiliation Agreement. See "PHYSICIAN NETWORK – UVM Medical Group." In addition, UVM Medical Center pays an annual dean's tax to the University for the benefit of the College of Medicine in an amount equal to 2.3% of the net patient revenues generated by UVM Medical Group, exclusive of Medicaid revenues. In 2015, the dean's tax payment was $6.1 million. The Agreement recognizes that the dean's tax will increase as physicians affiliated with the System hospitals become employed by UVM Medical Group, and starting in 2015, UVM Medical Center has agreed to a minimum payment of $1.0 million in additional dean's tax regardless of additional net patient revenues attributed to any such increase in employed physicians.

In its role as a teaching hospital, UVM Medical Center helps to train more than 450 medical students from the University's College of Medicine each year across all four years of their medical training. UVM Medical Center also trains 307 residents and fellows in 16 training residencies and 26 fellowship programs accredited annually by the Accreditation Council for Graduate Medical Education and similar bodies. UVM Medical Center professional staff and physicians also provide clinical training for many of the 1,140 students in the University's College of Nursing and Health Sciences, in programs including nursing, physical therapy, athletic training, exercise and movement science, radiation therapy, nuclear medicine technology, communications sciences and disorders and medical laboratory science. In addition, UVM Medical Center sponsors several internship programs that prepare registered nurses to work in adult critical care, operating rooms, and pediatric intensive care units.

The University is Vermont's state university, and is the only comprehensive research university in the state. Together, UVM Medical Center and the College of Medicine and College of Nursing and Health Sciences constitute Vermont's only academic medical center and serve as a biomedical research center, with three federally-funded Centers of Biomedical Research Excellence (behavior and health, lung biology, and immunology and infectious diseases). As part of these research activities, more than 400 UVM Medical Center physicians were active in more than 1,000 clinical research trials across all specialty areas as of January 1, 2016.

In the University's fiscal year which ended on June 30, 2015, the College of Medicine and UVM Medical Center received more than $84 million in external research funding, increasing $3.6 million from the prior fiscal year.

GOVERNANCE AND MANAGEMENT

General

UVM Health Network is governed by a 19-member Board of Trustees (the "Board") with two seats remaining vacant pending further Board action to fill them. Its bylaws designate the following standing committees of the Board: Planning, Investment, Compensation, Finance, Audit, Population Health Management and Quality, Governance and Executive. The members of each standing committee, except the Executive Committee, are comprised of up to five representatives from each affiliate of the Network (nominated by the affiliate) and ultimately approved by the Board. The Chair of the Board, the Network President and Chief Executive Officer ("CEO") and the Chair of each subsidiary Board serve *ex officio* (with vote) on each standing committee. The Executive Committee is comprised of Board officers and Chairs of the Finance and Planning Committees and is authorized to make decisions on matters of urgency between Board meetings involving up to $10 million.

Each of the UVM Medical Center, CVMC, CPI, CVPH and ECH is governed by a separate Board subject to the reserved powers of the Network. Each also has separate board committees, but to minimize duplication of efforts and to promote unified governance across the Network, several committees of the Network Board and the Affiliates' Boards, such as Finance, Planning, Investment, Compensation, Audit and Quality, meet jointly and consolidate their functions.

Reserved Powers

Under the bylaws of UVM Health Network and each of the Affiliates (other than UVM Medical Group), each of the following actions of an Affiliate requires the approval of UVM Health Network:

(a) election of the trustees of the Affiliate from nominees submitted by the Affiliate to the Network;

(b) adoption of annual operating and capital budgets and any change in an amount greater than $1 million per line item to a budget previously approved;

(c) adoption of strategic plans;

(d) sale, lease, disposition, mortgage, or encumbrance of all or substantially all of its assets;

(e) any merger, consolidation, business combination or joint venture, or the creation or acquisition of any subsidiary organization;

(f) the filing of a voluntary bankruptcy petition;

(g) any project or expenditure requiring issuance of a certificate of need;

(h) amendment of its articles of incorporation or bylaws;

(i) incurrence of any long-term indebtedness;

(j) developing or terminating programs and services; and

(k) election or appointment of its President/CEO.

Additionally, UVM Health Network may initiate any of the above actions on behalf of an Affiliate, if approved by a super-majority (at least 75%) vote of the Board of the Network.

The reserved powers held by UVM Medical Center and the University with respect to UVM Medical Group are described in "PHYSICIAN NETWORK – UVM Medical Group", below.

Network Board of Trustees

Of the 17 Network trustees, 15 were elected by the Board for initial terms commencing January 1, 2014. Seven of the 15 of the elected trustees were elected from nominees submitted by UVM Medical Center, four from nominees of CVMC, and four from nominees of CPI. The elected trustees serve initial staggered terms of two to five years. All of the initial elected trustees are also incumbent trustees of UVM Medical Center, CVMC or CPI, but upon completion of a trustee's initial term, the vacancy will be filled by a nominee submitted by the Board's Governance Committee who need not be an incumbent trustee of any subsidiary. The Board also includes the President and CEO of the Network and the Dean of the University's College of Medicine, who serve *ex officio* with full voting rights. The Board has adopted guidelines to ensure that trustees have a mix of governance skills and reflect the regional diversity of the Network.

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APPENDIX A

The name, occupations and terms of the current members of the Board of Trustees are as follows:

Name	Occupation	Term Expires
John R. Brumsted, MD	President and CEO, UVM Health Network	*Ex officio*
Mike Dellipriscoli	Senior Vice President and Chief Financial Officer ("CFO") Sentinel Asset Management, National Life Group	2018
A. Donald Gilbert	Chair, UVM Health Network Board; Retired President and CEO, Vermont Gas Systems, Inc.	2017
Kathleen "Scottie" Ginn	Chair, UVM Medical Center Board; Retired Vice President of Engineering, International Business Machines Corporation	2017
Marta Marble	President, Marble Consulting	2019
Stephen P. Marsh	President, Community National Bank	2016
Philip B. Mead, MD	Retired Obstetrician, UVM Medical Center	2016
Frederick C. Morin, III, MD	Dean, UVM College of Medicine	*Ex officio*
Gretchen B. Morse	Former Executive Director, United Way of Chittenden County	2019
Robert Perkins	Retired, New York State Electric & Gas Corp.	2019
John Powell	Co-owner, Powell Design-Build	2019
Jane Preston	Director of Governmental Affairs, Greenberg Traurig, LLP	2018
Thomas Robbins	Chair, UVM Health Network; Vice President, Finance & Administration, and CFO, Vermont State Colleges	2017
Paul Sands	Retired President and General Manager, WPTZ TV	2016
Allie Stickney	Retired President and CEO, Wake Robin Corp.	2018
Greg Voorheis	Senior Grant Manager, State of Vermont Department of Labor	2016
Fred Woodward	Retired President, Clinton Community College	2017

Executive Management

UVM Health Network does not have direct employees. Instead, the senior leadership of UVM Health Network is employed by UVM Medical Center or one of the other Affiliates and furnished to UVM Health Network to fulfill system-wide responsibilities. As a consequence, most Network executives hold dual positions at both UVM Health Network and at UVM Medical Center or another System hospital. The persons holding senior executive positions in UVM Health Network are listed below with their ages and summaries of their backgrounds.

- **John Brumsted, MD (63)** – President and CEO, UVM Health Network, and CEO, UVM Medical Center. Dr. Brumsted was named to his current positions in 2012. A 30-year veteran of UVM Medical Center, Dr. Brumsted has served in a number of leadership roles, including chief medical officer, chief quality officer and interim CEO. He has also served as a senior associate dean for clinical affairs at the UVM College of Medicine, and medical director of The Vermont Health Plan and Vermont Managed Care. Dr. Brumsted earned his bachelor of arts degree at Dartmouth College and medical degree at Dartmouth Medical School, conducted his internship at Hartford Hospital in Connecticut, and his residency and fellowship at the Medical Center Hospital of Vermont (a predecessor of UVM Medical Center). He is a board-certified obstetrician-gynecologist with a sub-specialty in reproductive endocrinology and infertility.

- **Theresa Alberghini DiPalma (54) –** Senior Vice President of Marketing and External Relations, UVM Health Network and UVM Medical Center. Ms. DiPalma was appointed to this position at the UVM Medical Center in 2003 and has enjoyed a career in government and the non-profit sector, focused on health care policy, regulation and management. Ms. Alberghini DiPalma worked for U.S. Senator Patrick Leahy in Washington, D.C. from 1985 to 1994, serving as his Senior Legislative Assistant for Health and then Legislative Director from 1992 to 1994. In 1994, Governor Howard Dean appointed her Chair of the Vermont Health Care Authority, a regulatory agency, and she served in his administration until 1999. In 2000, she began her tenure at Vermont's academic medical center. Ms. Alberghini DiPalma received a bachelor of arts degree from Vassar College.

- **Adam P. Buckley, MD (47) –** Chief Information Officer, UVM Health Network. Dr. Buckley was appointed to his current position after serving as the interim Chief Information Officer for the Medical Center from mid-2014 until his appointment to the Network role in May 2015. Prior to his role as CIO, Dr. Buckley was the Chief Medical Information Officer at the UVM Medical Center. His focus as CMIO was optimization of the Medical Center's electronic medical record and stabilization of the team that supports the record. Dr. Buckley came to the Medical Center and the Network with 12 years of experience in academic medicine primarily focused on quality, patient safety and graduate medical education. Dr. Buckley served in a variety of leadership roles both at Beth Israel Medical Center in New York City and Stony Brook University Medical Center in Stony Brook, New York. Dr. Buckley received his Medical Degree from George Washington University Medical Center in Washington D.C. and completed his residency in Obstetrics and Gynecology at the McGaw Medical Center of Northwestern University in Chicago IL. He holds two board certifications, one in OB/GYN and a second in Clinical Informatics.

- **Claude Deschamps, MD (60) –** President and CEO, UVM Medical Group and a member of the UVM Health Network Leadership Counsel. Dr. Deschamps became President of the UVM Medical Group in 2014. He practiced as a thoracic surgeon at the Mayo Clinic ("Mayo") and served as the Chair of Surgery there from 2005 – 2013 before joining UVM Medical Group. A native of Montreal, Quebec, he received his medical training at the University of Montreal and the University of Montreal Affiliated Hospitals, and in Rochester, Minnesota, at Mayo.

- **Todd Keating (56)** – CFO, UVM Health Network. Mr. Keating has more than 26 years of experience in health care finance. He joined UVM Health Network in 2014, moving from UMass Memorial Healthcare, Worcester, Massachusetts, where he had most recently served as senior vice president of business development, helping to lead the merger of The University of Massachusetts Medical Center with Memorial Healthcare. Prior to that, Mr. Keating served as treasurer and chief financial officer at UMass Memorial Healthcare from 1998 to 2013. Before 1998, he held numerous business and finance positions at UMass Memorial Healthcare starting in 1993. He received a bachelor of arts degree from Tufts University and a master of business administration degree from Fuqua School of Business at Duke University.

- **Spencer Knapp (66)** – Senior Vice President and General Counsel, UVM Health Network and UVM Medical Center. Mr. Knapp has served since 2002 as Senior Vice President and General Counsel of UVM Medical Center, and as General Counsel of UVM Health Network since its organization in 2011. Mr. Knapp has oversight of all legal affairs in the System. He has more than 35 years of legal experience in corporate and health law matters and transactions. Prior to joining UVM Medical Center, Mr. Knapp provided outside counsel services to it as a partner of Dinse, Knapp & McAndrew, a Burlington law firm, where he served as managing partner for 17 years. He holds a bachelor of science degree from Trinity College and a juris doctor degree from Cornell Law School.

- **Paul Macuga (59)** – Senior Vice President and Chief Human Resources Officer, UVM Health Network and UVM Medical Center. Mr. Macuga has served as the Senior Vice President and Chief Human Resources Officer for UVM Medical Center since 2004. Prior to joining UVM Medical Center, Mr. Macuga worked in health care human resources for over twenty years (14 in a senior executive capacity) in the Chicago area. His experience includes working in community hospitals, teaching hospitals and large health care systems. Mr. Macuga holds a master of science degree in industrial relations and a bachelor of science degree in business administration from Loyola University.

- **Todd Moore (50)** – Senior Vice President, Accountable Care and Revenue Strategy, UVM Health Network. Mr. Moore has served in this position since 2011. In 2012, he also assumed the position of CEO of OneCare Vermont, a statewide accountable care organization ("ACO") founded by the UVM Medical Center and Dartmouth-Hitchcock Health. Mr. Moore also works with providers and payers in northeastern New York serving on the Board of Managers for another large regional ACO, Adirondacks ACO. See "STRATEGIC INTIATIVES," below. Mr. Moore joined UVM Medical Center in 2007 as Vice President of Revenue Cycle. Prior to joining UVM Medical Center, Mr. Moore served for 14 years as an executive consultant to large health care providers and insurers as a Principal at the Mercer Consulting Group, a founder and partner of his own firm (Performance Logic), and as a regional executive for the Cerner Corporation, a leading health information technology company. He also served previously as a technology consultant to the financial services industry with Accenture. Mr. Moore holds a master of business administration degree in finance from the University of Chicago and bachelor of science degree in industrial engineering from the University of Illinois.

- **Stephens Mundy (58)** – President and CEO, CVPH, and Executive Vice President for northeastern New York, UVM Health Network. Mr. Mundy was appointed CEO of CVPH in 2002. From 1996 – 2002, Mr. Mundy was the CEO of St. Joseph's Hospital, a 375-bed hospital located in Parkersburg, West Virginia. From 1993 to 1996 he was the CEO of Putnam General Hospital in Hurricane, West Virginia. He held the positions of Associate Administrator and Chief Operating Officer at Henrico Doctor's Hospital, a 350-bed hospital located in Richmond, Virginia, from 1988 to 1993. Mr. Mundy received a bachelor's degree in business administration from Roanoke College and a master of health administration degree from the Medical College of Virginia.

- **Diana Scalise (56)** – Senior Vice President, Strategic and Business Planning, UVM Health Network. Ms. Scalise was appointed to her current position in 2013, and is responsible for the development and monitoring of the strategic plan, capital planning, service line planning, business planning, provider and hospital relations, and business development for the Network. Ms. Scalise has more than 20 years of health care leadership experience. Prior to her appointment at UVM Health Network, Ms. Scalise served as the Vice President for Strategic Planning and Business Development of UVM Medical Center beginning in 2005. Ms. Scalise received a bachelor of science degree in biochemistry and medical technology from Plattsburgh State University, and a master of business administration degree from Rensselaer Polytechnic Institute.

- **Howard Schapiro, MD (61)** – Chief Clinical Integration Officer, UVM Health Network. Dr. Schapiro was appointed to his current position in January 2014 after serving as Interim President and CEO of UVM Medical Group from 2012 to 2013. In his current role, Dr. Schapiro oversees the provider integration initiatives of UVM Health Network. Before holding these positions, Dr. Schapiro was the chairman and health care service leader of anesthesiology at UVM Medical Center for more than 16 years, and was engaged in clinical practice as an anesthesiologist and as an Associate Professor of Anesthesiology at the University's College of Medicine. He served from 2010 – 2013 as the Chair of the Finance Committee of UVM Medical Group, which was responsible for the compensation and finances of 500 employed physicians. Dr. Schapiro received his bachelor of science degree in biology and a master of science degree in natural science and epidemiology from SUNY Buffalo, and received his medical training at the University's College of Medicine.

- **Judy Tarr Tartaglia (57)** – President and CEO, CVMC, and Executive Vice President, Vermont Community Hospital Division, UVM Health Network. Ms. Tartaglia became President and CEO of CVMC in 2007. Prior to joining CVMC she was the President and CEO of Miles Health Care, a hospital with long-term care facilities in Maine affiliated with MaineHealth. She also served as CFO at Miles Health Care before being appointed as CEO. Ms. Tartaglia has served as chair of both the Maine Healthcare Financial Management Association and the Maine Hospital Association, and is currently immediate past chair of the Vermont Association of Hospitals and Health Systems. Ms. Tartaglia has a bachelor's degree in business administration from The University of South Florida, and a master of hospital administration degree from St. Joseph's College in Maine.

- **Eileen Whalen MHA, RN (60)** – President and Chief Operating Officer, UVM Medical Center and a member of the UVM Health Network Leadership Counsel. Ms. Whalen was appointed to her current position in January 2015, following more than 35 years of experience in health care. Before joining UVM Medical Center, she served as CEO of Harborview Medical Center in Seattle, Washington, from 2008 to 2014, and as executive vice president at the University of Arizona Medical Center, Tucson, Arizona, from 2004 to 2008. Ms. Whalen has also held numerous leadership positions in trauma, emergency and critical care services. She is a nationally-recognized trauma systems expert and has been the president and a founding member of the Society of Trauma Nurses, a published author and a board member of prominent health care societies and associations. Ms. Whalen is a graduate of Niagara University where she received a bachelor of science degree in nursing. She also holds a master of health and hospital administration degree from Chapman University. Persons holding executive leadership positions at member hospitals of UVM Health Network have joint reporting responsibilities within their own organizations and to the senior executives of the Network indicated above.

Centralized Network Services

UVM Health Network provides centralized management and administrative services to System hospitals, UVM Medical Group and other affiliated entities. Those services include certain executive management, treasury, finance, planning, payer contracting, information technology, quality assurance, risk management, revenue cycle, and legal, among others.

Integration Councils

In order to integrate administrative and clinical services among all System hospitals, UVM Health Network has established six "Integration Councils" described below. The Integration Councils include representatives from each System hospital with appropriate expertise.

- **Finance and Supply Chain Council**, responsible for implementing system-wide cost management and margin enhancement opportunities in non-salary expenses and enhancing business processes and cost management through a single centralized supply chain and use of informatics.

- **Clinical Quality Council**, responsible for improving quality of care and clinical outcomes by standardizing treatment across the continuum of care and ensuring that each patient is treated at the "right place" by effectively using existing capacity and service capabilities.

- **Human Resources Council**, responsible for supporting the integrated delivery system by pursuing complementary human resource strategies, sharing resources and reducing costs for human resources-related activities.

- **Information Technology Council**, responsible for developing a common information technology platform to support patients and providers and to facilitate the aggregation of data for population health management.

- **Planning Council**, responsible for developing strategic and capital planning processes.

- **Marketing and Communications Council**, responsible for aligning communications and marketing efforts with system objectives, developing the system brand, and collaborating to enhance cost-effectiveness and efficiencies within marketing and communications.

FACILITIES

The System's affiliated facilities currently include an academic medical center, two community hospitals, and a critical access hospital. A description of each follows.

UVM Medical Center - A Member of the Obligated Group

UVM Medical Center has two hospital campuses, more than 30 satellite clinic locations and several business and support services locations.

The Medical Center Campus

- The Medical Center Campus in Burlington, Vermont, includes a number of interconnected hospital buildings with an aggregate of approximately 1,497,000 gross square feet and an average age of plant of 11.93 years (accumulated depreciation divided by the current year's depreciation). Inpatient units range in age from 10 to 74 years old. UVM Medical Center owns

this campus. The Medical Center Campus underwent a $378 million construction program, completed in October 2005, that included the construction of a new ambulatory care center, new operating rooms, a new emergency department, birthing center, inpatient mental health unit, patient access center, laboratory, central plant, four-story underground parking garage, and educational center complex built in collaboration with the University's College of Medicine. The emergency department at the Medical Center Campus is the only Level 1 Trauma Care center in the region. The Medical Center Campus also includes a Level III neonatal intensive care unit, the Vermont Cancer Center, a medical intensive care unit, a surgical intensive care unit, invasive cardiology and interventional radiology suites, a renal dialysis unit, three linear accelerators in a radiation oncology unit, and diagnostic radiology facilities that include one 1.0-Tesla open MRI scanner, one 1.5-Tesla MRI scanner, one 3.0-Tesla MRI scanner, four CT scanners, a PET/CT scanner, and a SPECT-CT scanner.

- UVM Medical Center is planning to construct a new inpatient bed facility on the Medical Center Campus that would replace a portion of its existing inpatient bed units (the "Inpatient Project"). The Inpatient Project would involve the construction of an inpatient building with approximately 180,000 gross square feet which would be located on the west side of the Medical Center Campus, above the existing emergency department parking lot. Plans for the inpatient building feature four floors of 32 single-occupancy medical-surgical rooms each, for a total of 128 inpatient rooms. The building would replace the most outdated inpatient rooms in UVM Medical Center's Shepardson 3 and 4 North building (built in 1960) and permit many of its remaining double-occupancy rooms to be converted to single-occupancy. The Inpatient Project has a total expected cost of approximately $187.3 million which includes capitalized interest of approximately $12.35 million. The Inpatient Project costs are expected to be funded by equity of approximately $44,947,000, fundraising of approximately $30,000,000, and borrowing of approximately $100,000,000 from a future issuance of tax-exempt bonds (for the remaining Project costs). A CON approving the Inpatient Project as proposed was issued by the Green Mountain Care Board on July 1, 2015. The CON is subject to several conditions that must be satisfied by UVM Medical Center prior to commencing construction on the Inpatient Project. Management expects to satisfy these conditions during 2016.

The Fanny Allen Campus

- The Fanny Allen Campus is located in Colchester, Vermont, and consists of an 118,189 gross square foot hospital facility. The facility, formerly a Catholic hospital, was constructed in 1972. An unrelated third party, the Fanny Allen Corporation ("Fanny Allen"), owns the land and building and leases them to UVM Medical Center through a lease with a term that extends through 2024. The lease prohibits UVM Medical Center from conducting activities at the Campus that conflict with the teachings, traditions and canon or other law of the Roman Catholic Church. The Fanny Allen Campus is currently the site of UVM Medical Center's 35-bed inpatient rehabilitation unit, a walk-in care center, and five outpatient surgical suites predominantly used for orthopedic and ophthalmology services. This campus also includes a three-story, 36,155 gross square feet medical office building with 24 condominium units. UVM Medical Center owns twelve of the condominium units and leases five others from Fanny Allen. Community physicians not employed by UVM Medical Center own the remaining units. The condominium units in the medical office building are subject to a ground lease between the unit owners and Fanny Allen that extends through 2024 and is subject to the same conditions as the main lease. UVM Medical Center does not plan to renew the main lease and is at an early stage of planning for replacement facilities for the services currently located at the Fanny Allen Campus upon termination of the lease in 2024.

Other Campuses and Facilities

- The University Health Center ("UHC") Campus is located in Burlington, Vermont, where the UVM Medical Center currently leases 188,229 square feet in a building owned by the University. The lease was amended on July 1, 2014. The amended lease has an initial five-year term and includes two successive five-year renewal periods. The campus currently houses neurology, radiology, some laboratory services, children's and adult primary care outpatient physician offices and outpatient psychiatry services that are associated with substance abuse and psychiatric research programs. The University has a significant presence in the building, which houses several University-affiliated research programs and the University's student health center. Several UVM Medical Center administrative departments are also located at UHC. UVM Medical Center is at an early stage of developing plans to relocate the services and functions currently located at UHC prior to the termination of the lease.

- The Tilley Drive Campus in South Burlington, Vermont houses specialty care outpatient campus programs within two buildings, including the pain center, outpatient cardiology clinics, cardiac rehabilitation program, endocrinology clinic, outpatient orthopedic clinics, physical therapy and radiology services (including general radiology and MRI imaging). While the facilities at Tilley Drive are currently leased, UVM Medical Center is in the process of exercising purchase options available under the lease. These acquisitions are the subject of a CON application to the Green Mountain Care Board. That application, which is separate from the one filed in connection with the Inpatient Project, seeks approval for the capital spending associated with the acquisitions in a sum not to exceed $52,641,971. The purchase and sale and option agreements are contingent upon securing a CON and upon the outcome of pending due diligence regarding the ability to permit and develop the property. The purchase of these properties, if approved, would allow the UVM Medical Center to develop a coordinated and consolidated outpatient campus at one central site using owned real estate, instead of leased facilities, to achieve long-term cost savings and direct control over the site. The timing of the actual acquisition, further development and any financing related to this property is uncertain at this time.

- UVM Medical Center operates numerous other outpatient, ambulatory care locations, and facilities. UVM Medical Center maintains approximately 30 primary care and subspecialty sites throughout northwestern and central Vermont, as well as a number of business support facilities throughout the region. While UVM Medical Center leases a number of sites, it has expanded its ownership to include most of its primary care sites, a renal dialysis site in South Burlington, Vermont, and a 175,000 square foot warehouse in Williston, Vermont, which houses UVM Medical Center's medical records storage and its supply chain central storage facilities.

Central Vermont Medical Center - A Member of the Obligated Group

CVMC has one main campus on 72 acres of land located in Berlin, Vermont. The campus includes an acute care hospital and an interconnected medical office building of approximately 296,000 gross square feet in size, both of which are owned by CVMC, as well as three additional separate medical office buildings. Two of those, totaling approximately 29,000 gross square feet, are condominiums and house medical specialty practices (both CVMC-owned and private), one primary care/medical oncology practice, private medical practice groups, and offices leased to the local community mental health center (Washington County Mental Health). CVMC also has several other outpatient care sites in leased buildings in the central Vermont area. Several of the leases for the buildings contain purchase options that may be exercised in the future. CVMC also owns and operates Woodridge Rehabilitation and Nursing, a 153-bed skilled nursing facility located on CVMC's campus that occupies approximately 72,600 gross square feet.

Champlain Valley Physicians Hospital - An Affiliate that is not a Member of the Obligated Group

CVPH comprises one main campus, eight satellite clinics, and two business and support services satellite locations.

- The main campus site is located in Plattsburgh, New York. It covers approximately 45 acres and consists of several interconnected buildings with a combined building area of approximately 571,000 gross square feet. The aggregate buildings consist of the main hospital, three medical office buildings, a cancer center, and an emergency care center. One of the medical office buildings is owned by Champlain Valley Medical Office Building Development Company, LLC (partially owned by CVPH), while the remaining buildings and grounds are owned by CVPH. The original main hospital building was built in 1926, and a 120,000 square foot seven-floor patient care tower was added in 1970. Since then, other additions and renovations have been constructed, most recently in 2006, when a new medical arts building containing a laboratory, pharmacy, oncology infusion center, non-invasive cardiology center and a variety of physician practices was built. The campus includes acute care medical surgical inpatient facilities, ambulatory treatment and diagnostic care services, long term care facilities, emergency services, laboratory, pharmacy, inpatient psychiatric units for adults and children, short stay recovery beds, physician offices, and a cancer treatment center. Other facilities on the main campus include an invasive cardiology suite, an electrophysiology suite, an interventional radiology suite, nuclear medicine suites, one linear accelerator in a radiation oncology unit, and a diagnostic radiology facility that includes a 1.5 Tesla open MRI scanner and two CT scanners.

- CVPH operates various other outpatient care locations and facilities in Plattsburgh, including an ambulatory surgery center (outpatient surgery, endoscopy, dialysis and diagnostic services), diagnostic imaging services, outpatient rehabilitation services, dental services, primary care services (which is expect to host a new residency program beginning in July 2016), and exercise, training and fitness services. CVPH also houses various business services (including administrative support staff for the hospital-based physician practices, the accounting department, the business office, off-site records storage, and an auxiliary storage warehouse) in two other buildings in Plattsburgh. With the exception of the ambulatory surgery center and the sports and rehabilitation center, which are owned by CVPH, these services are in leased spaces.

Elizabethtown Community Hospital - An Affiliate that is not a Member of the Obligated Group

ECH is a 25-bed critical access hospital located in Elizabethtown, New York providing health care to communities throughout Essex County, New York. The hospital owns approximately 37,000 gross square feet and offers an inpatient unit (both acute and sub-acute care), an emergency department, access to specialists, rehabilitation therapy, laboratory and pharmacy, radiology, chemotherapy/infusion treatment, and a cardiac rehabilitation program. The hospital also owns a network of five community-based health centers offering convenient access to primary care throughout the area. ECH is expanding and renovating its inpatient facilities at a cost of approximately $11 million with long-term borrowing (to be guaranteed by UVM Medical Center) of approximately $5 million. The project is underway with an anticipated completion in early 2017.

Pursuant to the non-binding letter of intent between UVM Health Network and ILH, the parent corporation of MLH, existing inpatient services of MLH would terminate and the hospital facilities would become a freestanding emergency room of ECH and part of the UVM Health Network. The letter of intent is subject to numerous contingencies, a definitive agreement, and regulatory approvals.

APPENDIX A

HEALTH CARE SERVICES

The Affiliates are licensed for 1,067 acute care beds (including bassinets) and 207 long term or skilled nursing beds. As of October 1, 2015, the Affiliates operate approximately 763 general acute care beds at four hospitals plus another 207 long-term or skilled nursing beds.

			Hospital Beds		LTC or
Hospital	City	State	Licensed	Staffed	SNF
UVM Medical Center	Burlington	VT	620	447	0
CVMC	Berlin	VT	122	78	153
CVPH	Plattsburgh	NY	300	215	54
ECH	Elizabethtown	NY	25	23	0
Total			1,067	763	207

Source: Affiliates' records.

All System hospitals provide general inpatient and outpatient care, emergency services, occupational health, and screening and imaging services such as MRI, CT, mammography and colonoscopy. All except ECH also provide cardiology, orthopedics, psychiatry, radiation oncology and urgent care. Both UVM Medical Center and CVPH provide cardiac catheterization and electrophysiology. Tertiary and quaternary services such as cardiac, pediatric and neonatal intensive care, cardiac surgery, burn care, and tissue transplants are offered only at UVM Medical Center.

The health care services provided by two of the Members of the Obligated Group, UVM Medical Center and CVMC, are described in more detail below under "Services of Obligated Group." Services of the other System hospitals are described separately under "Services of Other Network Hospitals."

Services of Obligated Group

- **UVM Medical Center.** UVM Medical Center provides hospital services as an acute-care teaching hospital and integrated physician services through UVM Medical Group, a multi-specialty physician practice, employing about 600 physicians, all of whom hold faculty positions at the UVM College of Medicine. UVM Medical Center's medical staff consists of approximately 800 physicians.

  UVM Medical Center provides a broad range of specialized tertiary and quaternary care services. It is the only Level I Trauma Center in its region. The University of Vermont Children's Hospital is a full-service pediatric hospital located within UVM Medical Center (i.e., a "hospital within a hospital"). UVM Medical Center offers the only open-heart surgery and interventional cardiology services in Vermont, and is also the exclusive provider in the state of neonatal intensive care services, inpatient renal dialysis, kidney and pancreas transplants, pediatric surgery, acute rehabilitation, and high-risk obstetrics.

  As the only hospital in Chittenden County, UVM Medical Center's services also include the full range of services offered in community hospitals as well as the following specialty services, by way of example: breast care center, elder care, echocardiography and electrophysiology, multiple sclerosis center, sleep center, hand microsurgery, spine center, sports medicine, cytogenetics and molecular diagnostic laboratory, and nuclear medicine.

- **CVMC.** CVMC is a community hospital that provides a range of inpatient and outpatient services and has a medical staff that includes more than 220 physicians. Programs include cardiac rehabilitation, cancer services (both chemotherapy and radiation therapy), and urgent care. CVMC's skilled nursing facility, Woodridge Rehabilitation and Nursing, offers a full range

of nursing and rehabilitation services, including physical therapy, occupational therapy and speech therapy.

Services of Other System Hospitals

- **CVPH.** CVPH is a community hospital that provides a range of inpatient and outpatient services and has a medical staff with 170 physicians. Programs include cardiac catheterization and ablation, cancer services, and an ambulatory surgical center. CVPH facilities also include a 96-bed skilled nursing facility.

- **ECH.** ECH is a critical access hospital with a medical staff of more than 70 physicians. Programs include rehabilitation, infusion, colonoscopy and imaging.

PHYSICIAN NETWORK

General

Each of the System hospitals provides professional services through open-model medical staffs that include employed physicians and independent physicians. Approximately 80% of the members of UVM Medical Center's medical staff was employed by UVM Medical Group as of April 2015. See "UVM Medical Group," below. Approximately 64% of the four System hospitals' medical staffs was employed by System hospitals as of April 2015.

UVM Health Network is in the process of developing an integrated, System-wide physician organization that is expected to employ and manage the employed physicians of all System hospitals. The goal of this arrangement is to align employed physicians with the Network's strategic goals, will be revenue-neutral to the Obligated Group as the physicians will provide professional services to the individual hospitals by contractual agreements. Under a plan approved by the Board of UVM Health Network, a single physician organization model would be developed by establishing the UVM Medical Group as the sole physician employer, over time.

As of April 30, 2015, there were 1,188 physicians on the System hospitals' respective medical staffs (some of whom belong to more than one System hospital's medical staff), and 760 employed physicians, as follows:

	Total physicians on medical staff	Average age
UVM Medical Center	802	50
CVMC	221	50
CVPH	170	51
ECH	74	51
Total	1,267	
Unique individuals	1,188	
Employed	760	

Source: Network records.

UVM Medical Group

UVM Medical Group is a Vermont non-profit corporation with UVM Medical Center as its sole corporate member. Under its bylaws, UVM Medical Group is currently governed by a Board of 19 voting directors that includes the 13 health care service leaders who serve as "chiefs" of their respective services, the

President of UVM Medical Group and five at-large directors elected by UVM Medical Group-employed physicians to serve three-year terms. The President and CEO of UVM Medical Center and the Dean of the University College of Medicine also serve on the board as ex officio non-voting directors and exercise certain "reserved powers" of approval, described below.

The Board of UVM Medical Group oversees all of the clinical activities and financial operations of UVM Medical Group, including the physician compensation plan. Under arrangements with UVM Medical Center, UVM Medical Group is obligated to cover from revenues generated from the services of its employed physicians all of the costs of its operation, including both indirect administrative expenses charged by UVM Medical Center and the direct costs of physician compensation and benefits.

The Board has several standing committees, including Finance, Patient Care and Operations, Research and Education, Workforce, and Nominating. Each committee includes at least one member of the UVM Medical Group Board and five additional members elected by UVM Medical Group physicians.

As the sole corporate member of UVM Medical Group, UVM Medical Center has reserved powers under UVM Medical Group's bylaws to approve certain major actions by UVM Medical Group, including operating and capital budgets, hiring, compensation plans, appointment of the UVM Medical Group President, and incurrence of debt. UVM Medical Group is required by its bylaws to operate in accordance with the Affiliation Agreement between UVM Medical Group and the University. See "ORGANIZATIONAL STRUCTURE AND AFFILIATIONS – Affiliation with the University."

All UVM Medical Group-employed physicians also hold appointments on the medical faculty of the College of Medicine and are jointly employed by the University. By contract, UVM Medical Group agrees to provide all the services of its employed physicians exclusively to UVM Medical Center to meet its physician needs, and in return, UVM Medical Center agrees to conduct all billing and other administrative services for the UVM Medical Group physicians, retains all of the physician revenues, and agrees to pay all compensation and benefits of the UVM Medical Group physicians.

UVM Medical Group physicians were responsible for approximately 84% of inpatient discharges and 92% of net patient revenue for inpatient discharges from UVM Medical Center for 2015.

INFORMATION TECHNOLOGY

System hospitals currently use a variety of information technology ("IT") platforms to support their clinical and administrative functions. UVM Medical Center implemented a hospital- and physician practice-wide Epic Systems Corporation ("Epic") electronic medical record ("EMR") in 2010. CVMC, CVPH, and ECH use a combination of other EMR solutions and, in certain circumstances, paper records.

The Information Technology Council (see "GOVERNANCE AND MANAGEMENT – System Integration Councils") has approved the implementation of a common EMR and revenue cycle platform throughout the System. Management believes that implementing a System-wide EMR is consistent with the strategy of creating a regional integrated delivery system and is becoming the national norm for large health systems. This model would facilitate collecting individual patient outcomes, aggregating the data in a way that allows for analysis and identifying opportunities to improve outcomes for large patient populations. This "Epic Connect" project will be rolled out over five years at an estimated cost of $151.2 million, of which $108.3 million would be capital costs. The project would be subject to the receipt of CONs in Vermont and New York.

System hospitals are participating in health information exchanges that have been developed by the Vermont Information Technology Leaders, Inc. ("VITL") and the Health Information Exchange of New York ("HIXNY"). UVM Medical Center and CVMC are fully connected to VITL for all areas except transmission of clinical data between providers. CVPH and ECH are connected to HIXNY. Neither

VITL nor the Vermont hospitals in UVM Health Network are connected to HIXNY due to conflicting user agreements and consent policies. The Network is working towards reconciling those conflicts so information can be shared across that platform.

STRATEGIC INITIATIVES

UVM Health Network was formed in 2011 in response to the changing nature of the health care landscape in Vermont and northeastern New York, including cost growth that has outpaced general inflation, access issues for both primary and specialty care, and the potential for inconsistent quality of care depending on where care was delivered. Its primary strategy has been to develop an integrated system of care for northeastern New York and northern Vermont that will foster operational efficiencies, support the provision of a coordinated continuum of services to the communities the Network serves, and position itself to be held clinically and fiscally accountable for the health of a defined population.

Initiatives from 2011 - 2015

Since its inception in 2011, the Network has pursued two complementary strategies in support of its vision: building an integrated delivery network and developing the capacity to manage the health of a population.

Building an Integrated Delivery Network. The System's market is rural, serving approximately one million people in Vermont and six northeastern New York counties (the "Service Area"). The Network has established corporate affiliations with health care providers in both states in order to gain administrative efficiencies and engage in coordinated regional planning through an integrated system of care that aims to improve access, enhance quality, and lower the costs of health care provided in the region. To date, this has included:

- **Governance.** The Network has implemented a governance and management structure intended to implement best practices for multi-hospital integrated health delivery systems and to position the System to meet the challenges and opportunities of health care reform.

- **The academic model.** The System is distinguished from other providers in the Service Area by its academic mission. Growth of the academic mission is important to the Network's continued reform efforts, particularly in northeastern New York, where insufficient access to primary care has led to what Management believes are unnecessarily high emergency department use and high hospitalization rates. The academic model also helps attract qualified providers to the region, both for education and training and to practice. The Network is currently pursuing this strategic initiative through the development of a family medicine residency program at CVPH, expected to begin in 2016. In addition, the Network implemented a medical student OB/GYN clerkship at CVPH in 2015 and a medical student clerkship in psychiatry at CVMC in 2012.

- **Clinical integration.** Clinical integration provides opportunities to conserve the System's resources and lower expenses while ensuring appropriate and timely access to services as locally as possible. UVM Health Network selected cardiovascular services to be the first clinical service line to develop a service distribution plan and a System-wide clinical and administrative structure to support that plan. That effort, led by cardiovascular clinicians from UVM Medical Center and CVPH, resulted in the consolidation of cardiac surgery at UVM Medical Center and the retention of catheterization and electrophysiology cases at CVPH that might otherwise have traveled to Burlington. In addition, cardiologists at System hospitals participate in regular multi-disciplinary echocardiogram and catheterization quality assurance reviews. Management believes that the development of a coordinated cardiology system in the

region has reduced costs while supporting increased quality, efficiency and access to cardiology services. Between January 1, 2013 and September 30, 2015, 282 patients were able to obtain care in New York who would otherwise likely have traveled to Vermont for their cardiovascular care.

- **Physician alignment.** System hospitals are engaged in planning to promote the deployment of physicians in a cost-effective manner that meets community needs. This includes, for example, the employment of the radiologists and pathologists at CVMC by UVM Medical Group, the placement of anesthesiologists at CVMC to optimize the efficiency of its operating rooms, the provision of additional general surgery call coverage by UVM Medical Group when needed at CVMC, and the implementation by UVM Medical Group of a pediatric cardiologist clinic and an endocrinology clinic at CVPH. System hospitals continue to review and optimize perioperative services.

- **Growth.** UVM Health Network is continuing the development of a regional system through discussions with other health care providers and organizations. This includes possible affiliations with Alice Hyde, ILH, SLHS, and others. See "ORGANIZATIONAL STRUCTURE AND AFFILIATIONS – Network Overview – Potential Expansion of the System.

- **Branding.** UVM Health Network completed the design and initial implementation of a comprehensive brand strategy in 2014. That strategy is designed to enhance understanding in the communities served by System hospitals of the unique resources available through a multi-hospital academic health system serving a primarily rural area.

Developing Population Health Capacity. UVM Health Network leadership is developing the infrastructure to support a network of physicians, hospitals and other providers who together will share responsibility for providing care to patients as the health industry moves into "population health management" – a system in which providers are clinically and fiscally accountable for the health of a defined population. While UVM Health Network's strategy is to reduce cost, provide greater access to care and increase the quality of care, the population health strategy will identify those populations in need of better care and work to bring providers together with common goals and incentives to improve care, including realigning financial incentives.

Developments to date on this strategy include:

- In 2012, UVM Medical Center and Dartmouth-Hitchcock Health formed OneCare Vermont, an ACO participating in the Medicare Shared Savings Program ("MSSP"). Participants in OneCare Vermont have included all of Vermont's hospitals, all of Vermont's designated community mental health agencies, all but one of Vermont's home health agencies, a number of skilled nursing facilities, three federally-qualified health centers, five rural health clinics, and a large number of physicians and other clinicians, including 325 primary care physicians. OneCare Vermont had approximately 53,000 attributed Medicare beneficiaries as of May 1, 2015. OneCare Vermont has also led the development of a Medicaid shared savings program and a commercial shared savings program (for plans offered through Vermont Health Connect), both of which began covering lives in January 2014. As of May 1, 2015, these two programs had added approximately another 47,000 covered lives to OneCare Vermont's value-based care management. Effective as of December 31, 2015, four of the critical access hospitals and two federally-qualified health centers have elected to terminate their participation in OneCare Vermont, reducing the number of attributed Medicare beneficiaries by about 12,000 and the number of attributed Medicaid and commercial insurance covered lives by about 2,000. OneCare Vermont has been accepted into Medicare's Next Generation ACO program and has deferred participation until 2017. UVM Health Network and its New York-based affiliate, CVPH, formed the Adirondacks ACO, LLC, which began participating in the MSSP for

attributed New York beneficiaries as of January 2014. Adirondacks ACO is a nine-county ACO, serving Medicare beneficiaries in Clinton, Essex, Franklin, Hamilton, Warren, Washington, and Northern Saratoga counties in New York, and Grand Isle and Chittenden counties in Vermont. The ACO is comprised of more than 400 primary and specialty care providers, including CVPH, ECH, UVM Medical Center, Adirondack Health, Alice Hyde, Glen Falls Hospital, Irongate Family Practice, HHHN, and other independent community primary care practices. Adirondacks ACO is positioned to provide population health management initiatives consistent with New York's Delivery System Reform Incentive Payment ("DSRIP") program. See "SERVICE AREA CHARACTERISTICS AND MARKET POSITION – Market Regulation and Health Reform Initiatives," below.

- In June 2014, UVM Medical Center, together with SLHS, acquired a majority ownership interest in the Accountable Care Organization of the North Country, an ACO participating in the MSSP through physicians of SLHS and community physicians in that region.

- CVPH and Adirondack Health, Glens Falls Hospital, and HHHN are partners in the Adirondack Health Institute ("AHI") in northeastern New York, a medical home project designed to address rapid changes and challenges to the health care industry by working with local providers and organizations through the coordination of planning, recruiting, clinical activities, outreach and managing of grant-supported programs. AHI expects to be funded under New York's DSRIP program and to partner with Adirondacks ACO in carrying out population health management initiatives with the objective of lowering costs and reducing avoidable hospital admissions.

Planning for 2016 - 2020

Strategic planning for the System for 2016-2020 is underway, and the major focus will be population health management with initiatives focused on improving quality, enhancing physician, clinical and academic integration across the System, integrating technologies and operational functions, promoting professional development and research and improving community access to care and engagement in health.

The Network's focus will increasingly be on efforts to improve population health rather than to pursue volume or market share strategies. Network priorities will include working with multiple providers and partners to improve health, reduce potentially-avoidable admissions, reduce re-admissions, develop pathways of care for chronic disease and respond to alternative payment methodologies that do not depend on today's fee-for-service approach. As a part of this plan, UVM Medical Center's goal is to have by 2018 80% of the care it provides paid for based on value-based contracts (those where payment depends on recognizing quality and outcomes) rather than traditional fee-for-service. This goal exceeds the current federal expectation announced by the Department of Health and Human Services to have 50% of care paid for based on quality and outcomes by 2018. Planning to achieve this goal is at an early stage, and there can be no assurance this goal will be achieved.

SERVICE AREA CHARACTERISTICS AND MARKET POSITION

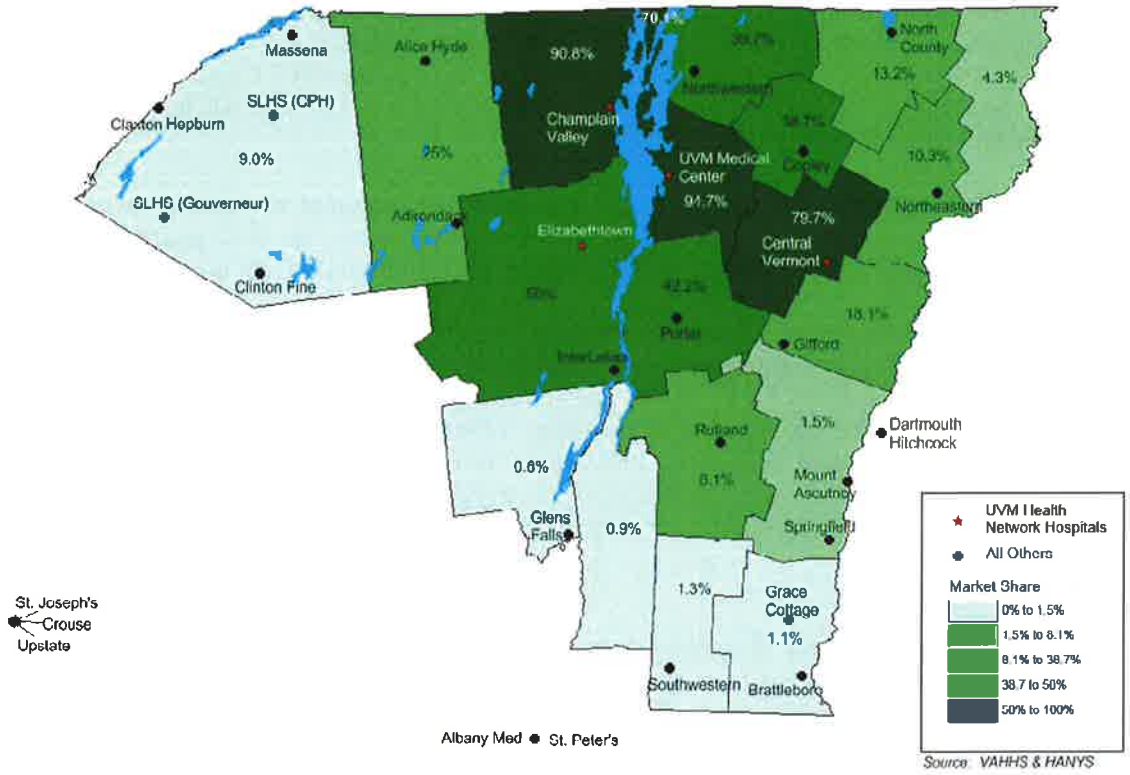
Service Area

System hospitals serve all of Vermont and six counties in northeastern New York (the "Service Area"). According to Woods and Poole Economics, Inc., during the next fifteen years, the total population of the Service Area is expected to grow by 4.7% (from 1,033,306 in 2015 to 1,081,582 in 2030), but the population of those 65 and older is expected to grow by 62% (from 183,436 in 2015 to 297,149 in 2030), off-setting a slight decline in younger age groups.

APPENDIX A

Market Share and Trends

System Inpatient Market Share
Calendar Year 2014



Source: System records.

As the map above indicates, inpatient market share is higher in the counties closest to where the affiliated hospitals are located, namely: Chittenden, VT (95-96%); Clinton, NY (90-91%); Washington, VT (77-80%); Grand Isle, VT (70-74%); and Essex, NY (47-50%). The UVM Medical Center has maintained approximately 60% market share of inpatients discharged from tertiary care hospitals. Overall Affiliate inpatient market share has consistently been 32-33% across the entire Service Area.

The System monitors market share with data obtained from the Vermont Association of Hospitals and Health Systems ("VAHHS") and the Hospital Association of New York ("HANYS"). Both of these organizations obtain data from surrounding states such as New Hampshire to assess the portion of patients traveling to neighboring states for care, but New Hampshire data have not been available since 2009. Dartmouth Hitchcock, a New Hampshire hospital along the Vermont border, has long served portions of eastern and southern Vermont. Since the New Hampshire data became unavailable, management has assumed that inpatient volume attributable to Vermont patients seeking care at Dartmouth Hitchcock has remained the same in order to extrapolate market share for years after 2009. Management notes, however, that 2009 was Dartmouth Hitchcock's highest volume in many years and that in intervening years most hospitals, including those within the System, have transitioned many patients to the outpatient setting.

Hospitals Serving the Region

The region is served by a number of local hospitals, including some critical access hospitals ("CAH"), as well as tertiary referral centers in New Hampshire and New York. The following table shows discharges

for regional hospitals as reported by the American Hospital Directory, which may vary slightly from records of the System as to Affiliate hospitals.

Hospital	State	Annual Discharges	Designation
UVM Medical Center	**VT**	**19,843**	**Tertiary Care**
CVPH	**NY**	**9,049**	**Gen Acute**
CVMC	**VT**	**3,092**	**Gen Acute**
ECH	**NY**	**280**	**CAH**
Total of System		**32,264**	
Albany Medical Center	NY	30,802	Tertiary Care
Upstate University Hospital	NY	26,046	Tertiary Care
St. Joseph's	NY	25,748	Tertiary Care
St. Peters Hospital	NY	23,331	Tertiary Care
Crouse	NY	19,690	Tertiary Care
Dartmouth Hitchcock	NH	18,202	Tertiary Care
Glens Falls Hospital	NY	12,248	Gen Acute
Rutland Regional Medical Center	VT	5,396	Gen Acute
Canton-Potsdam Hospital	NY	4,543	Gen Acute
Southwestern VT Medical Center	VT	3,538	Gen Acute
Northwestern Medical Center	VT	2,383	Gen Acute
Adirondack Medical Center	NY	2,368	Gen Acute
Claxton-Hepburn Medical Center	NY	2,254	Gen Acute
Massena Memorial Hospital	NY	2,209	Gen Acute
Alice Hyde Medical Center	NY	2,128	Gen Acute
Springfield Hospital	VT	1,681	CAH
Brattleboro Memorial Hospital	VT	1,638	Gen Acute
Porter Hospital	VT	1,581	CAH
Copley Hospital	VT	1,523	CAH
Northeastern VT Regional Hospital	VT	1,519	CAH
North Country Hospital	VT	1,178	CAH
Gifford Medical Center	VT	1,153	CAH
Mt. Ascutney Hospital	VT	320	CAH
Inter-Lakes Health	VT	196	CAH
Grace Cottage Hospital	NY	177	CAH

Source: AHD.com

Market Regulation and Health Reform Initiatives

Health care providers and facilities in Vermont are highly-regulated. Vermont has a CON law that requires review and approval of capital expenditures by hospitals in excess of $3 million, new equipment purchases in excess of $1 million, and any new health care service with annual operating costs in excess of $500,000. Vermont also requires annual review and approval of hospital budgets. The primary regulatory body since 2011 has been the Green Mountain Care Board, a five-member independent body appointed by the Governor. The Green Mountain Care Board was established in part to help implement the "unified and universal" health system for Vermont envisioned by Act 48, adopted by the Vermont Legislature in 2010. While the "single-payer" system that the framers of Act 48 contemplated did not come to fruition, other aspects of that reform legislation remain intact, including a focus on containing costs. The Green Mountain Care Board has used its hospital budget approval authority as one of its key tools to contain the growth of health care costs, including capping the growth in hospitals' net patient revenues at 3.7 percent in 2015. The Green Mountain Care Board is currently in discussions with the U.S. Centers for Medicare and Medicaid Services ("CMS") for an "all-payer waiver" that would create an all-payer system in Vermont. An all-payer system in Vermont would provide the Green Mountain Care Board with oversight over all payers, including Medicare, Medicaid and insurance companies. Although the discussions with CMS are on-going and the Green Mountain Care Board would like to implement an all-payer system by January 1, 2017, the discussions are still preliminary, and whether the Green

Mountain Care Board will be able to obtain agreement with CMS or implement an all-payer system and how such a system would impact the System cannot be determined at this time.

The Green Mountain Care Board is also responsible under Act 48 and succeeding legislation for coordinating and implementing payment and delivery system reform. That work has been supported by a State Innovation Model ("SIM") grant of $45 million awarded to Vermont in 2013 by the Center for Medicare and Medicaid Innovation within CMS (now known as the CMS Innovation Center) to test payment reform models, with a particular focus on moving the majority of Vermonters' health care away from fee-for-service payments to value-based payments.

Three ACOs were formed in Vermont to participate in the MSSP created by the federal Affordable Care Act. The Green Mountain Care Board and the Department of Vermont Health Access, (Vermont's Medicaid agency), have also sponsored a shared savings program ("SSP") for Medicaid patients (the "Medicaid SSP") in which two of the three ACOs participate, and Vermont's major commercial payers are also participating in a Commercial SSP under the aegis of the Green Mountain Care Board. UVM Medical Center is participating in these efforts, most notably through OneCare Vermont, a statewide ACO formed in 2012 by UVM Medical Center and Dartmouth-Hitchcock Health that includes most Vermont hospitals and a large number of physicians and community-based providers. (*See* "STRATEGIC INITIATIVES".)

Health care providers and facilities are also highly regulated in New York. Although New York does not require review or approval of hospital operating budgets, it has a CON law that requires review and approval by the New York State Department of Health of new hospital projects and services. The Department of Health also has broad regulatory oversight of hospital operations and services.

Currently, New York is implementing a health reform initiative under a waiver agreement with CMS that will allow the state to reinvest $8 billion of savings generated by the state's Medicaid program with the objectives of preserving access to essential safety-net providers and reducing avoidable hospital admissions through the DSRIP program. The goal of DSRIP funding is to reduce avoidable hospital admissions by 25% over a five-year period. To qualify for DSRIP funding, New York hospitals must meet certain eligibility criteria. The System's New York affiliated hospitals, CVPH and ECH, both meet these eligibility criteria and are seeking to participate in the DSRIP programs through Adirondacks ACO and Adirondack Health Institute, a non-profit organization established by CVPH and other New York providers to engage in population health management initiatives.

HISTORICAL FINANCIAL PERFORMANCE

Financial Summary

The following is a summary of a consolidated financial statement of the operations for the Obligated Group Members (UVM Health Network, UVM Medical Center and CVMC) derived from the consolidated financial statements of the Network, which have been audited by PricewaterhouseCoopers LLP. This summary includes data for the fiscal years ended September 30, 2013, 2014 and 2015. For the fiscal year ended September 30, 2015, total unrestricted revenue and other support reported by the Obligated Group comprised approximately 80% of total unrestricted revenue and other support reported by the Network.

Information for the years ended September 30, 2013, 2014 and 2015 is derived from the Network's audited consolidated financial statements for those years. Audited financial statements for the Network and Affiliates for the fiscal years ended September 30, 2014 and 2015 are included in Appendix B. All elimination and reporting adjustments have been made to present the information in accordance with U.S. generally accepted accounting principles. Certain prior year amounts have been reclassified to conform to current period presentations, the effect of which Management does not believe is material.

This data should be read in conjunction with the audited consolidated financial statements for the fiscal years ended September 30, 2014 and 2015, and related notes included in Appendix B.

Obligated Group
Statement of Operations Summary

($ in 000's)	2013 Actual	2014 Actual	2015 Actual
Net Patient Service Revenue after provision for bad debt	$1,062,508	$1,120,004	$1,189,206
Enhanced Medicaid Graduate Medical Education Revenue[1]	67,221	30,279	30,001
Net Patient Service Revenue after provision for bad debt and Enhanced Medicaid Graduate Medical Education Revenue	$1,129,729	$1,150,283	$1,219,207
Premium Revenue and Payer Incentives	12,792	12,507	11,272
Other Revenue	55,245	65,757	87,563
Total Unrestricted Revenue & Other Revenue	$1,197,766	$1,228,547	$1,318,042
Operating Expenses			
Salary, Payroll taxes & Fringes	700,421	730,166	774,065
Depreciation & Interest	74,361	75,295	70,483
Other Expenses	379,437	366,467	392,235
Total Expenses	$1,154,219	$1,171,928	$1,236,783
Net Income from Operations	**$43,547**	**$56,619**	**$81,259**
Operating Margin %	**3.64%**	**4.61%**	**6.17%**
Total Non-Operating Revenue	46,846	7,401	1,837
Excess of Revenue Over Expenses	**$ 90,393**	**$ 64,020**	**$ 83,096**
Other changes in Net Assets	9,422	9,972	(39,368)
Increase Unrestricted Net Assets	**$ 99,815**	**$ 73,992**	**$ 43,728**

(1) In 2013, the Obligated Group, recognized $67,221 of Enhanced Medicaid Graduate Medical Education Revenue, of which $37,200, was for prior fiscal years.

APPENDIX A

MANAGEMENT'S DISCUSSION AND ANALYSIS OF RECENT FINANCIAL PERFORMANCE OF THE OBLIGATED GROUP

2015 compared to 2014

Operating margin for 2015 was 6.17%, an increase from 4.61% in the previous year and the fifth consecutive annual increase. Total unrestricted revenues were 7.28% higher than the previous year. Net patient service revenue was 5.99% higher than the previous year.

Year-over-year margin improvement was driven by a slight increase in inpatient and outpatient volumes and increased revenues through 340B and specialty pharmacy programs. Inpatient volumes brought increased activity within the medical and surgical service lines over the prior year. The decrease in Premium Revenue is directly related to the decrease in meaningful use payments. Other revenue was favorable to the prior year by 33.16% due to strong performance from the outpatient pharmacy, 340B and specialty pharmacy programs. Within the specialty pharmacy, the Hepatitis C drug, Harvoni, was the primary driver of the increase in revenues.

Expenses were 5.53% higher than the previous fiscal year from annual inflationary expense increases and expenses related to additional volume. The year-over-year expense increases were due primarily to salaries, while the decreases in depreciation and interest partially offset the increase in supplies and other. A portion of the growth in salaries and supplies and other expenses was associated with the higher inpatient volumes experienced throughout the year.

2014 compared to 2013

The Obligated Group's operating margin for 2014 was 4.61%, up from 3.64% in 2013, in part due to an increase in outpatient revenues.

Net patient service revenue was $1.15 billion, 1.82% higher than in 2013. Consistent with the national trend, there was a shift from inpatient services to outpatient services in Vermont; however, an overall increase in outpatient volumes helped maintain net patient revenue consistent from the prior year.

During 2013, the State of Vermont implemented the first year of Enhanced Medicaid reimbursement payments for Graduate Medical Education. Payments of approximately $67.2 million during 2013 included approximately $37.2 million in payments that were for prior periods, retroactive to July 1, 2011, when the new reimbursement program first became effective.

Other revenue for 2014 was $65.8 million, a $10.5 million increase from 2013. The additional increase in other revenue is primarily attributable to increased ACO funding revenue from grant sources and other participants, a one-time resident FICA refund settlement, one-time revenue items from a State contract and miscellaneous other small items that contributed incrementally.

Total expenses in 2014 were $1.17 billion, a 1.5% increase over 2013. A 2.7% decrease in non-salary expenses due to expense control across the organization helped offset in part the 4.2% expense increase in salaries. The 4.2% increase in salaries is generally consistent with the recent trend of 4.0%-6.0% per year for the last three years.

Utilization Statistics

Services at UVM Medical Center & CVMC	2013	2014	2015
Staffed Beds	525	525	525
Inpatient Discharges (including psych, inpatient rehab, newborns)	26,108	24,299	25,338
Inpatient Days (census days, including psych, inpatient rehab, newborns)	139,381	134,541	139,117
Length of Stay (including psych, inpatient rehab, newborns)	5.34	5.53	5.47
Outpatient Days (census days, including psych, inpatient rehab, newborns)	29,049	31,905	32,624
Case Mix Index – UVM Medical Center	1.60	1.66	1.66
Case Mix Index – CVMC	1.13	1.18	1.18
OR Cases	20,565	20,029	19,769
ED Visits[(1)]	88,627	86,263	84,946
Physician Visits	809,682	848,353	880,042

[(1)] In 2015, CVMC opened up an urgent care center, providing an alternative to its emergency department.

Source: Obligated Group records.

Inpatient discharges have remained relatively consistent with a slightly decreasing trend consistent with national trends as more care is provided through the outpatient setting. Inpatient days have been stable with a slight increase related to an increase in case mix and average length of stay. Outpatient days have seen a consistent upward trend consistent with the shift from inpatient to outpatient services. Operating room cases have a modest decline related to a reduction in less acute dental and eye cases and a modest decline in other operating room cases. Emergency department visits declined primarily due to the planned opening by CVMC of an express care practice which redirected volumes from the emergency department to the express practice site in May of 2014. Physician visits have an upward trend primarily related to the addition of new physicians.

Payer Mix

Obligated Group – Net Revenue Payer Mix

Net Patient Service Revenue	2013	2014	2015
Medicare	28.1%	30.2%	29.4%
Medicaid	10.9%	8.0%	7.7%
Commercial	51.9%	54.7%	57.2%
Self-pay	3.8%	2.6%	1.6%
Public Agency / Workers Comp	2.8%	2.5%	2.3%
Other	2.5%	2.0%	1.8%
Net Patient Service Revenue – Total	**100.0%**	**100.0%**	**100.0%**

Payer mix for the reporting periods has been relatively consistent. Management believes that the decrease in Medicaid is related to annual payment term adjustments that have not kept pace with annual expense inflation. The increase in commercial payer mix is related to higher annual payment adjustments than annual expense inflation to cover the cost shift from Medicare and Medicaid.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts due from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Under the terms of various agreements, regulations,

and statutes, certain elements of third-party reimbursement are subject to negotiation, audit, and/or final determination by the third-party payers. In addition, laws and regulations governing Medicare and Medicaid programs are 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. Differences between amounts previously estimated for retroactive adjustments and amounts subsequently determined to be recoverable or payable are included in net patient service revenue in the year that such amounts become known. Changes in prior-year estimates increased net patient service revenue by approximately $2,377,000 and $3,238,000 in the years ended September 30, 2014 and 2015, respectively.

A summary of the payment arrangements with major third-party payers follows:

Medicare

Inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient rehabilitation services are paid based on a prospective per discharge methodology. These rates vary according to a patient classification system based upon services provided, the patient's level of functionality and other factors. Outpatient services are paid based upon a prospective standard rate for procedures performed or services rendered. The Network is reimbursed for cost-reimbursable items at tentative rates, with final settlement determined after submission of annual cost reports by the Network and audits thereof by the Medicare Audit Contractor. Medicare reimbursement for professional billings is determined by a standard fee schedule that is determined by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("CMS"). The percentage of net patient service revenue derived from the Medicare program for the Obligated Group was approximately 29% and 30% in the years ended September 30, 2015 and 2014, respectively. In 2015, the Obligated Group received Medicare payments for indirect and direct graduate medical education of $32.8 million, Medicare disproportionate share hospital payments of $8.8 million, and Medicare meaningful use payments of $5.1 million. Meaningful use payments are being phased out over time. For a discussion of ongoing pressures on governmental payments for graduate medical education and disproportionate share hospital payments, see "BONDHOLDERS' RISKS – Health Care Reform" and "BONDHOLDERS' RISKS – Patient Service Revenues" in the forepart of this Official Statement.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. As with Medicare, reimbursement is based on a diagnosis-related group ("DRG") system that is based on clinical, diagnostic, and other factors. For inpatient rehabilitation and neonatal cases, additional reimbursement is paid through a per diem add-on. In Vermont, additional reimbursement for inpatient psychiatric cases is based on a per diem rate calculation, including adjustments for diagnostic factors and length of stay. Outpatient services rendered to Medicaid beneficiaries are paid based upon a prospective standard rate. Certain laboratory, mammography, therapy, and dialysis services are paid on a fee schedule. Medicaid reimbursement for professional services is determined by a standard fee schedule. The Medicaid program accounted for approximately 8% of the Obligated Group's net revenue for the years ended September 30, 2015 and 2014.

Commercial Insurers

Services rendered to patients with commercial insurance are generally reimbursed at standard charges, less a negotiated discount or according to DRG or negotiated fee schedules. Approximately 47% and 44% of the Obligated Group's net revenues were derived from contracted insurers in 2015 and 2014, respectively. Approximately 11% of the Obligated Group's net revenues were derived from non-contracted insurers in the years ended September 30, 2015 and 2014. The Network has reached

agreements in principle with the two primary payors in the Service Area for the current year and is working to document these agreements.

Enhanced Medicaid Graduate Medical Education Revenues (Hospital and Professional)

Under an Amendment to the Vermont State Medicaid Plan TN#11-019 (the "State Plan Amendment"), UVM Medical Center has received increased Vermont Medicaid payments to support graduate medical education ("GME") since 2013. The State Plan Amendment was approved by CMS in May 2013 with an effective date of July 1, 2011, the date of submission by the Department of Vermont Health Access. The State Plan Amendment provided for enhanced Medicaid payments of GME through two funding mechanisms: (1) payments to "qualified teaching hospitals" and (2) payments to "qualified teaching physicians." Under the definitions contained in the State Plan Amendment, UVM Medical Center is a qualified teaching hospital and physicians employed by UVM Medical Group are qualified teaching physicians.

The nonfederal source of these payments is provided by payments from the University from its governmental appropriations from the State of Vermont ("the State"). The University has entered into a contract with the State to provide annual amounts during the State's fiscal year as the nonfederal share of GME payments for that year. UVM Medical Center expects that the University will enter into similar contracts for subsequent years, though there is no assurance of this. UVM Medical Center has also entered into a contract with the State, by which UVM Medical Center agrees to assess and monitor program benefits to Medicaid beneficiaries and to report to the State annually on its performance on certain quality measures and improvement focus areas for Medicaid beneficiaries pertaining to UVM Medical Center's GME programs, and the State agrees to provide GME payments to UVM Medical Center during the State's fiscal year. UVM Medical Center expects to enter into similar contracts with the State for future years, but these are subject to continued funding by the University of the nonfederal source. The State, UVM Medical Center and the University have also entered into an MOU dated June 10, 2013, that describes the State Plan Amendment and these funding arrangements.

UVM Medical Center received GME funding from the State under the State Plan Amendment totaling $30.3 million and $30.0 million for 2014 and 2015, respectively. The $30.0 million includes reimbursement to UVM Medical Center as a qualified teaching hospital in an amount of $11.5 million and reimbursement to the UVM Medical Group as qualified teaching physicians in an amount of $18.5 million. Under the MOU, both the University and the State retain the right to discontinue GME payments at any time in the future.

Premium Revenue

Premium revenue consisted primarily of payer incentives and meaningful use dollars (i.e., information technology incentive payments) for 2015.

Other Revenue

Other revenue consists primarily of research revenue, non-patient related contract revenues, sales of pharmaceuticals and related products, cafeteria sales, parking garage income, net assets released from restrictions used for operations, and rental income.

Liquidity, Cash and Investments

Liquidity, as measured by days cash on hand calculated in accordance with the Master Indenture, was at 183 days as of September 30, 2015. The table below shows the liquidity position of the Obligated Group for the past three fiscal years. Cash and equivalents are invested in direct-deposit money market funds with various banking partners. Board-designated assets are the long-term savings and operating reserves

of the Obligated Group, which are invested in a balanced mix of growth oriented and income-producing securities.

Liquidity Position – Unrestricted Cash & Investments
Obligated Group
(In Thousands)

Cash & Unrestricted Investments	2013	2014	2015
Cash & Equivalents	$197,318	$220,185	$195,000
Board Designated Assets	$304,174	$328,291	$396,913
Total Cash & Unrestricted Investments	**$501,492**	**$548,476**	**$591,913**
Operating Expenses			
Operating Expenses	$1,154,219	$1,171,928	$1,236,783
Less: Depreciation & Amortization	$55,977	$57,776	$54,614
Total Operating Expenses	**$1,098,242**	**$1,114,152**	**$1,182,169**
Days Cash on Hand	**167 Days**	**180 Days**	**183 Days**

Capitalization

The capitalization of the Obligated Group for the past three fiscal years is set forth below. Management attributes the improved ratio, which declined from 40.02% in 2013 to 34.01% in 2015, to increases in net assets during the three year period, combined with amortization of existing debt and minimal new debt issuances.

A future bond issuance of up to $100 million is planned to fund the Inpatient Project. See "FACILITIES – UVM Medical Center – A Member of the Obligated Group – The Medical Center Campus." This additional bond issuance is not reflected in the tables below and is subject to regulatory approvals and market conditions. If the additional $100 million issuance is completed, on a pro forma basis, the total debt to capitalization ratio would increase to approximately 40% after factoring in the new bond issuance.

Total Debt to Capitalization
Obligated Group
(In Thousands)

Debt & Capitalization	2013	2014	2015
Current Installment of Long Term Debt	$14,009	$13,730	$13,995
Long Term Debt, excluding current installments	$386,515	$373,791	$355,963
Total Debt less unamortized discount and debt issuance costs	$400,524	$387,521	$369,958
Net Assets (Unrestricted)	$600,250	$674,242	$717,970
Total Debt to Capitalization Ratio	**40.02%**	**36.50%**	**34.01%**

Including the Inpatient Project mentioned above, the Obligated Group has budgeted $670 million for routine and project capital through 2019. Other than the potential $100 million new money bond issue for the Inpatient Project, the only contemplated additional debt of the Obligated Group to support this capital plan is a $45 million debt issuance for a property acquisition that will secure a location for the future development of a dedicated outpatient campus See "FACILITIES-Other Campuses and Facilities".

Debt Service Coverage

The following table displays the Obligated Group's maximum annual debt service ("MADS") coverage for 2013 through 2015.

Debt Service Coverage
Obligated Group
(In Thousands; Calculated In Accordance with the Master Indenture)

Income Available for Debt Service	2013	2014	2015
Net Income from Operations	$43,547	$56,619	$81,259
Nonoperating Revenue*	$42,367	$8,824	$5,819
Excess of Revenues over Expenses	$85,914	$65,443	$87,078
Depreciation and Amortization	$55,977	$57,776	$54,614
Interest Expense	$18,384	$17,519	$15,869
Income Available for Debt Service	$160,275	$140,738	$157,561
MADS	$31,135	$31,135	$31,135
Debt Service Coverage Ratio	**5.15x**	**4.52x**	**5.06x**

*Only includes "Investment Income" & "Other"

Outstanding Indebtedness and Debt Profile

As of September 30, 2015, the total outstanding indebtedness of the Obligated Group was $369 million, of which 83% is fixed rate debt and 17% is variable rate debt. All of the variable rate debt is effectively fixed through the use of interest rate swap agreements. Of the total debt, $254 million is publicly issued and the remaining is directly placed with banks or other holders. Approximately $29 million of the debt that is bank-held is subject to a bank put right in 2023.

In addition to this debt, the Obligated Group maintains an unsecured bank line of credit in the amount of $2 million with People's United Bank (the Obligated Group's Master Trustee and Bond Trustee for the 2016A Bonds, among other debt). Currently, and as of September 30, 2015, there is no outstanding balance drawn on this line of credit. The line of credit carries an interest rate tied to the prime rate as published in the Wall Street Journal, adjusting daily, with a floor of 3.25%.

CVMC expects to refinance certain outstanding long-term debt issued by the Agency in the first calendar quarter of 2016 with a bank loan. UVM Medical Center expects to enter into a $30 million line of credit in the first calendar quarter of 2016 to provide additional liquidity for System hospitals. The System

currently expects that CPI, CVPH and ECH will join the Obligated Group in the second calendar quarter of 2016. Any joinder of CPI, CVPH and ECH would be consistent with the requirements of the Master Indenture.

Interest Rate Swap Agreements

For certain variable-rate debt, interest rate swap agreements are used to manage interest rate risk and hedge the risk of cash flow volatility. The table below summarizes the Obligated Group's swap agreements as of September 30, 2015. None of the swap agreements currently require collateral posting. Both the Obligated Group and its swap agreements counterparties are exposed to credit risk in the event of nonperformance or early termination of the agreements. In addition, each agreement may be terminated following the occurrence of certain events, at which time the Obligated Group or the counterparty may be required to make a termination payment to the other. The below table summarizes the outstanding swap agreements for the Obligated Group.

Obligated Group Swaps	Notional 09/30/15 (In 000's)	Counterparty	Expiration Date	Pay Fixed	Receive Floating
LIBOR Swap (Series B-1)	$27,595	Citibank, N.A	12/01/34	3.76%	66.5% of LIBOR + 32bps
LIBOR Swap (Series B-2)	$27,595	Citibank, N.A.	12/01/34	3.76%	66.5% of LIBOR + 32bps
LIBOR Swap	$8,928	People's United Bank	09/30/28	2.67%	100% of LIBOR

Investment Policy

The Investment Subcommittee of the Finance Committee (the "Investment Committee") is responsible for establishing investment policy and providing oversight to the management of the investment funds in consultation with the CFO and the investment managers. The Investment Committee advises and regularly reports to the Finance Committee on matters related to the prudent management and investment of the surplus funds, endowment, pension and captive insurance assets of the corporation, including the establishment and monitoring of investment policies and objectives, asset allocation for the investment funds, establishment of benchmarks for investment performance, selection, monitoring, performance, retention, and replacement, from time to time, of investment advisor(s), manager(s), and custodian(s), establishment and review of investment strategies, and establishment of policies for the annual use of investment assets.

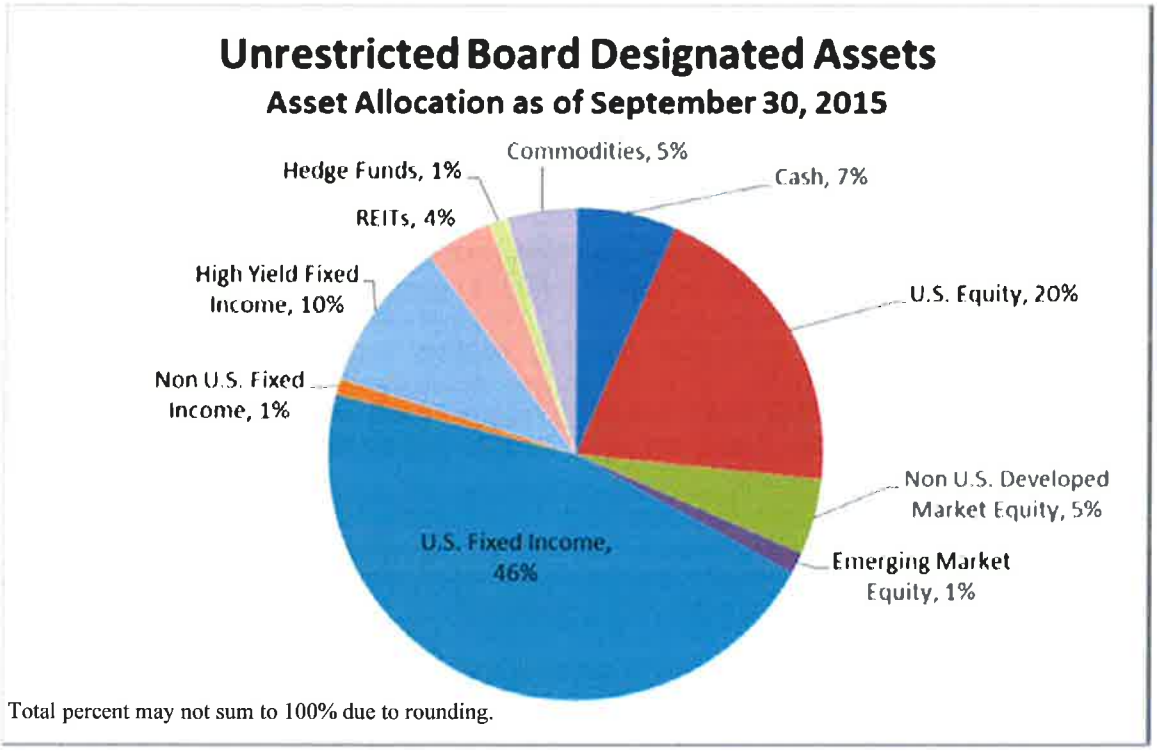
The surplus funds and endowment portfolios are invested in a balanced mix of growth-oriented and income-producing investments. The pension plan assets are invested with the goal of minimizing funding volatility, and the captive insurance portfolio is invested at a 75% allocation to fixed income and 25% in growth assets.

As of September 30, 2015, the investment portfolio balances were as follows:

Obligated Group - Investment Portfolios
As of September 30, 2015

Investable Assets (in 000s)	Obligated Group
Unrestricted	
Board - designated assets	$396,913
Restricted	
Permanent endowment	$31,486
Specific purpose	$30,766
Total	**$459,165**

The following chart displays the asset allocation of the unrestricted board designated assets as of September 30, 2015. All assets in this investment pool can be converted to cash in 30 days or less, with many of the underlying investments providing liquidity in a week or less.



Total percent may not sum to 100% due to rounding.

ADDITIONAL INFORMATION

Insurance

VMC Indemnity Company, Ltd. ("VMCIC") is a captive insurance company licensed and incorporated under the laws of Bermuda that writes professional liability and general liability coverage to UVM

Medical Center, UVM Medical Group, CVMC, CVPH, ECH, and all of their employed providers. UVM Medical Center is the sole shareholder of VMCIC. All UVM Health Network hospitals maintain workers compensation coverage, property insurance, directors and officers liability insurance, automobile, fiduciary and other insurance coverage in types and amounts that management believes is consistent with similarly-situated health care systems.

Retirement / Pension Plans

Substantially all employees are covered under a defined benefit pension plan, defined contribution plan, or combination thereof. UVM Medical Center and CVMC each maintain a defined benefit pension and defined contribution plan. Both defined benefit pension plans are closed to new participants. All new participants are eligible for the defined contribution plan. The UVM Medical Center pension plan is frozen and the CVMC pension plan is partially frozen, meaning that participants age 50 and above as of December 31, 2011, continue to accrue benefits. Funding status as of September 30, 2015, was 91% and 75% for UVM Medical Center and CVMC, respectively. The Obligated Group plans to make $12.8 million in pension contributions during 2016, which is greater than the minimum funding requirements. See note 13 to the audited financial statement included as Appendix B for further information concerning pension liabilities and funding.

Labor Relations

UVM Medical Center's nurses (approximately 1,800 total headcount as of January 1, 2016) and technical employees (approximately 300 as of January 1, 2016) are unionized and are represented by the Vermont Federation of Nurses and Health Professionals, UPV/AFT, AFL-CIO Local 5221. With a workforce of nearly 7,000 employees, this means that approximately 24% of UVM Medical Center's employees are members of a labor union. The nurses and technicians each have separate labor contracts. The nurses labor contract expires July 9, 2018. The technicians' labor contract expires in March 2016. Negotiations for a new collective bargaining agreement with the technicians' union began in November 2015.

CVPH is a dual-union facility represented by both New York State Nurses Association ("NYSNA") and SEIU 1199. As of December 23, 2015, the workforce at CVPH is comprised of 2,516 employees, with 2,027 employees being members of a labor union. SEIU 1199 covers more than half of the workforce, representing approximately 1,237 individuals, including ancillary support services professionals, technicians and licensed practical nurses. NYSNA represents approximately 790 individuals, including registered nurses, rehabilitation therapists, pharmacists, information services personnel and accountants. CVPH's current SEIU 1199 contract expires on April 30, 2016 and the NYSNA contract expires on December 31, 2016.

ECH had approximately 27 registered nurses as of December 23, 2015, or 11% of its workforce, represented by NYSNA. The labor contract expires on July 1, 2016. Negotiations for a new collective bargaining agreement are expected to begin in March or April 2016.

CVMC does not have any organized labor unions as part of its workforce.

UVM Health Network Management considers its relationship with its employees and its unions to be generally constructive.

Litigation

Professional and general liability claims have been asserted against System hospitals by various claimants. The claims are in various stages. Other professional and general liability claims may be asserted against System hospitals. It is the opinion of Management that adequate insurance is maintained (including through VMCIC) to provide for all professional and general liability losses that have arisen.

System hospitals are also defendants in various employment termination and discrimination actions and commercial actions arising out of the normal course of their operations. Although the outcome of any such claims or actions cannot be currently determined, Management is of the opinion that the eventual liability therefrom, if any, will not have a material adverse effect on the financial position of System hospitals or the ability of the Obligated Group to make required debt service payments.

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APPENDIX B

CONSOLIDATED FINANCIAL STATEMENTS OF THE UNIVERSITY OF VERMONT HEALTH NETWORK, INC. AND SUBSIDIARIES

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The University of Vermont Health Network Inc. and Subsidiaries

Consolidated Financial Statements
September 30, 2015 and 2014

APPENDIX B

The University of Vermont Health Network Inc. and Subsidiaries
Index
September 30, 2015 and 2014

Independent Auditor's Report

To the Board of Trustees of
The University of Vermont Health Network Inc. and its Subsidiaries

We have audited the accompanying consolidated financial statements of The University of Vermont Health Network Inc. and its Subsidiaries (the "Network"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on the 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 our 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, we consider internal control relevant to the Network'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 Network'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 The University of Vermont Health Network Inc. and its Subsidiaries as of September 30, 2015 and 2014, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP, 101 Seaport Boulevard, Suite 500, Boston, MA 02210
T: (617) 530 5000, F: (617) 530 5001, www.pwc.com/us

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The other financial 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 other financial information has been subjected to the auditing procedures applied in the audits 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 other financial information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The other financial information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and changes in net assets of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and changes in net assets of the individual companies.

PricewaterhouseCoopers LLP

December 18, 2015

The University of Vermont Health Network Inc. and Subsidiaries
Consolidated Balance Sheets
September 30, 2015 and 2014

(in thousands)	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 228,791	$ 268,216
Patient and other trade accounts receivable - net of allowance for doubtful accounts of $33,979 and $38,300, respectively	193,634	202,182
Inventories	31,863	29,766
Current portion of assets whose use is limited or restricted	35,773	27,876
Receivables from third-party payers	6,812	4,329
Prepaid, other current assets, and short-term investments	45,556	37,187
Total current assets	542,429	569,556
Assets whose use is limited or restricted		
Board-designated assets	417,370	349,054
Assets held by trustee under bond indenture agreements	23,542	28,405
Restricted assets	20,452	28,422
Donor-restricted assets for specific purposes	31,482	33,538
Donor-restricted assets for permanent endowment	31,486	31,373
Total assets whose use is limited or restricted	524,332	470,792
Property and equipment, net	619,964	599,973
Other	20,728	21,468
Total assets	$ 1,707,453	$ 1,661,789
Liabilities and Net Assets		
Current liabilities		
Current installments of long-term debt	$ 28,015	$ 28,233
Accounts payable	37,220	36,386
Accrued expenses and other liabilities	49,005	60,463
Accrued payroll and related benefits	107,457	96,219
Third-party payer settlements	15,346	16,441
Incurred but not reported claims	28,444	24,073
Total current liabilities	265,487	261,815
Long-term liabilities		
Long-term debt - net of current installments	417,618	439,051
Malpractice and workers' compensation claims net of current portion	31,351	32,459
Pension and other postretirement benefit obligations	94,420	70,663
Other	35,102	30,671
Total long-term liabilities	578,491	572,844
Total liabilities	843,978	834,659
Commitments and contingent liabilities		
Net assets		
Unrestricted	792,549	755,263
Temporarily restricted	37,765	38,873
Permanently restricted	33,161	32,994
Total net assets	863,475	827,130
Total liabilities and net assets	$ 1,707,453	$ 1,661,789

The accompanying notes are an integral part of these consolidated financial statements.

APPENDIX B

The University of Vermont Health Network Inc. and Subsidiaries
Consolidated Statements of Operations
Years Ended September 30, 2015 and 2014

(in thousands)	2015	2014
Unrestricted revenue and other support		
Net patient service revenue	$ 1,536,497	$ 1,455,153
Less: Provision for bad debts	(35,429)	(42,386)
Net patient service revenue after provision for bad debts	1,501,068	1,412,767
Enhanced Medicaid Graduate Medical Education revenues-Hospital	11,511	11,461
Enhanced Medicaid Graduate Medical Education revenues-Professional	18,490	18,818
Net patient service revenue after provision for bad debts and Enhanced Medicaid Graduate Medical Education revenues	1,531,069	1,443,046
Premium revenue	11,571	42,925
Other revenue	103,731	81,580
Total unrestricted revenue and other support	1,646,371	1,567,551
Expenses		
Salaries, payroll taxes, and fringe benefits	982,631	929,559
Supplies and other	418,885	399,380
Purchased services	63,695	58,501
Depreciation and amortization	72,785	76,654
Interest expense	19,219	21,184
Underwriting expenses	13,696	9,902
Medical claims	668	12,350
Total expenses	1,571,579	1,507,530
Income from operations	74,792	60,021
Nonoperating gains (losses)		
Investment income	9,445	15,277
Change in fair value of interest rate swap agreements	(5,642)	(2,058)
Loss on the extinguishment of debt	(346)	-
Other	5,841	2,189
Total nonoperating gains, net	9,298	15,408
Excess of revenue over expenses	84,090	75,429
Net change in unrealized (losses) gains on investments	(12,875)	15,417
Net assets released from restrictions for capital purchases	3,386	3,281
Pension related adjustments	(37,780)	(19,238)
Other adjustments	465	(1,334)
Increase in unrestricted net assets	$ 37,286	$ 73,555

The accompanying notes are an integral part of these consolidated financial statements.

The University of Vermont Health Network Inc. and Subsidiaries
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

(in thousands)	2015	2014
Unrestricted net assets		
Excess of revenue over expenses	$ 84,090	$ 75,429
Net change in unrealized (losses) gains on investments	(12,875)	15,417
Net assets released from restrictions for capital purchases	3,386	3,281
Pension related adjustments	(37,780)	(19,238)
Other adjustments	465	(1,334)
Increase in unrestricted net assets	37,286	73,555
Temporarily restricted net assets		
Gifts, grants, and bequests	6,018	9,390
Investment income	185	339
Net change in unrealized gains on investments	(1,606)	(281)
Net realized gains on investments	1,394	3,149
Net assets released from restrictions used in operations	(3,415)	(2,372)
Net assets released from restrictions used for nonoperating purposes	(198)	(188)
Net assets released from restrictions used for capital purchases	(3,386)	(3,281)
Transfer of net assets	(100)	(383)
(Decrease)/Increase in temporarily restricted net assets	(1,108)	6,373
Permanently restricted net assets		
Gifts, grants, and bequests	1,164	63
Change in beneficial interest in perpetual trusts	(1,097)	1,216
Transfer of net assets	100	383
Increase in permanently restricted net assets	167	1,662
Increase in net assets	36,345	81,590
Net assets		
Beginning of year	827,130	745,540
End of year	$ 863,475	$ 827,130

The accompanying notes are an integral part of these consolidated financial statements.

APPENDIX B

The University of Vermont Health Network Inc. and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

(in thousands)	2015	2014
Cash flows from operating activities		
Increase in net assets	$ 36,345	$ 81,590
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	72,785	76,654
Provision for bad debts	35,429	42,386
Contributions restricted for long-term use	(1,392)	(3,104)
Pension related adjustments	37,780	19,238
Loss on extinguishment of debt	346	-
Loss (gain) on disposal of property and equipment	791	(2,396)
Loss on interest rate swap agreements	5,642	2,058
Realized and unrealized losses (gains) on investments	6,131	(29,649)
Undistributed losses (gains) of affiliated companies	1,769	(1,638)
Change in beneficial interest in perpetual trusts	1,097	(1,216)
Increase (decrease) in cash resulting from a change in		
Patient and other accounts receivable	(26,881)	(68,776)
Other current and noncurrent assets	(3,062)	6,142
Estimated receivables from third-party payers	(2,483)	622
Accounts payable and accrued expenses	(11,564)	(10,999)
Accrued payroll and related expenses	11,238	5,316
Other current and noncurrent liabilities	2,052	(56)
Estimated settlements with third-party payer settlements	(1,095)	(4,485)
Pension and other postretirement benefit obligations	(14,023)	(14,875)
Net cash provided by operating activities	150,905	96,812
Cash flows from investing activities		
Acquisitions of property and equipment	(86,830)	(65,180)
Proceeds from sale of property and equipment	32	2,770
Purchase of investments	(646,359)	(232,403)
Proceeds from sale of investments	564,290	226,478
Use of bond proceeds deposited with trustees	4,895	-
Net cash used in investing activities	(163,972)	(68,335)
Cash flows from financing activities		
Proceeds from restricted contributions & restricted investment income	1,392	3,104
Payments on long-term debt	(51,485)	(23,005)
Proceeds from debt issuance	23,840	9,903
Payment of debt issuance costs	(203)	-
Borrowings on line of credit	17,967	17,770
Repayments on line of credit	(17,869)	(16,885)
Net cash used in financing activities	(26,358)	(9,113)
Net increase (decrease) in cash and cash equivalents	(39,425)	19,364
Cash and cash equivalents		
Beginning of year	268,216	248,852
End of year	$ 228,791	$ 268,216
Supplemental cash flow information		
Cash paid during the year for interest	$ 19,256	$ 19,668
Capital expenditures included in accounts payable	5,808	5,322
Assets acquired under capital lease	5,674	2,165

The accompanying notes are an integral part of these consolidated financial statements.

The University of Vermont Health Network Inc. and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

1. Organization

The University of Vermont Health Network Inc. ("UVM Health Network"), established as of October 1, 2011, is a nonprofit, tax-exempt Vermont corporation and the sole corporate member of University of Vermont Medical Center, Inc., The University of Vermont Health Network - Central Vermont Medical Center, Inc., and Community Providers, Inc. UVM Health Network became the sole corporate member of University of Vermont Medical Center, Inc. and The University of Vermont Health Network - Central Vermont Medical Center, Inc. on October 1, 2011, and of Community Providers, Inc. on January 1, 2013. UVM Health Network's purpose is to establish an integrated regional health care system for the development of a highly coordinated health care network to improve the quality, increase the efficiencies, and lower the costs of health care delivery in the regions it serves.

The University of Vermont Medical Center, Inc. ("UVM Medical Center") is a tertiary care teaching hospital that, in affiliation with The University of Vermont ("UVM"), serves as Vermont's academic medical center. As a regional referral center, UVM Medical Center provides advanced level care throughout Vermont and Northern New York, with a full time emergency department which is also certified as a Level 1 Trauma Center. It is UVM Medical Center's mission to improve the health of the people in the communities that it serves by integrating patient care, education, and research in a caring environment. As a charitable organization, UVM Medical Center lives its mission through a number of community benefit programs, many done in collaborative partnership with other community based organizations. These include, but are not limited to, community wellness programs, education, direct grants, free access to a community health resource center, direct financial assistance to patients, and other subsidized programs.

UVM Medical Center is the sole member of the following subsidiaries: University of Vermont Medical Center Health Ventures, Inc.; University of Vermont Medical Group; University of Vermont Health Network Specialty Care Transport, LLC; University of Vermont Medical Center Skilled Nursing, LLC; University of Vermont Medical Center Foundation, Inc.; University of Vermont Medical Center Executive Services, LLC; and VMC Indemnity Company Ltd. ("VMCIC"). Vermont Managed Care, Inc. ("VMC") is a wholly owned subsidiary of UVM Medical Center Health Ventures. The following entities are partly owned or controlled by University of Vermont Medical Center: Medical Education Center Condominium Association, Inc.; OB Net Services, LLC; Copley Woodlands, Inc.; University of Vermont Medical Group – New York, PLLC; and OneCare Vermont Accountable Care Organization, LLC ("OCV").

The University of Vermont Health Network - Central Vermont Medical Center, Inc. ("CVMC") provides health care services under three distinct business units: Central Vermont Hospital, Woodridge Rehabilitation and Nursing ("Woodridge"), and Central Vermont Medical Group Practice. CVMC works collaboratively to meet the needs and improve the health of the residents of central Vermont. CVMC's hospital provides 24-hour emergency care and has a full spectrum of inpatient and outpatient services.

Community Providers, Inc.'s ("CPI") primary purpose is to develop and coordinate a community and regionally focused healthcare system in Northern New York that provides appropriate, cost-effective care, emphasizing wellness and prevention, and promising both public and patient education.

CPI includes The University of Vermont Health Network - Champlain Valley Physician Hospital ("CVPH"), Mediquest Corp., Emergency Medical Transport of CVPH, Inc., Champlain Valley Health Network, Inc., and The University of Vermont Health Network-Elizabethtown Community Hospital ("ECH"). CVPH is the sole member of The Foundation of CVPH, Champlain Valley Open

MRI, LLC, and Valcour Imaging, Inc., and is a member in Adirondack Accountable Care Organization, LLC ("ADK ACO").

2. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements have been prepared on the accrual basis of accounting and include the accounts of UVM Health Network and its subsidiaries for which it controls or serves as the sole corporate member. All significant intercompany balances and transactions have been eliminated in consolidation. The assets of members of the consolidated group may not be available to meet the obligations of another member of the group.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Significant estimates include the allowances for doubtful accounts and contractual allowances, receivables and accruals for estimated settlements with third-party payers, contingencies, self-insurance program liabilities, accrued medical claims, pension and postretirement costs, and the valuation of investments and interest rate swaps. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include all highly liquid investments with maturities of three months or less when purchased, excluding amounts classified as assets whose use is limited or restricted.

Most of UVM Health Network's banking activity, including cash and cash equivalents, is maintained with multiple regional banks and from time to time cash deposits exceed federal insurance limits. It is UVM Health Network's policy to monitor these banks' financial strength on an ongoing basis.

Inventories

Inventories are stated using the lesser of average cost or fair value.

Prepaid and Other Current Assets

Prepaid and other current assets include miscellaneous non-trade receivables and prepaid expenses primarily related to software maintenance and other contracts. The carrying value of prepaid and other current assets is reviewed if the facts and circumstances suggest that it may be impaired.

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted primarily include board-designated assets, assets held by trustees under indenture agreements, donor-restricted assets, and restricted assets which are held for insurance-related liabilities. Board-designated assets may be used at the Board's discretion. A significant portion of the assets are made up of investments.

Investments and Investment Income

Investments in equity securities and mutual funds with readily determinable fair market values and all investments in debt securities are recorded at fair value. Investments for which a market value is not readily determinable, including investments in common collective trusts and hedge funds, are either recorded at cost or at their reported fair value based on information provided by the fund manager, and are reviewed for reasonableness by management. Investment income or loss (including realized gains and losses on investments, interest, and dividends), to the extent not capitalized, is included in nonoperating gains (losses), unless the income or gain (loss) is restricted by donor or law. Realized gains or losses on the sale of investments are determined by use of

average costs. Unrealized gains and losses on investments carried at fair value are excluded from the excess of revenue over expenses and reported as an increase or decrease in net assets. Declines in fair value that are judged to be other-than-temporary are reported as realized losses.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated financial statements.

UVM Health Network reviews its investments to identify those for which fair value is below cost. UVM Health Network then makes a determination as to whether the investment should be considered other-than-temporarily impaired. UVM Health Network recognized $7,686,000 and $828,000 in losses related to declines in value that were other-than-temporary in nature for the years ended September 30, 2015 and 2014, respectively.

Property and Equipment
Property and equipment acquisitions are recorded at cost or, in the case of gifts, at fair market value at the date of the gift. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized using the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements.

Depreciation is calculated using the following estimated useful lives:

Land improvements	2 – 25 years
Leasehold improvements	2 – 30 years
Building and improvements	5 – 40 years
Equipment, furniture, and fixtures	3 – 30 years

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support and are excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets 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 these long-lived assets must be maintained, expiration of donor restrictions is reported when the donated or acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less costs to sell.

Costs of Borrowing
Interest cost incurred on borrowed funds during the period of construction of capital assets, net of investment income on borrowed assets held by trustees, is capitalized as a component of the cost of acquiring those assets. Approximately $651,000 and $411,000 of interest was capitalized during the years ended September 30, 2015 and 2014, respectively. Net deferred financing costs totaled $9,449,000 and $11,063,000 at September 30, 2015 and 2014, respectively. Such amounts are reported as an offset to long term debt and are amortized over the period the related obligations

are outstanding using the effective interest method. Accumulated amortization of deferred financing costs totaled $5,374,000 and $6,461,000 at September 30, 2015 and 2014, respectively.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by UVM Health Network has been limited by donors or law to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by UVM Health Network in perpetuity.

Consolidated Statement of Operations
For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as unrestricted revenue and other support and expenses. Peripheral or incidental transactions are reported as nonoperating gains (losses).

Excess of Revenue Over Expenses
The consolidated statements of operations include the excess of revenue over expenses. Changes in unrestricted net assets which are excluded from the excess of revenue over expenses, consistent with industry practice, primarily include unrealized gains and losses on investments (other than those on which other-than-temporary losses are recognized), contributions of long-lived assets (including assets acquired using contributions restricted by donors for acquiring such assets), and pension related adjustments.

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts due from patients and third-party payers for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Under the terms of various agreements, regulations, and statutes, certain elements of third-party reimbursement are subject to negotiation, audit, and/or final determination by the third-party payers. In addition, laws and regulations governing Medicare and Medicaid programs are 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. Differences between amounts previously estimated for retroactive adjustments and amounts subsequently determined to be recoverable or payable are included in net patient service revenue in the year that such amounts become known. Changes in prior-year estimates increased net patient service revenue by approximately $7,370,000 and $2,377,000 in the years ended September 30, 2015 and 2014, respectively.

UVM Health Network has agreements with third-party payers that provide for payments to UVM Health Network at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare
Inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient rehabilitation services are paid based on a prospective per discharge methodology. These rates vary according to a patient classification system based upon services provided, the patient's level of functionality and other factors. Outpatient services are paid based upon a prospective standard rate for procedures performed or services rendered. UVM Health Network is reimbursed for cost-reimbursable items at tentative rates, with final settlement determined after submission of annual cost reports by UVM Health Network and audits thereof by the Medicare Audit Contractor ("MAC"). Medicare reimbursement for professional billings is determined by a standard fee schedule that is determined by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. The

percentage of net patient service revenue derived from the Medicare program was approximately 32% and 31% in the years ended September 30, 2015 and 2014, respectively.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. As with Medicare, reimbursement is based on a diagnosis-related group ("DRG") system that is based on clinical, diagnostic, and other factors. For inpatient rehabilitation and neonatal cases, additional reimbursement is paid through a per diem add-on. In Vermont, additional reimbursement for inpatient psychiatric cases is based on a per diem rate calculation, including adjustments for diagnostic factors and length of stay. Outpatient services rendered to Medicaid beneficiaries are paid based upon a prospective standard rate. Certain laboratory, mammography, therapy, and dialysis services are paid on a fee schedule. Medicaid reimbursement for professional services is determined by a standard fee schedule. The Medicaid program accounts for approximately 8% and 12% of UVM Health Network's net revenue for the years ended September 30, 2015 and 2014, respectively.

Managed Care and Commercial Insurers

Services rendered to patients with commercial insurance are generally reimbursed at standard charges, less a negotiated discount or according to DRG or negotiated fee schedules. Approximately 51% and 49% of UVM Health Network's net revenues were derived from contracted insurers in the years ended September 30, 2015 and 2014, respectively. Approximately 9% and 8% of UVM Health Network's net revenues were derived from noncontracted insurers in the years ended September 30, 2015 and 2014, respectively.

Enhanced Medicaid Graduate Medical Education Revenues (Hospital and Professional)

Under an Amendment to the Vermont State Medicaid Plan TN#11-019 (the "State Plan Amendment"), UVM Medical Center received increased Vermont Medicaid payments to support graduate medical education ("GME") beginning in fiscal year 2013. The State Plan Amendment was approved by the Centers for Medicare and Medicaid Services in May 2013 with an effective date of July 1, 2011, the date of submission by the State's Department of Vermont Health Access. The State Plan Amendment provided for enhanced Medicaid payments of GME through two funding mechanisms: (1) payments to "qualified teaching hospitals" and (2) payments to "qualified teaching physicians." Under the definitions contained in the State Plan Amendment, UVM Medical Center is a qualified teaching hospital and physicians employed by UVM Medical Group are qualified teaching physicians.

The nonfederal source of these payments was provided by payments from UVM from its governmental appropriations from the State of Vermont ("the State"). UVM has entered into a contract with the State to provide annual amounts during the State's fiscal year as the nonfederal share of GME payments for that year. UVM Medical Center expects that UVM will enter into similar contracts for subsequent years, though there is no assurance of this. UVM Medical Center entered into a contract with the State, by which UVM Medical Center agrees to assess and monitor program benefits to Medicaid beneficiaries and to report to the State annually on its performance on certain quality measures and improvement focus areas for Medicaid beneficiaries pertaining to UVM Medical Center's GME programs, and the State agrees to provide GME payments to UVM Medical Center during the State fiscal year. UVM Medical Center expects to enter into similar contracts with the State for future years, but these are subject to continued funding by UVM of the nonfederal source. The State, UVM Medical Center and UVM have also entered into a Memorandum of Understanding ("MOU"), dated June 10, 2013 that describes the State Plan Amendment and these funding arrangements.

UVM Medical Center received GME funding from the State under the State Plan Amendment totaling $30.0 million and $30.3 million for the fiscal years ending September 30, 2015 and September 30, 2014, respectively. The $30.0 million includes reimbursement to UVM Medical Center as a qualified teaching hospital in an amount of $11.5 million and reimbursement to the UVM Medical Group as qualified teaching physicians in an amount of $18.5 million. Under the MOU, both UVM and the State retain the right to discontinue GME payments at any time in the future.

Premium Revenue
Premium revenue consisted primarily of payer incentives and meaningful use dollars for the year ended September 30, 2015.

For the year ended September 30, 2014, premium revenue primarily consisted of revenue from VMC. VMC had agreements with various insurers to provide medical services through its provider network to subscribing participants. Under these agreements, VMC received monthly capitation payments based on the number of each insurer's participants, regardless of services actually performed by VMC's network of providers. The remaining two payer contracts under these agreements ended by the second quarter of fiscal year 2015. No additional payer contracts are anticipated in the near future under the VMC risk-arrangement model.

Other Revenue
Other revenue consists primarily of research revenue, nonpatient related contract revenues, sales of pharmaceuticals and related products, cafeteria sales, parking garage income, net assets released from restrictions used for operations, and rental income.

Research Grants and Contracts
Revenue related to research grants and contracts is recognized as the related costs are incurred. Research grants and contracts are accounted for as exchange transactions. Amounts received in advance of incurring the related expenditures are recorded as unexpended research grants and are included within accrued expenses and other liabilities. Amounts expended in advance of the receipt of funding are included within patient and other trade accounts receivable.

Reserves for Outstanding Losses and Loss-Related Expenses for Malpractice and Workers' Compensation Claims
The liabilities for outstanding losses and loss-related expenses and the related provision for losses and loss-related expenses include estimates for malpractice losses incurred but not reported, losses pending settlement, as well as for workers' compensation claims and underwriting expenses. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liabilities may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liabilities are actuarially reviewed on an annual basis and any adjustments required are reflected in underwriting expenses.

Income Taxes
Entities within the UVM Health Network, with the exception of entities specifically named below, are incorporated and recognized by the Internal Revenue Service ("IRS") as tax-exempt under Section 501(c)(3) of the Internal Revenue Code (the "Code"). Accordingly, the IRS has determined that these organizations are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. UVM Medical Center Specialty Care Transport, UVM Medical Center Executive Services, 116 Realty, LLC, and UVM Medical Center Skilled Nursing are single-member

limited liability corporations. As such, for tax purposes, these organizations are treated as divisions of UVM Medical Center. OCV and ADK ACO are limited liability companies taxed as partnerships. Earnings and losses are passed through to the owners, which are tax-exempt, and are treated in the same manner for tax purposes. No provision for federal income taxes has been recorded in the accompanying consolidated financial statements for these organizations.

University of Vermont Health Ventures, VMC, Mediquest and CVHN are for-profit subsidiaries subject to federal and state taxation. The tax provisions and related tax assets and liabilities for these entities are not material to the consolidated financial statements.

UVM Health Network accounts for recognition and measurement of uncertain tax positions in accordance with Accounting Standards Codification (ASC) 740 *Income Taxes*, which addresses how to account for and report the effects of taxes based on income. No provision for uncertain tax positions is recorded in the accompanying consolidated financial statements.

VMCIC is currently not a taxable entity under the provisions of the territory of Bermuda and, accordingly, no provision for taxes has been recorded by VMCIC. In the event that such taxes are levied, VMCIC has received an undertaking from the Bermuda Government exempting it from all such taxes until March 31, 2035.

Asset Retirement Obligations
UVM Health Network recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that UVM Health Network considers are those for which it has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control. The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized.

The estimated future undiscounted value of the asset retirement obligation is approximately $4,002,000 and $3,103,000 at September 30, 2015 and 2014, respectively, substantially all of which relates to the estimated costs to remove asbestos that is contained within UVM Health Network's facilities. The initial asset retirement obligation was calculated using discount rates of 4.5%-6.0%. The recorded asset retirement obligation at September 30, 2015 and 2014 was approximately $2,406,000 and $1,665,000, respectively.

Defined Benefit Pension and Other Postretirement Benefit Plans
UVM Health Network recognizes the overfunded or underfunded status of its defined benefit pension and other postretirement benefit plans (collectively, "postretirement benefit plans") in the consolidated balance sheet. Changes in the funded status of the plans are reported in the year in which the changes occur as a change in unrestricted net assets presented below the excess of revenue over expenses in the consolidated statements of operations and changes in net assets.

Fair Value Measurements
Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (also referred to as an "exit price"). A fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. In determining fair value, the use of various valuation approaches, including market, income, and cost approaches, is permitted.

GAAP establishes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

UVM Health Network uses the following fair value hierarchy to present its fair value disclosures:

Level 1 Quoted (unadjusted) prices for identical assets or liabilities in active markets. Active markets are those in which transactions for the asset or liability occur with sufficient frequency and volume to provide pricing information on an ongoing basis.

Level 2 Other observable inputs, either directly or indirectly, including:

- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time).
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates).
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 Unobservable inputs that cannot be corroborated by observable market data.

Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the above fair value hierarchy.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value:

Mutual Funds
The fair values of mutual funds are based on quoted market prices.

Money Market Funds
The fair values of money market funds are based on quoted market prices.

Debt Securities
The estimated fair values of debt securities are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. The marketable debt securities classified as Level 2 were classified as such due to the usage of observable market prices for similar securities that are traded in less active markets or when observable market prices for identical securities are not available. Marketable debt instruments are priced using: nonbinding market consensus prices that are corroborated with observable market data; quoted market prices for similar instruments; or pricing models, such as a discounted cash flow model, with all significant inputs derived from or corroborated with observable market data. These Level 2 debt securities primarily include corporate bonds, notes and other debt securities.

Common Collective Trusts and Hedge Funds
The estimated fair values of common collective trusts and hedge funds are determined based upon the net asset value ("NAV") provided by the fund managers and assessed for reasonableness by management.

Beneficial Interest in Perpetual Trusts
The estimated fair values of UVM Health Network's beneficial interests in perpetual trusts are determined based upon information provided by the trustees and assessed for reasonableness by management.

Interest Rate Swap Agreements
Interest rate swap agreements are valued at the present value of the estimated series of cash flows resulting from the exchange of fixed rate payments for floating rate payments from the counterparty over the remaining life of the contract from the balance sheet date. Each floating rate payment is calculated based on forward market rates at the valuation date for each respective payment date. The valuation based on the estimated series of cash flows is obtained from third parties and assessed by management for reasonableness. Because the inputs used to value the contract can generally be corroborated by market data, the fair value is categorized as Level 2.

Reclassifications
Certain amounts in the 2014 financial statements have been reclassified to conform to the 2015 presentation.

3. Adoption of New Accounting Guidance

UVM Health Network early adopted ASU 2015-03 *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, which required debt issuance costs to be recognized as a direct reduction to the carrying amount of the debt liability. As such, UVM Health Network reclassified debt issuance costs totaling $11,063,000 as of September 30, 2014, from other long term assets to long term debt.

In May 2015, the FASB issued ASU 2015-07, *Disclosures for Certain Entities That Calculate Net Asset Value per Share (or its Equivalent)*, which removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using net asset value per share as the practical expedient. This guidance is effective in fiscal year 2017, however, early adoption is permitted. UVM Health Network has elected to adopt the guidance early, and the impact of the adoption of the new standard is limited to the notes to the financial statements.

In May 2014, the FASB issued a standard on *Revenue from Contracts with Customers*. This standard implements a single framework for recognition of all revenue earned from customers. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services by allocating transaction price to identified performance obligations and recognizing revenue as performance obligations are satisfied. Qualitative and quantitative disclosures are required 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 standard is effective for fiscal years beginning after December 15, 2017. UVM Health Network is evaluating the impact this will have on the combined financial statements upon adoption in fiscal year 2019.

4. Charity Care and Community Service

UVM Health Network provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because UVM Health Network does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The amount of charges foregone for services and supplies furnished under UVM Health Network's charity care policy aggregated approximately $17,102,000 and $27,777,000 for the years ended September 30, 2015 and 2014, respectively.

Approximately $6,928,000 and $10,763,000 of UVM Health Network's total expenses for the years ended September 30, 2015 and 2014 arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on UVM Health Network's total expenses divided by gross patient service revenue. For the years ended September 30, 2015 and 2014, respectively, UVM Health Network used $178,000 and $250,000 in charitable endowment earnings to help defray the costs of indigent care.

5. Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted at September 30, 2015 and 2014 consisted of the following:

(in thousands)	2015	2014
Equities	$ 22,288	$ 14,450
Mutual funds	117,933	88,687
Money market funds	45,824	21,153
Bonds and notes	54,887	39,861
Common collective trusts		
Bond funds	149,352	130,588
U.S. treasury obligation funds	43,907	38,507
International equity funds	68,993	68,149
Domestic equity funds	3,186	29,805
Commodity funds	17,770	23,155
Real estate funds	17,315	27,672
Total common collective trusts	300,523	317,876
Beneficial interest in perpetual trusts	12,975	14,072
Hedge funds	5,297	2,569
Real estate	378	-
	560,105	498,668
Less: Current portion	(35,773)	(27,876)
	$ 524,332	$ 470,792

Investment income and gains (losses) for the years ended September 30, 2015 and 2014 consisted of the following:

(in thousands)	2015	2014
Nonoperating revenue and expenses		
Investment income	$ 2,489	$ 3,913
Net realized gains	6,956	11,364
Investment income recorded in nonoperating gains	9,445	15,277
Net change in unrealized (losses) gains on investments	(12,875)	15,417
Changes in temporarily restricted net assets		
Investment income	185	339
Net change in unrealized (losses) on investments	(1,606)	(281)
Net realized gains on investments	1,394	3,149
	(27)	3,207
Changes in permanently restricted net assets		
Change in beneficial interest in perpetual trusts	(1,097)	1,216
	$ (4,554)	$ 35,117

The cost and estimated fair value of securities classified as available-for-sale by the organization, which excludes beneficial interest in perpetual trusts of $12,975,000 and $14,072,000, and includes short-term investments of $15,106,000 and $6,205,000 as of September 30, 2015 and 2014, respectively, and long-term investments of $3,924,000 and $4,222,000 as of September 30, 2015 and 2014, respectively, is as follows:

	2015		
(in thousands)	Cost	Gross Unrealized Gains/(Losses)	Estimated Fair Value
Mutual funds	$ 121,576	$ 4,347	$ 125,923
Equities	31,080	(1,183)	29,897
Real estate	728	(15)	713
Hedge funds	5,378	422	5,800
Money market funds	46,604	(133)	46,471
Bonds and notes	57,292	(550)	56,742
Common collective trusts	275,988	24,626	300,614
	$ 538,646	$ 27,514	$ 566,160

	2014		
(in thousands)	Cost	Gross Unrealized Gains/(Losses)	Estimated Fair Value
Mutual funds	$ 80,845	$ 11,788	$ 92,633
Equities	16,531	2,364	18,895
Real estate	192	13	205
Hedge funds	2,597	431	3,028
Money market funds	21,670	131	21,801
Bonds and notes	40,546	(233)	40,313
Common collective trusts	289,418	28,730	318,148
	$ 451,799	$ 43,224	$ 495,023

The following tables present information as of September 30, 2015 and 2014, about UVM Health Network's financial assets and liabilities that are measured at fair value on a recurring basis:

	2015				
(in thousands)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	NAV as Practical Expedient	Fair Value
Mutual funds	$ 125,923	$ -	$ -	$ -	$ 125,923
Equities	29,897	-	-	-	29,897
Money market funds	46,471	-	-	-	46,471
Hedge funds	-	-	-	5,800	5,800
Bonds and notes	21,512	35,230	-	-	56,742
Common collective trusts	-	-	-	300,614	300,614
Beneficial interest in perpetual trusts	-	-	12,975	-	12,975
Real estate	713	-	-	-	713
	$ 224,516	$ 35,230	$ 12,975	$ 306,414	$ 579,135
Interest rate swap agreements	$ -	$ 24,762	$ -	$ -	$ 24,762

	2014				
(in thousands)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	NAV as Practical Expedient	Fair Value
Mutual funds	$ 92,633	$ -	$ -	$ -	$ 92,633
Equities	18,895	-	-	-	18,895
Money market funds	21,801	-	-	-	21,801
Hedge funds	-	-	-	3,028	3,028
Bonds and notes	30,468	9,845	-	-	40,313
Common collective trusts	-	-	-	318,148	318,148
Beneficial interest in perpetual trusts	-	-	14,072	-	14,072
Real estate	205	-	-	-	205
	$ 164,002	$ 9,845	$ 14,072	$ 321,176	$ 509,095
Interest rate swap agreements	$ -	$ 19,120	$ -	$ -	$ 19,120

The table below summarizes the fair value measurements of the investments in certain entities that calculate net asset value per share as of September 30, 2015 and 2014.

	2015					
Category of Investment	Fair Value	Unfunded Commitments	Remaining Life, if Applicable	Redemption Terms, If Currently Eligible	Redemption Restrictions and Terms	Redemption Restrictions and Terms in Place at Year End
Common Collective Trusts	$ 300,614	Not applicable	Not applicable	Daily	Not applicable	Not applicable
Hedge Funds	$ 5,800	Not applicable	Not applicable	Ranges from 60 - 95 days notice, quarterly	100% of these funds are either not under lock or have a lock of one year or less,	None

	2014					
Category of Investment	Fair Value	Unfunded Commitments	Remaining Life, if Applicable	Redemption Terms, If Currently Eligible	Redemption Restrictions and Terms	Redemption Restrictions and Terms in Place at Year End
Common Collective Trusts	$ 318,148	Not applicable	Not applicable	Daily	Not applicable	Not applicable
Hedge Funds	$ 3,028	Not applicable	Not applicable	At least 60 days notice, quarterly	100% of these funds are either not under lock or have a lock of one year or less.	None

As of and for the years ended September 30, 2015 and 2014, the fair value of the assets and change in the value of the assets measured using significant unobservable inputs (Level 3) were related to beneficial interests in perpetual assets.

6. Property and Equipment

A summary of property and equipment at September 30, 2015 and 2014 is as follows:

(in thousands)	2015	2014
Land	$ 24,262	$ 20,461
Land improvements	17,647	17,125
Leasehold improvements	50,176	45,786
Buildings	715,687	694,424
Equipment, furniture, and fixtures	463,484	414,939
	1,271,256	1,192,735
Less: Accumulated depreciation	(669,729)	(608,611)
	601,527	584,124
Construction–in–progress	18,437	15,849
	$ 619,964	$ 599,973

UVM Health Network wrote off approximately $12,766,000 and $5,916,000 in gross property and equipment in the years ended September 30, 2015 and 2014, respectively. In conjunction with these write offs, a loss on disposal of property and equipment of $791,000 and a gain on disposal of property and equipment $2,396,000 was recorded in the years ended September 30, 2015 and 2014, respectively. These gains and losses are included in supplies and other expense. At September 30, 2015 and 2014, UVM Health Network had commitments to purchase approximately $4,510,000 and $19,397,000, respectively, of property and equipment.

UVM Health Network recorded depreciation expense of $72,176,000 and $76,074,000 for the years ended September 30, 2015 and 2014, respectively.

7. Long-Term Debt

Long-term debt at September 30, 2015 and 2014 consisted of the following:

(in thousands)	2015	2014
Vermont Educational and Health Buildings Financing Agency		
Hospital Revenue Bonds		
Series 2009A loan, fixed rate (5.08% to 7.23%), payable through 2024	$ 10,113	$ 10,999
Series 2008A Bonds, variable rate (0 .01.% at September 30, 2015), payable through 2030	54,706	54,705
Series 2007A Bonds, fixed rate (4.00% to 4.75%), payable through 2037 (including unamortized premium of $82 and $86 at September 30, 2015 and 2014, respectively)	55,347	55,791
Series 2004B Bonds, fixed rate (4.00% to 5.50%), payable through 2035 (including unamortized premium of $113 and $119 at September 30, 2015 and 2014, respectively)	141,088	143,843
Series 2004A Bonds, fixed rate (3.00% to 5.00%), payable through 2025 (including unamortized premium of $0 and $903 at September 30, 2015 and 2014, respectively)	-	31,383
Series 2013A Bonds, fixed rate (2.60%) payable through 2027	28,687	29,012
Series 1996 loan, fixed rate (3.50%), payable through 2021	7,519	8,683
Series 2015A Bonds, Fixed rate (2.27%), payable through 2023	23,840	-
County of Clinton Industrial Development Agency		
Hospital Revenue Bonds		
Series 2006A & 2006B Bonds, variable rate (0.14% at September 30, 2015), payable through 2017	2,800	4,115
Series 2007B Bonds, variable rate (0.10% at September 30, 2015), payable through 2042	11,185	11,395
Essex County Capital Resource Corporation		
Hospital Revenue Bonds		
Series 2011 Bonds, variable rate (1.63% at September 30, 2015), payable through 2032	5,360	5,590
Other long-term debt		
Series 2002A Key Bank Bonds, variable rate (1.61% at September 30, 2015), payable through 2024	5,450	5,950
Series 2007A Key Bank Bonds, variable rate (1.61% at September 30, 2015), payable through 2042	17,580	17,895
Associates in Radiology of Plattsburg, LLC Note Payable, fixed rate (3.00%), payable through 2017	2,259	3,334
Community Bank Loan Payable, fixed rate (3.50%), payable through 2017	15,312	15,944
Capital lease, fixed rate (0.30% to 19.51%), payable through 2020	8,993	8,489
KeyBank line of credit, variable rate (2.00% at September 30, 2015)	4,983	4,885
KeyBank loan, fixed rate (3.13%), payable through 2023	43,810	48,310
People's United loan, variable rate (1.24%) payable through 2028	8,928	9,446
Other debt	7,122	8,578
	455,082	478,347
Less: Current portion	(28,015)	(28,233)
Less: Unamortized discount and debt issuance costs	(9,449)	(11,063)
Long–term debt	$ 417,618	$ 439,051

Obligated Group

UVM Medical Center and CVMC presently are the sole members of the UVM Health Network Obligated Group.

The Master Trust Indenture contains provisions permitting the addition, withdrawal or consolidation of members of the Obligated Group under certain conditions. The Master Trust Indenture constitutes joint and several obligations of the members of the Obligated Group.

An obligated group does not exist for the CPI entities.

Revenue Bonds

On May 21, 2008, UVM Medical Center converted the Series 2004B auction rate bonds from 35-day variable-rate bonds to fixed-rate bonds through a mandatory tender of the bonds as provided for under the original bond agreement. The tender was financed through the reissuance of $160,525,000 of Series 2004B bonds as tax-exempt fixed-rate bonds, and a payment of $2,700,000 from UVM Medical Center's debt service reserve funds. The Series 2004B bonds require UVM Medical Center to maintain a debt service reserve fund. As of September 30, 2015 and 2014, the reserve fund balances were approximately $15,527,000 and $15,031,000, respectively.

Also on May 21, 2008, UVM Medical Center in connection with the Vermont Educational and Health Buildings Financing Agency (the "Agency"), issued $54,705,000 of tax-exempt variable-rate hospital revenue bonds ("Series 2008A"), the proceeds of which were used to refund its Series 2000B bonds in the amount of $50,000,000, pay an early termination payment in the amount of $3,128,000 on a related interest rate swap, and pay issuance costs in the amount of $1,577,000. The Series 2008A bonds are collateralized by an irrevocable letter of credit from a bank in the amount of $55,334,000 (covers principal of $54,705,000 and interest of $629,000), which expires in 2021. The interest rate on the Series 2008A bonds is set weekly. Series 2008A bondholders have the option to put the bonds back to UVM Medical Center. Such bonds would be subject to remarketing efforts by UVM Medical Center's remarketing agent. To the extent that such remarketing efforts were unsuccessful, the nonmarketable bonds would be purchased from the proceeds of the letter of credit. Monthly payments of principal on the letter of credit borrowings would commence on the first calendar day of the first month that commences more than one year after the borrowing. Repayment in full of the letter of credit would be required by the earlier of four years from the date of the borrowing under the letter of credit or the stated expiration date, currently, April 30, 2021.

In conjunction with these transactions, the notional amount of the original swap agreement covering the 2004B bonds was reduced from $135,000,000 to $55,190,000 and transferred to the 2008A bonds in exchange for the payment of $3,128,000.

UVM Medical Center and certain of its subsidiaries are obligated under various other revenue bonds, capital leases, and notes payable. Various trustee-held funds are required under the terms of the loan agreements. Under one of the loan agreements, a reserve fund is required only upon the failure to meet certain financial ratios. As of September 30, 2015 and 2014, no funding has been required under this agreement.

UVM Medical Center has granted a mortgage on substantially all of its property and an interest in its gross receipts, as defined in connection with the issuance of its long-term debt.

The 2008A letter of credit was not drawn upon as of September 30, 2015, and the scheduled maturities of long-term debt assumes the Series 2008A bonds are not put back to the UVM Health Network Obligated Group. If the letter of credit was drawn upon, the repayment would begin one year and one day from the date of the letter of credit being drawn upon. The repayment schedule would occur over the remaining three years of the letter of credit term. The repayment of principal would be as follows: $21,176,000 in year two, $21,176,000 in year three and $12,354,000 in the final year.

Series 1996 Bond Refinancing
In November 2011, the Series 1996 Bonds were redeemed with the proceeds of a term loan made to CVMC by People's United Bank in the amount of $11,600,000. The term loan has a fixed rate of interest of 3.50% and matures November 1, 2021. Interest payments are made monthly and principal payments in the amount of $582,000 are made semi-annually each May and November, beginning May 1, 2012 and ending on November 1, 2021. The term loan is collateralized with assets, mortgage, and all other collateral securing repayment of the Obligation as defined in the Master Trust Indenture of the Obligated Group.

Series 2002A Bonds
The Series 2002A bonds are bank qualified bonds held by Key Bank, payable in annual installments ranging from $500,000 to $700,000, plus interest at one month LIBOR times 0.6501 plus 153 basis points (1.61% at September 30, 2015) through July 2024.

Series 2006A & 2006B Bonds
The Series 2006A and 2006B bonds are County of Clinton Industrial Development Agency, Variable Rate Demand Civic Facility Revenue Bonds, Series 2006A (tax-exempt) of $12,650,000 and Series 2006B (taxable) of $100,000, payable in annual installments ranging from $1,210,000 to $1,430,000 plus interest. Interest is payable semi-annually at a variable rate reset weekly by a remarketing agent (0.14% at September 30, 2015) from July 1, 2007 through July 1, 2017. The bonds are collateralized by a direct-pay letter of credit with a bank aggregating the outstanding principal amount plus 35 days interest at an assumed rate of 8% per annum for the term of the bonds.

The 2006A letter of credit was not drawn upon as of September 30, 2015, and the scheduled maturities of long-term debt assumes the Series 2006A bonds are not put back to the borrower. If the letter of credit was drawn upon, the repayment term would continue to follow the original amortization schedule of the bonds to be repaid not later than the scheduled payments described in the original bond agreement. CVPH's letter of credit matures on February 22, 2017.

Series 2007A Bonds
The Series 2007A bonds are bank qualified bonds held by Key Bank, payable in annual installments ranging from $285,000 to $1,125,000, plus interest at one month LIBOR times 0.6501 plus 153 basis points (1.61% at September 30, 2015) through July 2042.

Series 2007B Bonds
The Series 2007B bonds are County of Clinton Industrial Development Agency, Variable Rate Demand Civic Facility Revenue Bonds, Series 2007B (tax-exempt), payable in annual installments ranging from $150,000 to $700,000, plus interest at one month LIBOR times 0.68 (0.10% at September 30, 2015) through July 2042. The bonds are collateralized by a direct-pay letter of credit with a bank aggregating the outstanding principal amount plus 35 days interest at an assumed rate of 8% per annum for the term of the bonds.

The 2007B letter of credit was not drawn upon as of September 30, 2015, and the scheduled maturities of long-term debt assumes the Series 2007B bonds are not put back to the borrower. If the letter of credit was drawn upon and the bond is not remarketed for 180 days, such bond shall be subject to mandatory redemption on the first business day of each month, commencing with the first such business day of the first full month after the bond redemption commencement date over 60 consecutive months in equal principal amounts plus accrued interest at the bank rate. CVPH's letter of credit matures on March 2, 2017.

Series 2011 Bonds
On December 1, 2011, ECH issued Essex County Capital Resource Corporation Revenue Bonds, Series 2011 in the amount of $6,160,000. The Series 2011 bonds were purchased by Key Bank, N.A. under a bond purchase agreement. As part of the agreement, the Series 2011 bonds are subject to mandatory redemption and are subject to optional tender by the bank for purchase by ECH at a price equal to the principal plus accrued and unpaid interest beginning on June 1, 2017. The Series 2011 bonds are collateralized by a mortgage that Key Bank holds with ECH. The Series 2011 bonds carry a variable interest rate of 65% of 1-month LIBOR plus 155 basis points (1.63% at September 30, 2015) due in quarterly installments through March 1, 2032.

Series 2013A Bonds
The 2000A Bonds were partially refunded in 2011. The remaining $32,550,000 balance of the initial aggregate principal amount of the Series 2000A Bonds with maturities between December 2025 and December 2027 were refunded in March 2013 and replaced with a tax-exempt direct bank private placement with TD Bank (the 2013A bonds), in the aggregate principal amount of $29,500,000 with a final maturity date in December 2027. The Series 2013A bonds carry a fixed interest rate of 2.60%. Bond issuance costs of $250,000 are recorded as deferred financing costs, net and will be amortized over the life of the loan. The 2013 refunding resulted in a loss on extinguishment of debt of $1,142,000.

Series 2015A Bonds
The remaining $30,480,000 par of the initial aggregate principal amount of the Series 2004A Bonds, with maturities between December 2015 and December 2023, were refunded in January 2015 and replaced with a tax-exempt direct bank private placement with Key Government Finance (the 2015A bonds), in the aggregate principal amount of $23,840,000 with a final maturity date in December 2023. Debt service reserve fund proceeds of $6,640,000 were used to buy down the par amount of the new bonds. The Series 2015A bonds carry a fixed interest rate of 2.27%. Bond issuance costs of $159,000 were recorded as deferred financing costs, net and will be amortized over the life of the loan. The 2015A refunding resulted in a loss on extinguishment of debt of $346,000.

People's United Loan
On September 30, 2013, UVM Medical Center entered into a mortgage for property ("Holly Court") in the amount of $9,903,000. The mortgage is payable through September 2028, and bears interest at a variable rate equal to one month LIBOR plus 105 basis points (1.24% at September 30, 2015). Concurrent with the issuance of the Holly Court mortgage, an interest rate swap was entered into whereby UVM Medical Center pays a fixed rate of 2.67% and receives a variable rate of one month LIBOR.

Scheduled Maturities of Long-Term Debt
As of September 30, 2015, scheduled maturities of long-term debt, not including a net unamortized premium of $195,000 for the next five years and thereafter are as follows:

(in thousands)

Years Ending September 30		
2016	$	28,015
2017		21,702
2018		31,625
2019		17,372
2020		16,837
Thereafter		339,336
	$	454,887

Loan Covenants
Under the terms of the master indenture agreement, the UVM Health Network Obligated Group is required to meet certain covenant requirements, as are CVPH and ECH for their respective long-term debt. In addition, the indenture provides for restrictions on, among other things, additional indebtedness and dispositions of property of the UVM Health Network Obligated Group.

Line of Credit
CVMC has a bank line of credit that exists with a maximum borrowing of $2,000,000 at September 30, 2015. The line was renewed for a two-year period on May 31, 2015, and bears interest at the Wall Street Journal prime rate adjusted daily with a floor of 3.25%, with advances collateralized. At September 30, 2015, CVMC did not have any outstanding borrowings under the line of credit.

CPI has an uncollateralized line of credit in the amount of $1,000,000 at September 30, 2015. The interest rate is set at a floating rate equal to LIBOR plus 150 basis points (2.00% at September 30, 2015). At September 30, 2015 CPI had outstanding borrowings under the line of credit of $1,000,000. This revolving line of credit is interest only payments with accrued interest and principal due upon maturity. The maturity date for the line of credit is May 31, 2017.

CVPH has an available uncollateralized line of credit in the amount of $4,984,000 at September 30, 2015. The interest rate is set at a floating rate equal to LIBOR plus 150 basis points (2.00% at September 30, 2015). At September 30, 2015, CVPH had outstanding borrowings under the line of credit of $4,983,000. The maturity date for the line of credit is July 31, 2016.

Long-Term Debt
The estimated fair value of UVM Health Network's long-term debt is based on the recently traded value for debt for which a public market exists, and an estimate of the exit price for debt in which no public market exists. The estimate of the exit price includes the observable inputs related to the interest rates of comparable U.S. Treasury securities. Such amounts at September 30, 2015 and 2014, are approximately $465,894,000 and $482,351,000, respectively. The fair value of debt is considered a Level 2 measurement.

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8. Interest Rate Swap Agreements

For certain variable rate debt, interest rate swap agreements are used to manage interest rate risk and hedge the risk of cash flow volatility. The table below details UVM Health Network's swap agreements. None of the swap agreements require collateral posting. Both UVM Health Network and the counterparties in the interest rate swap agreements are exposed to credit risk in the event of nonperformance or early termination of the agreements. In addition, each agreement may be terminated following the occurrence of certain events, at which time UVM Health Network or the counterparty may be required to make a termination payment to the other.

Swap	Bond Series	Notional Amount September 30 2015 ($ in 000's)	Notional Amount September 30 2014 ($ in 000's)	Counterparty	Expiration Date	Pay Fixed	Receive Floating
LIBOR Swap (Series B-1)	2008A	$ 27,595	$ 27,595	Citibank, NA	December 1, 2034	3.76 %	66.5% of LIBOR + 32bps
LIBOR Swap (Series B-2)	2008A	27,595	27,595	Citibank	December 1, 2034	3.76 %	66.5% of LIBOR + 32bps
LIBOR Swap	Holly Court Loan	8,928	9,446	Peoples United Bank	September 30, 2028	2.67 %	LIBOR + Swap Rate
LIBOR Swap	Series 2006A	2,800	4,115	Key Bank	July 1, 2017	3.50 %	69.0% of LIBOR
LIBOR Swap	Series 2007B	11,185	11,395	Key Bank	July 1, 2042	4.06 %	68.0% of LIBOR
LIBOR Swap	Series 2007A	17,580	17,895	Key Bank	July 1, 2042	4.00 %	65.0% of LIBOR
SIFMA Swap	Series 2011	5,120	5,120	Key Bank	December 1, 2021	3.24 %	65.0% of LIBOR

The fair value of interest rate swap agreements, all of which are recorded as other long-term liabilities at September 30, is as of follows:

	Fair Value	
(in thousands)	**2015**	**2014**
2008A Swaps	$ (13,209)	$ (9,914)
Holly Court Loan	(571)	(230)
2006A Swap	(118)	(224)
2007B Swap	(3,943)	(3,130)
2007A Swaps	(6,261)	(5,016)
2011 Swap	(660)	(606)
	$ (24,762)	$ (19,120)

The effect of interest rate swap agreements on the consolidated statement of operations and changes in net assets for 2015 and 2014 are as follows:

	Amount of Gain/(Loss) Recognized in Statement of Operations	
(in thousands)	**2015**	**2014**
2008A Swaps	$ (3,295)	$ (1,348)
Holly Court Loan	(341)	(75)
2006A Swap	106	161
2007B Swap	(813)	(341)
2007A Swaps	(1,245)	(517)
2011 Swap	(54)	62
	$ (5,642)	$ (2,058)

9. Operating Leases

UVM Health Network has entered into certain operating lease agreements for the rental of building space and equipment. Rental expense, inclusive of common area maintenance charges, amounted to $17,100,000 and $16,239,000 for the years ended September 30, 2015 and 2014, respectively.

Minimum future lease payments required under noncancelable operating leases at September 30, 2015, were as follows:

(in thousands)

Years Ending September 30,	
2016	$ 10,573
2017	6,703
2018	5,626
2019	3,537
2020	1,971
Thereafter	1,463
	$ 29,873

10. Net Assets

Temporarily Restricted Net Assets
At September 30, 2015 and 2014, temporarily restricted net assets are available for the following purposes:

(in thousands)	**2015**	**2014**
Indigent care	$ 1,174	$ 1,179
Education and research	12,836	13,178
Children's programs	3,958	3,581
Capital projects	2,704	1,951
Other health care services	15,632	17,459
Long-term care services at Woodridge	1,461	1,525
	$ 37,765	$ 38,873

At September 30, 2015 and 2014, temporarily restricted net assets include approximately $19,310,000 and $19,573,000, respectively, of accumulated gains on permanently restricted net assets, which are subject to board appropriation in accordance with state law.

Permanently Restricted Net Assets
At September 30, 2015 and 2014, income earned on permanently restricted net assets is restricted to:

(in thousands)	2015	2014
Indigent care	$ 4,554	$ 4,802
Education and research	7,699	7,243
Other health care services	19,984	19,975
Long-term care services	924	974
	$ 33,161	$ 32,994

Endowment Funds
UVM Health Network's endowment consists of 94 funds established for a variety of purposes. UVM Health Network does not currently have any unrestricted funds designated by the Board of Trustees (the "Board") to function as endowment. Accordingly, for the purposes of this disclosure, endowment funds include only donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law
UVM Health Network has interpreted relevant state laws for the states in which it operates as requiring realized and unrealized gains of permanently restricted net assets to be retained in a temporarily restricted net asset classification until appropriated by the Board and expended. These state laws allow the Board to appropriate the net appreciation of permanently restricted net assets as is prudent considering UVM Health Network's long and short-term needs, present and anticipated financial requirements, and expected total return on its investments, price level trends, and general economic conditions. In the years ended September 30, 2015 and 2014, $649,000 and $630,000, respectively, was appropriated.

As a result of this interpretation, UVM Health Network classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment when explicit donor stipulations requiring permanent maintenance of the historical fair value are present, and (b) the original value of subsequent gifts to the permanent endowment when explicit donor stipulations requiring permanent maintenance of the historical fair value are present. The remaining portion of the donor-restricted endowment fund is comprised of accumulated gains not required to be maintained in perpetuity. These amounts are classified as temporarily restricted net assets until those amounts are appropriated for expenditure in a manner consistent with the donor's stipulations. UVM Health Network considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: duration and preservation of the fund, purposes of the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, and the expected total return from income and the appreciation of investments, other resources of UVM Health Network, and the investment policies of UVM Health Network.

Endowment Net Asset Composition and Changes in Endowment Net Assets

The following is a summary of the endowment net asset composition by type of fund at September 30, 2015 and 2014, and the changes therein for the years then ended:

Endowment Net Asset Composition by Type of Fund

	September 30, 2015		
(in thousands)	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ 19,283	$ 22,529	$ 41,812
Adjustments for funds with deficiencies	27	-	27
	$ 19,310	$ 22,529	$ 41,839

	September 30, 2014		
(in thousands)	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ 19,573	$ 21,367	$ 40,940
Adjustments for funds with deficiencies	-	-	-
	$ 19,573	$ 21,367	$ 40,940

Changes in Endowment Net Assets

	2015		
(in thousands)	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at September 30, 2014	$ 19,573	$ 21,367	$ 40,940
Investment return			
Investment income	228	-	228
Net appreciation	97	-	97
Total investment return	325	-	325
Appropriations of endowment assets for expenditure	(649)	-	(649)
Adjustment for funds with deficiencies	27	-	27
Other	34	1,162	1,196
Endowment net assets at September 30, 2015	$ 19,310	$ 22,529	$ 41,839

	2014		
(in thousands)	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at September 30, 2013	$ 17,656	$ 20,733	$ 38,389
Acquired endowment net assets at October 1, 2013	-	-	-
Investment return			
Investment income	697	-	697
Net appreciation	2,480	-	2,480
Total investment return	3,177	-	3,177
Appropriations of endowment assets for expenditure	(630)	-	(630)
Other	(630)	634	4
Endowment net assets at September 30, 2014	$ 19,573	$ 21,367	$ 40,940

Beneficial Interest in Perpetual Trusts
The above amounts exclude UVM Health Network beneficial interest in perpetual trusts, which are not within management's investment control. Such beneficial interests totaled $12,975,000 and $14,072,000 at September 30, 2015 and 2014, respectively.

Charitable Remainder Trust
UVM Health Network has received an irrevocable charitable remainder trust, for which UVM Health Network does not serve as trustee. For this trust, UVM Health Network recorded its beneficial interest in those assets as contributions revenue and pledges receivable at the present value of the expected future cash inflows. Trusts are recorded at the date UVM Health Network has been notified of the trust's existence and sufficient information regarding the trust has been accumulated to form the basis for an accrual. Changes in the value of these assets are recorded in either temporarily or permanently restricted net assets.

Funds With Deficiencies
From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor requires UVM Health Network to retain as a fund of perpetual duration. There were $27,000 and $0 in deficiencies at September 30, 2015 and 2014, respectively.

Investment Return Objectives and Spending Policy
UVM Health Network has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to the programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity or for a donor-specified period(s). Under this policy, the endowment assets are invested in a manner to generate returns at least equal to and preferably greater than the consumer price index. To satisfy its return objective, UVM Health Network targets a diversified asset allocation that provides for a balanced portfolio.

11. Malpractice and Other Contingencies

Malpractice and Workers' Compensation
UVM Medical Center, CVMC and CPI are insured against malpractice losses under a claims-made insurance policy with VMCIC, its wholly owned subsidiary. VMCIC has reinsurance with commercial carriers for coverage above a self-insured per claim retainage amount of $5,000,000, $1,000,000 and $2,000,000 for UVM, CVMC and CPI respectively for Professional Liability, and per claim retainage amount of $2,000,000, $1,000,000 and $1,000,000 for UVM, CVMC and CPI respectively for Commercial General Liability with a $20,000,000 aggregate for Professional Liability and $10,000,000 for Commercial General Liability, with limits on such reinsurance. VMCIC provides claims-made coverage to certain affiliates of UVM Medical Center for periods prior to the merger that created UVM Medical Center.

UVM Health Network, excluding ECH (discussed below), is also self-insured for workers' compensation claims, and maintains an excess insurance policy to limit its exposure on claims up to $1,000,000 per occurrence in the year ended September 30, 2015, with a $25,000,000 aggregate limit.

Prior to 2010, ECH provided for workers' compensation insurance through participation in the Healthcare of New York Workers Compensation Trust ("Trust"); a group self-insured trust regulated by the New York State Workers' Compensation Board ("WCB"). Participation in the Trust subjects ECH to joint and several liability. Should the Trust's assets be insufficient to cover its debts, each Trust member would be subject to a proportional premium assessment to fund the shortage. The Trust uses reinsurance agreements to reduce its exposure to large losses on both an individual and aggregate claim basis. On December 31, 2011, the Trust was voluntarily terminated. ECH has not been notified of any assessment resulting from participation in the Trust. In addition, management of ECH monitors the financial stability of the Trust on an ongoing basis in order to mitigate the risk of joint and several liability. Effective January 2010, ECH terminated the agreement with the self-insured trust and is covered under an indemnity plan with an insurance company. However, ECH remains liable for any claims during the period they were participating in the Trust, including any future assessments of the Trust.

The reserves for outstanding losses at UVM Medical Center CVMC and CPI have been discounted at a rate of 2.5% and 2.7% at September 30, 2015 and 2014, resulting in an increase in the reserve for professional liability of approximately $3,372,000 at September 30, 2015 and $857,000 at September 30, 2014, and a reduction in the reserve for workers' compensation of approximately $397,000 and $471,000 at September 30, 2015 and 2014, respectively.

As a result of changes in estimates of incurred events in prior years, primarily professional liability, the estimate of incurred losses increased by approximately $3,046,000 and $3,273,000 for the years ended September 30, 2015 and 2014, respectively.

Employee Health and Dental Insurance
UVM Medical Center and CVMC maintain self-insured plans for employee health and dental insurance. Under the terms of the plans, employees and their dependents are eligible for participation and, as such, UVM Medical Center and CVMC are responsible for paying claims and third party administrator costs. UVM Medical Center maintained a stop-loss insurance policy for its medical plan to limit its exposure on nondomestic claims to the first $550,000 per member per plan year ending December 31, 2015. UVM Medical Center and CVMC maintain self-insured plans for employee dental.

Effective January 1, 2013, CVPH became self-insured for employee health insurance. Under the terms of the plan, employees and their dependents are eligible for participation and, as such, CVPH is responsible for the administration of the plan and any resultant liability incurred. CVPH maintained a specific stop-loss insurance policy to limit its exposure on cumulative claims exceeding $300,000 per member per year during the year ended September 30, 2015. Included in accounts payable and accrued expenses is a health insurance claims reserve of $850,000 related to claims incurred but not paid as of September 30, 2015.

Other Contingencies
UVM Health Network and its subsidiaries are parties in various legal proceedings and potential claims arising in the ordinary course of business. In addition, the health care industry as a whole is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to government review and interpretation, as well as regulatory actions, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenue from patient services. Management does not believe that these matters will have a material adverse effect on UVM Health Network's consolidated financial position or results of operations.

12. Statutory Capital and Surplus

VMCIC is registered under the Bermuda Insurance Act of 1978 and related regulations (the "Act") and is obligated to comply with various provisions of the Act regarding minimum levels of solvency and liquidity. Statutory capital and surplus at September 30, 2015 and 2014, was $11,514,000 and $15,601,000, respectively. The required minimum statutory capital at September 30, 2015 and 2014 was $3,947,000 and $2,599,000, respectively. In addition, a minimum liquidity ratio must be maintained whereby liquid assets, as defined by the Act, must exceed 75% of defined liabilities. The required minimum level of liquid assets was $29,620,000 and $19,529,000 at September 30, 2015 and 2014, respectively. The measurement of the required minimum level of liquid assets at September 30, 2015 and 2014 is $51,008,000 and $40,927,000, respectively. UVM Health Network reports all of VMCIC's investments in marketable securities as restricted assets in the accompanying consolidated balance sheets.

13. Pension Plans

Substantially all employees of UVM Health Network are covered under various noncontributory defined benefit pension plans, various defined contribution pension plans, or combinations thereof. Total expense for these plans consists of the following:

(in thousands)	Years Ending September 30 2015	2014
Defined benefit plans	$ 637	$ 2,230
Defined contribution plans	33,847	31,161
	$ 34,484	$ 33,391

In addition to providing pension benefits, UVM Medical Center sponsors a defined benefit postretirement health care plan for retired employees. Substantially all of UVM Medical Center's employees who are at least age 55 with 15 years of service and all employees who are eligible for retirement may become eligible for such benefits. The postretirement health care plan is contributory with retiree contributions adjusted annually. The marginal cost method is used for accounting purposes for postretirement healthcare benefits.

The premiums paid by retirees participating in the UVM Medical Center postretirement health care plan exceed the cost covered by UVM Medical Center. Therefore, the projected benefit obligation has been reduced to zero.

Information regarding UVM Health Network benefit obligations, plan assets, funded status, expected cash flows and net periodic benefit cost follows within this footnote.

Benefit Obligations

(in thousands)	2015	2014
Changes in benefit obligations		
Projected benefit obligations - beginning of year	$ (417,629)	$ (377,958)
Service cost	(4,899)	(4,495)
Interest cost	(18,149)	(18,824)
Benefits paid	16,495	15,282
Actuarial loss	(13,835)	(32,509)
Administrative expenses paid	1,955	875
Projected benefit obligation - end of year	(436,062)	(417,629)
Accumulated benefit obligation	(430,252)	(412,279)
Changes in plan assets		
Fair value of plan assets - beginning of year	346,966	311,658
Actual gain on plan assets	(1,694)	34,355
Contributions	14,820	17,110
Benefits paid	(16,495)	(15,282)
Administrative expenses paid	(1,955)	(875)
Fair value of plan assets - end of year	341,642	346,966
Funded status of the plan (long-term)	$ (94,420)	$ (70,663)

Unrestricted net assets at September 30, 2015 and 2014 include unrecognized actuarial losses of $84,262,000 and $46,482,000, respectively, related to the defined benefit plan. Of this amount, $1,740,000 and $1,312,000 was recognized in net periodic pension costs in the years ended September 30, 2015 and 2014, respectively. The expected amortization of the unrecognized losses to be recognized in net periodic pension costs in the year ended September 30, 2016 is $1,960,000. The reconciliation of the unrecognized actuarial losses for the years ended September 30, 2015 and 2014 is as follows:

(in thousands)	2015	2014
Unrecognized actuarial losses - beginning of year	$ 46,482	$ 27,244
Net loss amortized during year	(1,740)	(1,312)
Net loss during year	39,520	20,550
Unrecognized actuarial losses - end of year	$ 84,262	$ 46,482

The cost components of the net periodic benefit cost for the years ended September 30, 2015 and 2014 are as follows:

(in thousands)	2015	2014
Service cost	$ 4,899	$ 4,495
Interest cost	18,149	18,824
Expected return on plan assets	(24,151)	(22,401)
Amortization of unrecognized net loss	1,740	1,312
Net periodic benefit cost	$ 637	$ 2,230

The assumptions used in accounting for the defined benefit pension plan are as follows:

	2015	2014
Weighted-average assumptions used to determine the benefit liability		
Discount rates	4.6% - 4.7%	4.4% - 4.5%
Rates of increase in future compensation levels	3.0% - 3.5%	3.0% - 3.5%
Weighted-average assumptions used to determine expense		
Discount rates	4.4% - 4.5%	5.0% - 5.2%
Rates of increase in future compensation levels	3.0% - 7.5%	3.0% - 3.5%
Expected long-term rate of return on plan assets	6.5% - 7.3%	6.5% - 7.5%

The expected long-term rate of return for the UVM Health Network Plans' total assets is based on the expected return of each of its asset categories, weighted based on the median of the allocation for each class. Equity securities are expected to return 9% to 11% over the long-term, while cash and fixed income is expected to return between 5% and 6%. Based on historical experience, UVM Health Network expects that the plans' asset managers will provide a modest (0.5% to 1.0% per annum) premium to their respective market benchmark indices.

Plan Assets

UVM Health Network's pension plans weighted-average asset allocations as of September 30, 2015 and 2014, by asset category, are as follows:

	2015	2014
Asset category		
Money market	2 %	0 %
Bonds	2	3
Equities	13	15
Mutual funds	38	35
Common collective trusts	45	47
	100 %	100 %

The following table presents information, as of September 30, 2015 and 2014, about UVM Health Network's pension assets that are measured at fair value on a recurring basis:

	2015			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	NAV as Practical Expedient NAV	Fair Value
Money market	$ 5,952	$ -	$ -	$ 5,952
Bonds	7,893	-	-	7,893
Equities	44,440	-	-	44,440
Mutual funds	130,019	-	-	130,019
Common collective trusts	-	-	153,338	153,338
	$ 188,304	$ -	$ 153,338	$ 341,642

The University of Vermont Health Network Inc. and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

	2014			
(in thousands)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	NAV as Practical Expedient NAV	Fair Value
Money market	$ 949	$ -	$ -	$ 949
Bonds	11,089	-	-	11,089
Equities	53,267	-	-	53,267
Mutual funds	123,028	-	-	123,028
Common collective trusts	-	-	158,633	158,633
	$ 188,333	$ -	$ 158,633	$ 346,966

The investment strategy established for pension plan assets is to meet present and future benefit obligations to all participants and beneficiaries, cover reasonable expenses incurred to provide such benefits, and provide a total return that maximizes the ratio of assets to liabilities by maximizing investment return at the appropriate level of risk.

There was no Level 3 activity for the years ended September 30, 2015 and 2014.

Cash Flows - Contributions
UVM Health Network expects to contribute $13,930,000 to its pension plans in the year ending September 30, 2016.

Cash Flows - Estimated Future Benefit Payments
The following benefit payments, which reflect expected future service as appropriate, are expected to be paid:

(in thousands)	
Years Ending September 30	
2016	$ 18,837
2017	20,406
2018	21,817
2019	23,262
2020	24,785
2021–2025	140,045

Multiemployer Defined Benefit Plan
CVPH contributes to a multiemployer defined benefit pension plan under the terms of their collective-bargaining agreement that covers its SEIU 1199 union-represented employees. Pension expense for the years ended September 30, 2015 and 2014 was approximately $4,522,000 and $4,886,000, respectively, and reflects increased funding requirements as a result of pension underfunding issues. CVPH may be liable for its share of unfunded vested benefits, if any, related to the union plan. Information from the union plan's administrator is not available to permit CVPH to estimate its share, if any, of unfunded vested benefits.

The risk of participating in this multiemployer plan is different from single-employer plans in the following aspects:

a. Assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers.

b. If a participating employer stops contributing to the plan, the unfunded obligations of the Plan may be borne by the remaining participating employers.

c. If CVPH chooses to stop participating in the multiemployer plan, CVPH may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

CVPH's participation in the plan for the year ended September 30, 2015, is outlined in the table below. The "EIN/Pension Plan Number" column provides the Employee Identification Number ("EIN") and the three digit plan number, if applicable. Unless otherwise noted, the most recent Pension Protection Act ("PPA") zone status available in 2014 is for the plan's year-end at December 31, 2013. The zone status is based on information that CVPH received from the Plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented. The last column lists the expiration date(s) of the collective-bargaining agreement to which the plan is subject.

Pension Fund	EIN/Pension Plan Number	Zone Status Pension Protection Act September 30, 2015	Zone Status Pension Protection Act December 31, 2014	FIP/RP Status Pending/ Implemented	Surcharge Imposed	Expiration Date of Collective-Bargaining Agreement
1199 SEIU Health Care Employees Pension Fund	13-3604862-001	not available	Green	June 26, 2009	No	April 30, 2016

CVPH was not listed on the Plans' Forms 5500 as providing more than 5 percent of the total contributions. At the date the consolidated UVM Health Network financial statements were issued, Form 5500 was not available.

14. Concentrations of Credit Risk

UVM Health Network grants credit without collateral to its patients, most of whom are local residents and are insured under third-party agreements. The mix of net receivables from patients and third-party payers at September 30, 2015 and 2014 is as follows:

	2015	2014
Medicare	27 %	27 %
Medicaid	12	8
Blue cross	23	19
Other third-party payers	24	26
Patients	14	20
	100 %	100 %

15. Transactions With UVM

UVM Medical Center's Affiliation Agreement with UVM was renewed as of June 19, 2014, for a five year term. The Affiliation Agreement expresses the shared goals of UVM and UVM Medical Center for teaching, clinical care and research, documents the many points of close collaboration between the two organizations, provides the underpinnings for UVM Medical Center's status as an academic medical center, and obligates UVM Medical Center to provide substantial, annual financial support to UVM. The current Affiliation Agreement provides for three components of financial support to UVM: (1) payments by UVM Medical Center, known as the "commitment," to fund two costs: (a) a portion of the salary, benefits and related expenses paid through UVM to physician-faculty who are jointly employed by both UVM and UVM Medical Group and, (b) a portion of the cost of UVM facilities, utilities and other campus operating expenses that are not paid or reimbursed by any form of federal funding; (2) an academic support payment paid by UVM Medical Center and, (3) a Dean's Tax paid by UVM Medical Group. The amounts of the commitment approximated $36,544,000 and $36,528,000 in the years ended September 30, 2015 and 2014, respectively. In addition, UVM Medical Center reimburses UVM for equipment rental, research, and certain other administrative expenses through the commitment. In addition to the commitment, UVM Medical Center made academic support payments to UVM in monthly installments. The amount of the academic support payment was $7,500,000 and $4,972,000 in the years ended September 30, 2015 and 2014, respectively. Under the Affiliation Agreement, the Dean's Tax is paid to UVM by UVM Medical Center in an amount equal to 2.3% of the Medical Group's net patient service revenues exclusive of all Medicaid revenues for that fiscal year. The amount of the Dean's Tax approximated $6,130,000 and $5,146,000 in the years ended September 30, 2015 and 2014, respectively.

Under the current affiliation agreement, the base payments for the academic support payments increased to $7,650,000 in fiscal year 2016, with an inflationary increase in the years thereafter.

16. Functional Expenses

UVM Health Network provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2015 and 2014, are as follows:

(in thousands)	2015	2014
Education and research	$ 2,699	$ 1,951
Health care services	1,291,204	1,235,262
Management and general	280,194	272,042
Total functional expenses	1,574,097	1,509,255
Less: Nonoperating expenses	2,518	1,725
Total operating expenses	$ 1,571,579	$ 1,507,530

17. Allowance for Doubtful Accounts

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, UVM Health Network analyzes its past history and identifies trends for each of its major categories of revenue (inpatient, outpatient, and professional) to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major categories of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

Accounts receivable, prior to adjustment for doubtful accounts, is summarized as follows at September 30, 2015 and 2014:

(in thousands)	2015	2014
Receivables		
Patients	$ 43,652	$ 61,974
Third-party payers	183,961	178,508
	$ 227,613	$ 240,482

The allowance for doubtful accounts is summarized as follows at September 30, 2015 and 2014:

(in thousands)	2015	2014
Allowance for doubtful accounts		
Patients	$ 16,205	$ 25,765
Third-party payers	17,774	12,535
	$ 33,979	$ 38,300

Bad debt expense for nonpatient related accounts receivable is reflected in total operating expenses on the statements of operations. Patient related bad debt is reflected as a reduction in patient service revenues on the statements of operations.

Net patient service revenue before the provision for bad debts and enhanced Medicaid graduate medical education revenues for the years ended September 30, 2015 and 2014, is summarized as follows:

(in thousands)	2015	2014
Net patient service revenue		
Patients	$ 21,608	$ 33,913
Third-party payers	1,514,889	1,421,240
	$ 1,536,497	$ 1,455,153

18. Subsequent Events

UVM Health Network has evaluated subsequent events through December 18, 2015, which is the date the consolidated financial statements were issued and has concluded that, there were no such events that require adjustments to the consolidated financial statements or disclosure in the notes to the consolidated financial statements.

APPENDIX B

Other Financial Information

The University of Vermont Health Network Obligated Group
Obligated Group Balance Sheets
September 30, 2015 and 2014

(in thousands)	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 195,000	$ 220,185
Patient and other trade accounts receivable-net of allowance for doubtful accounts of $26,387 and $26,697, respectively	145,195	140,625
Due from related parties	184	30,827
Inventories	26,549	24,822
Estimated receivable from third-party payers	6,812	4,329
Prepaid, other current assets, and short-term investments	21,548	18,672
Total current assets	395,288	439,460
Assets whose use is limited or restricted		
Board-designated assets	396,913	328,291
Assets held by trustee under bond indenture agreements	21,597	26,454
Restricted assets	718	732
Donor restricted assets for specific purposes	30,766	32,866
Donor restricted assets for permanent endowment	31,486	31,373
Total assets whose use is limited or restricted	481,480	419,716
Property and equipment, net	499,438	479,437
Other assets		
Notes receivable and other assets	8,645	6,418
Investment in affiliated companies	23,170	25,658
Pledges receivable	1,667	364
Total other assets	33,482	32,440
	$ 1,409,688	$ 1,371,053
Liabilities and net assets		
Current liabilities		
Current installments of long-term debt	$ 13,995	$ 13,730
Accounts payable	26,947	24,367
Accrued expenses and other liabilities	46,909	58,568
Accrued payroll and related benefits	89,652	79,388
Third-party payer settlements	15,913	13,077
Incurred but not reported claims	11,833	11,490
Total current liabilities	205,249	200,620
Long-term liabilities		
Long-term debt, net of current installments	355,963	373,791
Malpractice and workers' compensation claims	1,579	1,827
Pension and other postretirement benefit obligations	46,434	38,276
Other	16,822	15,123
Total long-term liabilities	420,798	429,017
Total liabilities	626,047	629,637
Commitments and contingent liabilities		
Net assets		
Unrestricted	717,970	674,242
Temporarily restricted	34,185	35,801
Permanently restricted	31,486	31,373
Total net assets	783,641	741,416
Total liabilities and net assets	$ 1,409,688	$ 1,371,053

APPENDIX B

The University of Vermont Health Network Obligated Group
Obligated Group Statements of Operations
Years Ended September 30, 2015 and 2014

(in thousands)	2015	2014
Unrestricted revenue and other support		
Net patient service revenue	$ 1,213,088	$ 1,152,804
Less: Provision for bad debts	(23,882)	(32,800)
Net patient service revenue after provision for bad debt	1,189,206	1,120,004
Enhanced Medicaid Graduate Medical Education revenues-Hospital	11,511	11,461
Enhanced Medicaid Graduate Medical Education revenues-Professional	18,490	18,818
Net patient service revenue after provision for bad debts and Enhanced Medicaid Graduate Medical Education revenues	1,219,207	1,150,283
Premium revenue	11,272	12,507
Other revenue	87,563	65,757
Total unrestricted revenue and other support	1,318,042	1,228,547
Expenses		
Salaries, payroll taxes and fringe benefits	774,065	730,166
Supplies and other	330,329	309,903
Purchased services	61,906	56,564
Depreciation and amortization	54,614	57,776
Interest expense	15,869	17,519
Total expenses	1,236,783	1,171,928
Income from operations	81,259	56,619
Nonoperating gains (losses)		
Investment income	5,988	11,233
Change in fair value of interest rate swap agreements	(3,636)	(1,423)
Loss on extinguishment of debt	(346)	-
Other	(169)	(2,409)
Total nonoperating gains	1,837	7,401
Excess of revenue over expenses	83,096	64,020
Net change in unrealized losses on investments	(7,330)	15,823
Net assets released from restrictions for capital purchases	2,726	937
Pension related adjustments	(18,824)	(6,312)
Other adjustments	(15,940)	(476)
Increase in unrestricted net assets	$ 43,728	$ 73,992

The University of Vermont Health Network Obligated Group
Obligated Group Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

(in thousands)	2015	2014
Unrestricted net assets		
Excess of revenues over expenses	$ 83,096	$ 64,020
Net change in unrealized losses on investments	(7,330)	15,823
Net assets released from restrictions for capital purchases	2,726	937
Pension related adjustments	(18,824)	(6,312)
Other adjustments	(15,940)	(476)
Increase in unrestricted net assets	43,728	73,992
Temporarily restricted net assets		
Gifts, grants, and bequests	4,271	7,288
Investment income	142	139
Net unrealized (losses) on investments	(1,310)	(281)
Net realized gains on investments	1,309	3,147
Net assets released from restrictions used in operations	(3,004)	(2,372)
Net assets released from restrictions used for nonoperating purposes	(198)	(188)
Net assets released from restrictions used for capital purchases	(2,726)	(937)
Transfer of net assets	(100)	(327)
(Decrease) Increase in temporarily restricted net assets	(1,616)	6,469
Permanently restricted net assets		
Gifts, grants, and bequests	1,110	55
Change in beneficial interest in perpetual trusts	(1,097)	1,216
Transfer of net assets	100	327
Increase in permanently restricted net assets	113	1,598
Increase in net assets	42,225	82,059
Net assets		
Beginning of year	741,416	659,357
End of year	$ 783,641	$ 741,416

The University of Vermont Health Network
Consolidating Balance Sheet
September 30, 2015

(in thousands)	Central Vermont Hospital and Medical Group Practice	Woodridge Rehabilitation and Nursing	CVMC Eliminations	Total CVMC	UVMMC (Hospital)	Obligated Group Eliminations	Total UVMMC Obligated Group	Community Providers, Inc	Other Entities	Eliminations	Total UVM Health Network
Assets											
Current assets											
Cash and cash equivalents	$ 7,932	$ 462	$ -	$ 8,394	$ 186,606	$ -	$ 195,000	$ 28,657	$ 5,134	$ -	$ 226,791
Patient and other trade accounts receivable, net	15,843	1,527	-	17,370	127,825	-	145,195	48,089	350	-	193,634
Due from related parties	2,240	-	(2,240)	-	2,830	(2,646)	184	-	2,232	(2,416)	-
Inventories	3,324	-	-	3,324	23,225	-	26,549	5,314	-	-	31,863
Current portion of assets whose use is limited or restricted	-	-	-	-	-	-	-	1,000	34,773	-	35,773
Receivables from third-party payers	1,220	-	-	1,220	5,592	-	6,812	-	-	-	6,812
Prepaid, other current assets, and short-term investments	1,570	-	-	1,570	19,978	-	21,548	21,160	2,848	-	45,556
Total current assets	32,129	1,989	(2,240)	31,878	366,056	(2,646)	395,288	104,220	45,337	(2,416)	542,429
Assets whose use is limited or restricted											
Board-designated assets	35,817	7,156	-	42,973	353,940	-	396,913	20,457	-	-	417,370
Assets held by trustee under bond indenture agreements	-	-	-	-	21,597	-	21,597	1,945	-	-	23,542
Restricted assets	-	-	-	-	718	-	718	5,906	13,828	-	20,452
Donor-restricted assets for specific purposes	5,073	-	-	5,073	25,693	-	30,766	716	-	-	31,482
Donor-restricted assets for permanent endowment	3,326	-	-	3,326	28,160	-	31,486	-	-	-	31,486
Total assets whose use is limited or restricted	44,216	7,156	-	51,372	430,108	-	481,480	29,024	13,828	-	524,332
Property and equipment, net	64,059	4,055	-	68,114	431,324	-	499,438	119,707	819	-	619,964
Other assets											
Long Term Investments	-	-	-	-	-	-	-	3,830	-	-	3,830
Notes receivable and other assets	1,531	-	-	1,531	7,114	-	8,645	1,654	-	-	10,299
Investment in affiliated companies	-	-	-	-	23,170	-	23,170	-	3,911	(23,374)	3,707
Pledges receivable	-	-	-	-	1,667	-	1,667	1,225	-	-	2,892
Total other assets	1,531	-	-	1,531	31,951	-	33,482	6,709	3,911	(23,374)	20,728
Total assets	$ 141,935	$ 13,200	$ (2,240)	$ 152,895	$ 1,259,439	$ (2,646)	$ 1,409,688	$ 259,660	$ 63,895	$ (25,790)	$ 1,707,453

The University of Vermont Health Network
Consolidating Balance Sheet
September 30, 2015

(in thousands)	Central Vermont Hospital and Medical Group Practice	Woodridge Rehabilitation and Nursing	CVMC Eliminations	Total CVMC	UVMMC (Hospital)	Obligated Group Eliminations	Total UVMMC Obligated Group	Community Providers, Inc	Other Entities	Eliminations	Total UVM Health Network
Liabilities and Net Assets											
Current liabilities											
Current installments of long-term debt	$ 2,149	$ 500	$ -	$ 2,649	$ 11,346	$ -	$ 13,995	$ 14,020	$ -	$ -	$ 28,015
Accounts payable	3,280	-	-	3,280	23,667	-	26,947	10,172	101	-	37,220
Accrued expenses and other liabilities	2,490	26	-	2,516	44,393	-	46,909	2,010	22	64	49,005
Accrued payroll and related benefits	8,992	703	-	9,695	79,957	-	89,652	18,159	83	(437)	107,457
Third-party payer settlements	3,218	-	-	3,218	12,695	-	15,913	(567)	-	-	15,346
Due to related parties	2,646	2,240	(2,240)	2,646	-	(2,646)	-	513	1,495	(2,008)	-
Incurred but not reported claims	-	-	-	-	11,833	-	11,833	1,850	14,761	-	28,444
Total current liabilities	22,775	3,469	(2,240)	24,004	183,891	(2,646)	205,249	46,157	16,452	(2,381)	265,487
Long-term debt, net of current installments	13,389	2,771	-	16,160	339,803	-	355,963	61,655	-	-	417,618
Malpractice and workers' compensation claims	1,317	262	-	1,579	-	-	1,579	5,209	24,563	-	31,351
Pension and other postretirement benefit obligations	32,309	-	-	32,309	14,125	-	46,434	47,986	-	-	94,420
Other	996	-	-	996	15,826	-	16,822	18,280	-	-	35,102
Total liabilities	70,786	6,502	(2,240)	75,048	553,645	(2,646)	626,047	179,287	41,025	(2,381)	843,978
Net assets											
Unrestricted	62,750	6,698	-	69,448	648,522	-	717,970	75,118	22,870	(23,409)	792,549
Temporarily restricted	5,073	-	-	5,073	29,112	-	34,185	3,580	-	-	37,765
Permanently restricted	3,326	-	-	3,326	28,160	-	31,486	1,675	-	-	33,161
Total net assets	71,149	6,698	-	77,847	705,794	-	783,641	80,373	22,870	(23,409)	863,475
Total liabilities and net assets	$ 141,935	$ 13,200	$ (2,240)	$ 152,895	$ 1,259,439	$ (2,646)	$ 1,409,688	$ 259,660	$ 63,895	$ (25,790)	$ 1,707,453

The University of Vermont Health Network
Consolidating Statement of Operations
Year Ended September 30, 2015

(in thousands)	Central Vermont Hospital and Medical Group Practice	Woodridge Rehabilitation and Nursing	Total CVMC	UVMMC (Hospital)	Obligated Group Eliminations	Total UVMMC Obligated Group	Community Providers, Inc	Other Entities	Eliminations	Total UVM Health Network
Unrestricted revenue and other support										
Net patient service revenue	$ 155,766	$ 13,636	$ 169,402	$ 1,043,913	$ (227)	$ 1,213,088	$ 320,780	$ 2,926	$ (297)	$ 1,536,497
Less: Provision for bad debt	(4,212)	(60)	(4,272)	(19,610)	-	(23,882)	(11,299)	(248)	-	(35,429)
Net patient service revenue after provision for bad debts	151,554	13,576	165,130	1,024,303	(227)	1,189,206	309,481	2,678	(297)	1,501,068
Enhanced Medicaid Graduate Medical Education revenues – Hospital	-	-	-	11,511	-	11,511	-	-	-	11,511
Enhanced Medicaid Graduate Medical Education revenues – Professional	-	-	-	18,490	-	18,490	-	-	-	18,490
Net patient service revenue after provision for bad debts and enhanced Graduate Medical Education revenues	151,554	13,576	165,130	1,054,304	(227)	1,219,207	309,481	2,678	(297)	1,531,069
Premium revenue	1,629	172	1,801	9,471	-	11,272	-	299	-	11,571
Other revenue	10,156	255	10,411	78,099	(947)	87,563	16,680	21,150	(21,662)	103,731
Total unrestricted revenue and other support	163,339	14,003	177,342	1,141,874	(1,174)	1,318,042	326,161	24,127	(21,959)	1,646,371
Expenses										
Salary, payroll taxes and fringe benefits	103,929	11,417	115,346	658,719	-	774,065	204,118	4,447	-	982,631
Supplies and other	32,381	3,168	35,549	295,987	(1,207)	330,329	99,511	1,300	(12,255)	418,885
Purchased services	9,914	391	10,305	51,900	(299)	61,906	-	2,165	(376)	63,695
Depreciation and amortization	9,035	736	9,771	44,843	-	54,614	17,883	288	-	72,785
Interest expense	920	123	1,043	14,826	-	15,869	3,350	-	-	19,219
Underwriting expenses	-	-	-	-	-	-	-	20,996	(7,300)	13,696
Medical claims	-	-	-	-	-	-	-	668	-	668
Total expenses	156,179	15,835	172,014	1,066,275	(1,506)	1,236,783	324,863	29,864	(19,931)	1,571,579
Income (loss) from operations	7,160	(1,832)	5,328	75,599	332	81,259	1,298	(5,737)	(2,028)	74,792
Nonoperating gains (losses)										
Investment income	18	106	124	5,864	-	5,988	2,193	1,264	-	9,445
Change in fair value of interest rate swap agreements	-	-	-	(3,636)	-	(3,636)	(2,006)	-	-	(5,642)
Loss on extinguishment of debt	-	-	-	(346)	-	(346)	-	-	-	(346)
Other	1,088	(6)	1,082	(919)	(332)	(169)	(245)	2,467	3,788	5,841
Total nonoperating gains	1,106	100	1,206	963	(332)	1,837	(58)	3,731	3,788	9,298
Excess (deficit) of revenue over expenses	8,266	(1,732)	6,534	76,562	-	83,096	1,240	(2,006)	1,760	84,090
Net change in unrealized losses on investments	(2,533)	(387)	(2,920)	(4,410)	-	(7,330)	(3,973)	(1,538)	(34)	(12,875)
Net assets released from restrictions for capital purchases	-	-	-	2,726	-	2,726	660	-	-	3,386
Pension related adjustments	(11,804)	-	(11,804)	(7,020)	-	(18,824)	(18,956)	-	-	(37,780)
Equity transfer amongst affiliates	-	-	-	(15,940)	-	(15,940)	15,982	1,635	(1,212)	465
Increase (decrease) in unrestricted net assets	$ (6,071)	$ (2,119)	$ (6,190)	$ 51,918	$ -	$ 43,728	$ (5,047)	$ (1,909)	$ 514	$ 37,286

APPENDIX C

DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL LEGAL DOCUMENTS

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DEFINITIONS OF CERTAIN TERMS

The following is a summary of the definitions of certain terms contained in the Loan Agreement, Trust Agreement and the Master Indenture and used in this Official Statement:

"Accounts" means any right to payment for goods sold or leased or for services rendered which is not evidenced by an instrument or chattel paper, whether or not it has been earned by performance.

"Account Lien Amount" means the product of (x) 50% multiplied by (y) an amount equal to the Obligated Group's net patient accounts (as shown in its Audited Financial Statements for the preceding Fiscal Year).

"Act" means Chapter 131, Sections 3851 to 3862, inclusive, of Title 16, Vermont Statutes Annotated, as amended.

"Affiliate" means a corporation, limited liability company, partnership, joint venture, association, business trust or similar entity organized under the laws of the United States of America or any state thereof which (i) is directly or indirectly controlled by any Member of the Obligated Group or by any Person which directly or indirectly controls any Member of the Obligated Group or (ii) controls, directly or indirectly, any Member of the Obligated Group. For purposes of this definition, control means the ownership of not less than 25% of the voting securities of a Person or the right to designate or elect not less than a majority of the members of its board of directors or other governing board or body by contract or otherwise.

"Agency" means the Vermont Educational and Health Buildings Financing Agency, and any successor thereto.

"Agency Representative" means each of the persons at the time designated to act on behalf of the Agency in a written certificate furnished to the Corporation and the Bond Trustee, which certificate shall contain the specimen signature(s) of such person(s) and shall be signed on behalf of the Agency by its Executive Director.

"Audited Financial Statements" means the combined financial statements of the Corporation and its subsidiaries, if any, for a twelve-month period, or for such other period for which an audit has been performed, prepared in accordance with generally accepted accounting principles, which have been audited and reported upon by independent certified public accountants. Audited Financial Statements shall also include, in an additional information section, unaudited combining financial statements for the same twelve-month period from which the accounts of any subsidiary which is not a Member of the Obligated Group have been eliminated and to which the accounts of any Member of the Obligated Group which is not a subsidiary have been added; provided, however, that for purposes of adding the accounts of a Member of the Obligated Group which is not a subsidiary, the balances of such accounts shall be extracted from audited financial statements of such Member of the Obligated Group and its subsidiaries, if any.

"Authorized Denominations" means $5,000 and any integral multiple thereof.

"Balloon Long-Term Indebtedness" means Long-Term Indebtedness twenty-five percent (25%) or more of the principal payments of which are due in a single year, which portion of the principal is not

required by the documents pursuant to which such Indebtedness is issued to be amortized by redemption prior to such year.

"Beneficial Owner" means the Person in whose name a Bond is recorded as beneficial owner of such Bonds by the Securities Depository or a Participant or an Indirect Participant on the records of such Securities Depository, Participant or Indirect Participant, as the case may be, or such Person's subrogee.

"Bond Fund" means the Vermont Educational and Health Buildings Financing Agency Revenue Bonds (The University of Vermont Medical Center Project) Series 2016A Bond Fund created and so designated by the Trust Agreement.

"Bond Registrar" means the Bond Registrar at the time serving as such under the Trust Agreement whether the original or a successor bond registrar.

"Bond Trustee" means the Bond Trustee at the time serving as such under the Trust Agreement whether the original or a successor trustee.

"Bond Year" means the period commencing on December 1 of any year and ending on November 30 of the following year.

"Bonds" means the Vermont Educational and Health Buildings Financing Agency Hospital Revenue Bonds (The University of Vermont Medical Center Project) Series 2016A, authorized to be issued pursuant to a resolution of the Agency, including such Bonds issued in exchange for other such Bonds pursuant to the Trust Agreement, or in replacement for mutilated, destroyed, stolen or lost Bonds pursuant to the Trust Agreement.

"Book-Entry System" means a book-entry system established and operated for the recordation of Beneficial Owners of the Bonds pursuant to the Trust Agreement.

"Business Day" means any day other than (i) a Saturday, a Sunday or any other day on which banks located in the city in which the office of the Bond Trustee is located are authorized or required to remain closed or (ii) a day on which the New York Stock Exchange is closed.

"Capitalization" means the sum of the aggregate Long-Term Indebtedness of the Members of the Obligated Group, excluding any Cross-over Refunded Indebtedness, plus the aggregate unrestricted fund balance of the non-profit Members of the Obligated Group and plus the aggregate excess of assets over liabilities of the proprietary Members of the Obligated Group, if any, all as calculated in accordance with generally accepted accounting principles.

"Closing Date" means the date on which the Loan Agreement becomes legally effective, the same being the date on which the Bonds are delivered against payment therefor.

"Code" means the Internal Revenue Code of 1986, as amended, and all regulations promulgated thereunder.

"Completion Indebtedness" means any Long-Term Indebtedness incurred for the purpose of financing the completion of facilities for the acquisition, construction or equipping of which Long-Term Indebtedness has theretofore 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 Long-Term Indebtedness theretofore incurred was originally incurred, and, to the extent

the same shall be applicable, 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 Long-Term Indebtedness theretofore incurred was originally incurred.

"Consultant" means a firm or firms which is not, and no member, stockholder, director, officer or employee of which is, an officer or employee of any Member of the Obligated Group or any Affiliate, and which is a professional management consultant of national repute for having the skill and experience necessary to render the particular report required by the provision of the Master Indenture in which such requirement appears and which is reasonably acceptable to the Master Trustee.

"Corporate Trust Office" means the office of the Master Trustee at which its principal corporate trust business is conducted, which is currently located in Burlington, Vermont.

"Corporation" means The University of Vermont Medical Center Inc. (formerly known as Fletcher Allen Health Care Inc.), an eligible institution under Chapter 131, Sections 3851 to 3862, inclusive, of Title 16, Vermont Statutes Annotated and a nonprofit hospital as defined in Section 1902 of Title 18 of Vermont Statutes Annotated, organized and existing under the laws of the State, and its successors and assigns and any surviving, resulting or transferee corporation thereof.

"Cross-over Date" means, with respect to Cross-over Refunding Indebtedness, the date on which the principal portion of the related Cross-over Refunded Indebtedness is to be paid or redeemed from the proceeds of such Cross-over Refunding Indebtedness.

"Cross-over Refunded Indebtedness" means Indebtedness refunded by Cross-over Refunding Indebtedness.

"Cross-over Refunding Indebtedness" means Indebtedness issued for the purpose of refunding other Indebtedness if the proceeds of such Refunding Indebtedness are irrevocably deposited in escrow to secure the payment on the applicable redemption date or maturity date of the Refunded Indebtedness, and the earnings on such escrow deposit (i) are required to be applied to pay interest on such Refunding Indebtedness until the Cross-over Date, and (ii) are not to be applied, directly or indirectly, to pay interest on such Refunded Indebtedness.

"Defaulted Interest" means any interest on any Bond which is payable, but is not punctually paid or duly provided for, on any Interest Payment Date.

"Defeased Municipal Obligations" means obligations of state or local government municipal bond issuers which are not callable at the option of the obligor prior to maturity or for which irrevocable instructions have been given by the obligor to pay such obligations on the date fixed for redemption and which are rated, based on an irrevocable escrow account or fund, in the highest rating category by each of S&P and Moody's, provision for the payment of the principal of, redemption premium, if any, and interest on which shall have been made by deposit in an irrevocable escrow fund or account with a trustee or escrow agent of Defeasance Obligations or cash, which escrow fund or account shall be applied only to the payment of the principal of, redemption premium, if any, and interest on such obligations of state or local government municipal bond issuers, when due and payable, and shall be sufficient, as verified by a nationally recognized independent certified public accountant, to pay the principal of, redemption premium, if any, and interest on such obligations of state or local government municipal bond issuers.

"Defeasance Obligations" means, with respect to the Trust Agreement, (1) cash, (2) noncallable Government Obligations, (3) evidences of ownership of proportionate interests in future interest and principal payments on Government Obligations held by a bank or trust company as custodian, under which the owner of the investment is the real party in interest and has the right to proceed directly and individually against the obligor and the underlying Government Obligations are not available to any person claiming through the custodian or to whom the custodian may be obligated, or (4) Defeased Municipal Obligations, or any combination thereof.

"Defeasance Obligations" means, with respect to the Master Indenture, (i) noncallable Government Obligations, (ii) evidences of ownership of a proportionate interest in specified noncallable Government Obligations, which Government Obligations are held by a bank or trust company organized and existing under the laws of the United States of America or any state thereof in the capacity of custodian, (iii) Defeased Municipal Obligations or (iv) evidences of ownership of a proportionate interest in specified Defeased Municipal Obligations, which Defeased Municipal Obligations are held by a bank or trust company organized and existing under the laws of the United States of America or any state thereof in the capacity of custodian.

"Defeased Obligations" means Obligations issued under a Supplement that have been discharged, or provision for the discharge of which has been made, pursuant to their terms and the terms of such Supplement.

"Depositary" means one or more banks or trust companies authorized under the laws of the United States of America, the State or the State of New York to engage in the banking business within the State and designated by the Agency, with the approval of the Corporation, as a depositary of money under the provisions of the Trust Agreement.

"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 changes 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.

"Derivative Indebtedness" means all or a portion of any Indebtedness incurred by a Member of the Obligated Group pursuant to or in connection with a Derivative Agreement.

"Derivative Period" means the period during which a Derivative Agreement is in effect.

"Designated Corporate Trust Office" means, initially, the corporate trust office of the Bond Trustee located at Two Burlington Square, Burlington, Vermont 05402, and thereafter any office designated by the Bond Trustee by notice to the Agency and the Corporation given pursuant to the Trust Agreement.

"Eminent Domain" means the eminent domain or condemnation power by which all or any part of the Property and Equipment may be taken for public use or any agreement that is reached in lieu of proceedings to exercise such power.

"Event of Default" means, with respect to the Loan Agreement, each of those events set forth in the Loan Agreement and summarized under the caption "SUMMARY OF THE LOAN AGREEMENT – Defaults and Remedies" herein, with respect to the Trust Agreement, each of those events set forth in the Trust Agreement and summarized under the caption "SUMMARY OF THE TRUST AGREEMENT – Events of Default" herein, and, with respect to the Master Indenture, each of those events set forth in the Master Indenture and summarized under the caption "SUMMARY OF THE MASTER INDENTURE – Defaults and Remedies -- Events of Default" herein.

"Fiscal Year" means the fiscal year of the Obligated Group, which shall be the period commencing on October 1 of any year and ending on September 30 of the following year unless the Master Trustee is notified in writing by the Obligated Group Representative of a change in such period, in which case the Fiscal Year shall be the period set forth in such notice; provided, however, that each Member of the Obligated Group shall have the same Fiscal Year.

"Fitch" means Fitch Ratings, a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, and, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, "Fitch" shall be deemed to refer to any other nationally recognized securities rating agency designated by the Agency, with the approval of the Hospital Representative, by notice to the Bond Trustee.

"Governing Body" means, when used with respect to any Member of the Obligated Group, its board of directors, board of trustees, or other board or group of individuals in which the powers of such Member of the Obligated Group are vested.

"Government Obligations" means, with respect to the Master Indenture, direct obligations of, or obligations the timely payment of the principal of and interest on which are fully and unconditionally guaranteed by, the United States of America.

"Government Obligations" means, with respect to the Trust Agreement, direct obligations of (including obligations issued or held in book-entry form on the books of) the Department of the Treasury of the United States of America.

"Governmental Restrictions" means federal, state or other applicable governmental laws or regulations affecting any Member of the Obligated Group or its health care facilities placing restrictions and limitations on the (i) fees and charges to be fixed, charged and collected by any Member of the Obligated Group or (ii) the amount or timing of the receipt of such revenues.

"Gross Receipts" means all Accounts and all revenues, income, receipts and money (other than proceeds of borrowing) received in any period by or on behalf of any Member of the Obligated Group, including, but without limiting the generality of the foregoing, (a) revenues derived from its operations, (b) gifts, grants, bequests, donations and contributions and the income therefrom, exclusive of any gifts, grants, bequests, donations and contributions to the extent specifically restricted by the donor to a particular purpose inconsistent with their use for the payment of Obligations, (c) proceeds derived from (i) insurance, except to the extent otherwise required by the provisions of the Master Indenture, (ii) Accounts, (iii) securities and other investments, (iv) inventory and other tangible and intangible property,

(v) medical or hospital insurance, indemnity or reimbursement programs or agreements and (vi) contract rights and other rights and assets now or hereafter owned, held or possessed by each Member of the Obligated Group, and (d) rentals received from the leasing of real or tangible personal property.

"Guaranty" means any obligation of any Member of the Obligated Group guaranteeing in any manner, directly or indirectly, any obligation of any Person that is not a Member of the Obligated Group which obligation of such other Person would, if such obligation were the obligation of a Member of the Obligated Group, constitute Indebtedness under the Master Indenture. For the purposes of the Master Indenture, the aggregate annual principal and interest payments on any indebtedness in respect of which any Member of the Obligated Group shall have executed and delivered its Guaranty shall, so long as no payments are required to be made thereunder and so long as such Guaranty constitutes a contingent liability under generally accepted accounting principles, be deemed to be equal to zero, provided that if there shall have occurred a payment by any Member of the Obligated Group on such Guaranty, then, during the period commencing on the date of such payment and ending on the day which is one year after such other Person resumes making all payments on such guaranteed obligation, (i) with respect to a historical computation, 100% of the amount actually paid by a Member of the Obligated Group for principal and interest on such guaranteed indebtedness during the period for which the computation is being made shall be taken into account and (ii) with respect to a projected computation, either (A) 100% of the amount payable for principal and interest on such guaranteed indebtedness during the period for which the computation is being made shall be taken into account or (B) at the option of the Obligated Group, the amount indicated in a written report of a Consultant that is delivered to the Master Trustee to be the amount that such Consultant estimates that the Obligated Group will have to pay for principal and interest on such guaranteed indebtedness during the period for which the computation is being made shall be taken into account.

"Holder" means, as applicable, the owner of any Obligation issued in registered form, or a person in whose name a Bond is registered in the registration books provided for in the Trust Agreement.

"Hospital Representative" means the Chief Executive Officer, the Chief Financial Officer and each of the other persons at the time designated to act on behalf of the Corporation in a written certificate furnished to the Agency and the Bond Trustee, which certificate shall contain the specimen signature(s) of such person(s) and shall be signed on behalf of the Corporation by its Chief Executive Officer or Chief Financial Officer.

"Income Available for Debt Service" means, with respect to the Obligated Group, as to any Fiscal Year, the excess of revenues over expenses before depreciation, amortization and interest expense on Long-Term Indebtedness, as determined in accordance with generally accepted accounting principles consistently applied; provided, however, that (1) no determination thereof shall take into account (a) 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, (b) any unrealized gains and losses on investments or (c) any non-cash nonrecurring items of an extraordinary nature which do not involve the receipt, expenditure or transfer of assets, and (2) revenues shall not include income from the investment of funds held in a Qualified Escrow to the extent that such income has been or is required to be applied to the payment of principal of or interest on Long-Term Indebtedness which is excluded from the determination of Long-Term Debt Service Requirement or Related Bonds secured by such Long-Term Indebtedness. The excess of revenues over expenses shall include realized investment income and amounts required to be set aside for collateral posted in connection with the valuation of Derivative Agreements, but shall not include the non-cash termination value of any Derivative Agreements.

"Indebtedness" means (i) all indebtedness of Members of the Obligated Group for borrowed money, (ii) all installment sales, conditional sales and capital lease obligations, incurred or assumed by any Member of the Obligated Group, and (iii) all Guaranties (other than any Guaranty by any Member of the Obligated Group of Indebtedness of any other Member of the Obligated Group), whether constituting Long-Term Indebtedness or Short-Term Indebtedness. Indebtedness shall not include obligations of any Member of the Obligated Group to another Member of the Obligated Group.

"Insurance Consultant" means a firm or person which is not, and no member, stockholder, director, officer or employee of which is, an officer or employee of any Member of the Obligated Group or an Affiliate, which is qualified to survey risks and to recommend insurance coverage for hospitals, health-related facilities and services and organizations engaged in such operations and, if being retained to evaluate alternative risk management programs, including self-insurance, which has the skill and experience necessary to render such an evaluation.

"Interest Account" means the account in the Bond Fund created and designated by the Trust Agreement.

"Interest Payment Date" means each June 1 and December 1.

"Interest Requirements" for any Bond Year means the amount that is required to pay interest on all Outstanding Bonds on each June 1 in such Bond Year and on December 1of the following Bond Year.

"Investment Obligations" means (1) Defeasance Obligations; (2) bonds, debentures, notes or other evidences of indebtedness issued by any of the following agencies or any other like governmental or government-sponsored agencies which are hereafter created: Bank for Cooperatives; Federal Intermediate Credit Banks; Federal Financing Bank; Federal Home Loan Bank System; Export Import Bank of the United States; Farmers Home Administration; Small Business Administration; Inter-American Development Bank; International Bank for Reconstruction and Development; Federal Land Banks; and Government National Mortgage Association; (3) direct and general obligations of any state of the United States of America or any municipality or political subdivision of such state, or obligations of any corporation, if such obligations are rated in one of the two highest rating categories by each of S&P and Moody's (without regard to gradations within any such categories) or, upon the discontinuance of either or both of such services, any other nationally recognized rating services; (4) negotiable or non-negotiable certificates of deposit, time deposits, or other similar banking arrangements, issued by any bank (including the Trustee), banking association or trust company or any savings and loan association, and either (x) the long-term obligations of such bank, banking association, trust company or savings and loan association are rated in one of the two highest rating categories by S&P and Moody's (without regard to any gradations within any such categories) or (y) the deposits are continuously secured as to principal, but only to the extent not insured by the Federal Deposit Insurance Corporation or similar corporation chartered by the United States of America, (a) by lodging with a bank or trust company, as collateral security, obligations described in paragraphs (1) or (2) above or other marketable securities eligible as security for the deposit of trust funds under applicable regulations of the Comptroller of the Currency of the United States or applicable state law or regulations, having a market value (exclusive of accrued interest) not less than the amount of such deposit, or (b) if the furnishing of security as provided in clause (a) of this paragraph is not permitted by applicable law, in such manner as may then be required or permitted by applicable state or federal laws and regulations regarding the security for, or granting a preference in the case of, the deposit of trust funds; (5) repurchase agreements with respect to obligations listed in clauses (1) or (2) above if entered into with a bank (including the Trustee), banking association, trust company or a broker or dealer (as defined by the Securities Exchange Act of 1934) which is a dealer

in government securities which reports to, trades with and is recognized as a primary dealer by a Federal Reserve Bank, and which is a member of the Securities Investors Protection Corporation if (a) such obligations that are the subject of such repurchase agreement are delivered to the Trustee or are supported by a safe-keeping receipt issued by a depository satisfactory to the Trustee, provided that such repurchase agreement must provide that the value of the underlying obligations shall be maintained at a current market value, calculated no less frequently than monthly, of not less than the repurchase price, (b) a prior perfected security interest in the obligations which are the subject of such repurchase agreement has been granted to the Trustee and (c) such obligations are free and clear of any adverse third party claims; (6) commercial paper rated in the highest rating category by S&P and Moody's; (7) money market mutual funds that invest primarily in obligations listed in clauses (1), (2) or (3) above which mutual funds are rated in the highest category by each of S&P and Moody's; (8) investment agreements continuously secured by the obligations listed in clauses (1), (2) or (4) above, with any bank, trust company or broker or dealer (as defined by the Securities Exchange Act of 1934) which is a dealer in government securities, reports to, trades with and is recognized as a primary dealer by, a Federal Reserve Bank, and is a member of the Securities Investors Protection Corporation if (i) such obligations are delivered to the Trustee or are supported by a safekeeping receipt issued by a depository satisfactory to the Trustee, provided that such investment agreements must provide that the value of the underlying obligations shall be maintained at a current market value, calculated no less frequently than monthly, of not less than the amount deposited thereunder, (ii) a prior perfected security interest in the obligations which are securing such agreement has been granted to the Trustee, and (iii) such obligations are free and clear of any adverse third party claims; and (9) investment agreements with any bank or trust company which has long-term obligations rated in one of the two highest rating categories by each of S&P and Moody's (without regard to any gradations within any such categories).

Any of the above-described investments may be issued by or acquired through the Bond Trustee or its affiliates, or any entity which the Bond Trustee or its affiliates provide services (and receives compensation) if such investment otherwise satisfies the requirements of this definition.

"Issuance Fund" means the Vermont Educational and Health Buildings Financing Agency Revenue Bonds (The University of Vermont Medical Center Project) Series 2016A Issuance Fund created and so designated by the Trust Agreement.

"Lien" means any mortgage, deed of trust or pledge of, security interest in or encumbrance on any Property of any Member of the Obligated Group which secures any Indebtedness or any other obligation of any Member of the Obligated Group or which secures any obligation of any Person, other than an obligation to any Member of the Obligated Group.

"Loan" means the loan of the proceeds of the Bonds made by the Agency to the Corporation pursuant to the Loan Agreement.

"Loan Agreement" means the Loan Agreement, dated as of February 1, 2016, by and between the Agency and the Corporation, including all amendments or supplements thereto as therein permitted.

"Loan Repayments" means those payments so designated by and set forth in the Loan Agreement.

"Long-Term Debt Service Coverage Ratio" means for any period of time the ratio determined by dividing the Income Available for Debt Service by Maximum Annual Debt Service.

"Long-Term Debt Service Requirement" means, for any period of twelve (12) consecutive calendar months for which such determination is made, the aggregate of the payments to be made in respect of principal of and interest on Outstanding Long-Term Indebtedness of the Obligated Group during such period, also taking into account (i) with respect to Balloon Long-Term Indebtedness (a) if a binding commitment has been provided for the refinancing of such Indebtedness, the amount of principal and interest which would be payable in such period based on the terms of such refinancing, (b) if no such binding commitment has been provided, then the amount of principal which would be payable in such period if such principal were amortized from the date of incurrence thereof over a period of (x) 25 years on a level debt service basis or (y) an amortization schedule set forth in an Officer's Certificate delivered to the Master Trustee, provided (1) such schedule does not extend the original final maturity of such Indebtedness and provides for level payments of principal and interest in each Fiscal Year that (together with the excess of amounts so deposited in each Fiscal Year over the amounts required to be made on such Balloon Long-Term Indebtedness) are not less than the amounts required to be made in each Fiscal Year by the terms of such Balloon Long-Term Indebtedness, and (2) a Member of the Obligated Group enters into a binding commitment with a financial institution (that would otherwise qualify as the Master Trustee under the Master Indenture) to deposit the amount of principal shown on such amortization schedule in each Fiscal Year, net of the amount of principal actually paid on such Balloon Long-Term Indebtedness during such Fiscal Year, using, in the case of (b), an interest rate equal to (A) if such Indebtedness is tax-exempt, the most recently published 30-year Revenue Bond Index as published in The Bond Buyer or (B) if such Indebtedness is not tax-exempt, the rate set forth in an opinion of a banking institution or an investment banking institution knowledgeable in health care finance delivered to the Master Trustee as the interest rate at which the Obligated Group could reasonably expect to borrow the same by issuing an Obligation with the same term as assumed above; provided, however, that if the date of calculation is within twelve (12) months of the actual maturity of such Indebtedness, the full amount of principal payable at maturity shall be included in such calculation; (ii) with respect to Variable Rate Indebtedness that is Long-Term Indebtedness, the interest on such Indebtedness shall be calculated at the rate which is equal to the average of the actual interest rates which were in effect (weighted according to the length of the period during which each such interest rate was in effect) for the most recent twelve-month period immediately preceding the date of calculation for which such information is available (or shorter period if such information is not available for a twelve-month period), except that, with respect to new Variable Rate Indebtedness, the interest rate for such Indebtedness for the initial interest rate period shall be the initial rate at which such Indebtedness was incurred and thereafter shall be calculated as set forth above; and (iii) with respect to Derivative Indebtedness, the interest on such Indebtedness during any Derivative Period and for so long as the provider of the Derivative Agreement has a long-term credit rating of at least "A" (without regard to any rating refinement or gradation by numerical modifier or otherwise) assigned to it by Moody's, if rated by Moody's, Fitch, if rated by Fitch, and S&P, if rated by S&P, and has not defaulted on its payment obligations thereunder shall be calculated by adding (x) the amount of interest payable by a Member of the Obligated Group on such Derivative Indebtedness pursuant to its terms and (y) the amount of interest payable by such Member of the Obligated Group under the Derivative Agreement and subtracting (z) the amount of interest payable by the provider of the Derivative Agreement at the rate specified in the Derivative Agreement; provided, however, that to the extent that the provider of any Derivative Agreement does not have a long-term credit rating of at least "A" (without regard to any rating refinement or gradation by numerical modifier or otherwise) assigned to it by Moody's, if rated by Moody's, Fitch, if rated by Fitch, and S&P, if rated by S&P, or is in default thereunder, the amount of interest payable by the Member of the Obligated Group shall be the interest calculated as if such Derivative Agreement had not been executed;

provided, however, that interest shall be excluded from the determination of Long-Term Debt Service Requirement to the extent the same is provided from the proceeds of the Long-Term Indebtedness and

provided further, however, that notwithstanding the foregoing, the aggregate of the payments to be made with respect to principal of and interest on Outstanding Long-Term Indebtedness shall not include principal and interest payable from funds available in a Qualified Escrow (other than principal and interest so payable solely by reason of the Obligated Group's failure to make payments from other sources).

"Long-Term Indebtedness" means all obligations for borrowed money incurred or assumed by any Member of the Obligated Group, including (a) Guaranties, (b) Short-Term Indebtedness if a binding commitment by an institutional lender exists to provide financing to retire such Short-Term Indebtedness and such commitment provides for the repayment of principal on terms which would, if such commitment were implemented, constitute Long-Term Indebtedness, and (c) the current portion of Long-Term Indebtedness, for any of the following:

(i) money borrowed for an original term, or renewable at the option of the borrower for a period from the date originally incurred, longer than one (1) year;

(ii) leases which are required to be capitalized in accordance with generally accepted accounting principles having an original term, or renewable at the option of the lessee for a period from the date originally incurred, longer than one (1) year; and

(iii) installment sale or conditional sale contracts having an original term in excess of one (1) year;

provided, however, that any Guaranty by any Member of the Obligated Group of any obligation of any Person, which obligation would, if it were a direct obligation of such Member of the Obligated Group, constitute Short-Term Indebtedness, shall be excluded.

"Master Indenture" or "Indenture" means the Master Trust Indenture, dated as of January 1, 1993, as amended and restated as of March 1, 2004, by and between the Corporation and the Master Trustee, including any amendments or supplements thereto.

"Master Trustee" means People's United Bank, N.A., and its successors in the trusts created under the Master Indenture.

"Maximum Annual Debt Service" means the highest Long-Term Debt Service Requirement for the current or any succeeding Fiscal Year.

"Maximum Annual Debt Service on the Bonds" means at any given time of determination, the maximum Principal and Interest Requirements for the Bonds for the then current or any succeeding Bond Year. For purposes of this definition, Principal and Interest Requirements for any Bond Year shall not include any principal or interest due in such Bond Year by reason of the failure of the Agency to pay the same when due in any prior Bond Year.

"Member of the Obligated Group" means, initially, the Corporation, University of Vermont Health Network and Central Vermont Medical Center, Inc., and, thereafter, any other Person which shall become a Member of the Obligated Group pursuant to the Master Indenture and not including any Person which shall have withdrawn from the Obligated Group pursuant to the Master Indenture.

"Moody's" means Moody's Investors Service, a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, and if such corporation shall be dissolved or

liquidated or shall no longer perform the functions of a securities rating agency, "Moody's" shall be deemed to refer to any other nationally recognized securities rating agency designated by the Agency, with the approval of the Hospital Representative, by notice to the Bond Trustee.

"Mortgage" means the Mortgage Deed, dated as of December 17, 2003, executed by the Corporation as security for the repayment of the Obligations, including any amendments to said mortgage.

"Mortgage Property" means the real property described in the Mortgage, together with all real property acquired as an addition to, in replacement of, or in substitution for, all or any part of the real property described in the Mortgage, less such real property as may be released from the Mortgage pursuant to the terms of the Master Indenture.

"Net Book Value", when used in connection with Property and Equipment or other Property of any Person, means the value of such property, net of accumulated depreciation, as it is carried on the books of such Person in conformity with generally accepted accounting principles, and when used in connection with Property and Equipment or other Property of the Obligated Group, means the aggregate of the values so determined with respect to such Property and Equipment or other Property of the Obligated Group determined in such a manner that no portion of Property and Equipment or other Property is included more than once.

"Non-Recourse Indebtedness" means any Indebtedness secured by a Lien, the liability for which is effectively limited to the Property, the purchase or acquisition or, in the case of vacant land only, the improvement of which was financed with the proceeds of such Non-Recourse Indebtedness and which is subject to such Lien with no recourse, directly or indirectly, to any other Property of any Member of the Obligated Group.

"Obligated Group" means, collectively, the Members of the Obligated Group.

"Obligated Group Representative" means the Person at the time designated to act on behalf of the Obligated Group in a written certificate furnished to the Master Trustee, which certificate shall contain a specimen signature of such Person and shall be signed on behalf of the Obligated Group by the Chief Executive Officer or Chief Financial Officer of the Corporation or by his designee.

"Obligation" means the evidence of particular Indebtedness issued under the Master Indenture.

"Obligation No. 21" means the Obligation so designated and issued under the Master Indenture and delivered to the Agency pursuant to the Loan Agreement.

"Officer's Certificate" means, with respect to the Loan Agreement, a certificate signed by an Agency Representative or a Hospital Representative, as the case may be.

"Officer's Certificate" means, with respect to the Master Indenture, a certificate signed by (i) the chairman of the Governing Body, or the president or chief executive officer, or the chief financial officer, or the chairman of the finance committee of the Governing Body of such Member of the Obligated Group as the context requires or (ii) the Obligated Group Representative. Each Officer's Certificate presented under the Master Indenture shall state that it is being delivered pursuant to (and shall identify the section or subsection of) the Master Indenture and shall incorporate by reference and use in all appropriate instances all terms defined in the Master Indenture. Each Officer's Certificate shall state (i) that the terms thereof are in compliance with the requirements of the section or subsection of the Master Indenture

pursuant to which such Officer's Certificate is delivered, or shall state in reasonable detail the nature of any non-compliance and the steps being taken to remedy such non-compliance, and (ii) that it is being delivered together with any opinions, schedules, statements or other documents required in connection therewith.

"Opinion of Bond Counsel" means an opinion in writing signed by an attorney or firm of attorneys acceptable to the Master Trustee and experienced in the field of municipal bonds whose opinions are generally accepted by purchasers of municipal bonds.

"Opinion of Counsel" means, with respect to the Trust Agreement, an opinion in writing signed by an attorney or firm of attorneys acceptable to the Bond Trustee who may be counsel for the Agency or the Corporation or other counsel.

"Opinion of Counsel" means, with respect to the Master Indenture, an opinion in writing signed by an attorney or firm of attorneys, acceptable to the Master Trustee, who may be counsel for any Member of the Obligated Group or other counsel acceptable to the Master Trustee.

"Outstanding" means, when used with reference to Bonds, as of a particular date, all Bonds theretofore issued under the Trust Agreement, except:

(1) Bonds theretofore cancelled by the Bond Registrar or delivered to the Bond Registrar for cancellation;

(2) Bonds for the payment of which money, Defeasance Obligations, or a combination of both, sufficient to pay, on the date when such Bonds are to be paid or redeemed, the principal amount of or the Redemption Price of, and the interest accruing to such date on, the Bonds to be paid or redeemed, has been deposited with the Bond Trustee or the Bond Registrar in trust for the Holders of such Bonds; Defeasance Obligations shall be deemed to be sufficient to pay or redeem Bonds on a specified date if the principal of and the interest on such Defeasance Obligations, when due, will be sufficient to pay on such date the Redemption Price of, and the interest accruing on, such Bonds to such date;

(3) Bonds in exchange for or in lieu of which other Bonds have been issued;

(4) Bonds deemed to have been paid in accordance with the Trust Agreement.

provided, however, that Bonds owned or held by or for the account of the Corporation, any Affiliate or any subsidiary or controlled affiliate of the Corporation or any Affiliate shall not be deemed Outstanding Bonds for the purpose of any consent or other action or any calculation of Outstanding Bonds provided for in the Articles in the Trust Agreement entitled "Events of Default and Remedies", "Supplemental Trust Agreements" and "Defeasance" and in the Section in the Loan Agreement entitled "Amendment of Agreement" and neither the Corporation nor any Affiliate as registered owners of such Bonds shall be entitled to consent or take any other action provided for in the above-mentioned provisions of the Trust Agreement or the Loan Agreement.

"Outstanding" when used with reference to Indebtedness means, as of any date of determination, all Indebtedness theretofore issued or incurred and not paid and discharged other than (i) Obligations theretofore cancelled by the Master Trustee or delivered to the Master Trustee for cancellation, (ii) Indebtedness deemed paid and no longer Outstanding under the documents pursuant to which such Indebtedness was incurred, (iii) Defeased Obligations and (iv) Obligations in lieu of which other

Obligations have been authenticated and delivered or have been paid pursuant to the provisions of the Supplement regarding mutilated, destroyed, lost or stolen Obligations unless proof satisfactory to the Master Trustee has been received that any such Obligation is held by a bona fide purchaser; provided, however, that for purposes of determining whether the Holders of the requisite principal amount of Obligations have concurred in any demands, direction, request, notice, consent, waiver or other action under the Master Indenture, Obligations or Related Bonds that are owned by any Member of the Obligated Group or by any person directly or indirectly controlling or controlled by or under direct or indirect common control with such Member shall be deemed not to be Outstanding, provided further, however, that for the purposes of determining whether the Master Trustee shall be protected in relying on any such direction, consent or waiver, only such Obligations or Related Bonds which the Master Trustee has actual notice or knowledge as being so owned shall be deemed to be not Outstanding.

"Permitted Liens" means those Liens described under the caption "SUMMARY OF THE MASTER INDENTURE - Particular Covenants -- Limitation on Creation of Liens" below.

"Person" means an individual, association, unincorporated organization, corporation, limited liability company, partnership, joint venture, business trust or a government or an agency or a political subdivision thereof, or any other entity.

"Pledged Assets" means all Gross Receipts of the Members of the Obligated Group, now owned or hereafter acquired, and all proceeds thereof.

"Principal Account" means the account in the Bond Fund created and so designated by the Trust Agreement.

"Principal and Interest Requirements" means for any Bond Year, the sum of the Principal Requirements and Interest Requirements for such Bond Year.

"Principal Requirements" means for any Bond Year the amount required to pay the principal of all Outstanding Serial Bonds on December 1 of the following Bond Year.

"Property" means any and all rights, titles and interests in and to any and all property whether real or personal, tangible or intangible and wherever situated.

"Property and Equipment" means all Property of the Members of the Obligated Group which is property and equipment under generally accepted accounting principles.

"Put Indebtedness" means Long-Term Indebtedness twenty-five percent (25%) or more of the principal of which is required, at the option of the owner thereof, to be purchased or redeemed at one time.

"Qualified Escrow" means amounts deposited in a segregated escrow fund or other similar fund or account in connection with the issuance of Long-Term Indebtedness or Related Bonds secured by such Long-Term Indebtedness which fund or account is required by the documents establishing such fund or account to be applied toward the Obligated Group's payment obligations with respect to principal of or interest on (a) the Long-Term Indebtedness or Related Bonds secured thereby which are issued under the documents establishing such fund or account or (b) Long-Term Indebtedness or Related Bonds secured thereby which are issued prior to the establishment of such fund or account.

"Rating Agency" means Moody's, S&P and Fitch.

"Redemption Fund" means the Vermont Educational and Health Buildings Financing Agency Hospital Revenue Bonds (The University of Vermont Medical Center Project) Series 2016A Redemption Fund created and so designated by the Trust Agreement.

"Redemption Price" means, with respect to Bonds or a portion thereof, the principal amount of such Bonds or portion thereof plus the applicable premium, if any, payable upon redemption thereof in the manner contemplated in accordance with the terms of the Trust Agreement.

"Register" means the register of the record owners of Bonds maintained by the Bond Registrar pursuant to the Trust Agreement.

"Regular Record Date" means the 15th day of the month (whether or not a Business Day) immediately preceding any Interest Payment Date.

"Related Bond Indenture" means any indenture, bond resolution or other comparable instrument pursuant to which a series of Related Bonds is issued.

"Related Bond Issuer" means the issuer of any issue of Related Bonds.

"Related Bond Trustee" means the trustee and its successors in the trusts created under any Related Bond Indenture.

"Related Bonds" means 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 (i) a Member of the Obligated Group in consideration of the execution, authentication and delivery of an Obligation to or for the order of such governmental issuer, or (ii) any Person other than a Member of the Obligated Group in consideration of the issuance to such governmental issuer (A) by such Person of any indebtedness or other obligation of such Person and (B) by a Member of the Obligated Group of a Guaranty in respect of such indebtedness or other obligation, which Guaranty is represented by an Obligation.

"Required Payments under the Loan Agreement" means the payments so designated by and set forth in the Loan Agreement.

"S&P" means Standard & Poor's Ratings Services, a division of The McGraw-Hill Companies, Inc., its successors and their assigns, and, if S&P shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, "S&P" shall be deemed to refer to any other nationally recognized securities rating agency designated by the Agency, with the approval of the Hospital Representative, by notice to the Bond Trustee.

"Securities Depository" means The Depository Trust Company, New York, New York, and any substitute for or successor to such securities depository that shall maintain a Book-Entry System with respect to the Bonds.

"Securities Depository Nominee" means the Securities Depository or the nominee of such Securities Depository in whose name there shall be registered on the Register the Bonds to be delivered to such Securities Depository during the continuation with such Securities Depository of participation in its Book-Entry System.

"Serial Bonds" means Bonds which are stated to mature in consecutive annual or semi-annual installments.

"Short-Term Indebtedness" means all obligations, other than any Guaranty of an obligation of a Person which is a Member of the Obligated Group and the current portion of Long-Term Indebtedness, incurred or assumed by one or more Members of the Obligated Group, for any of the following:

(i) money borrowed for an original term, or renewable at the option of the borrower for a period from the date originally incurred, of one (1) year or less;

(ii) leases which are capitalized in accordance with generally accepted accounting principles having an original term, or renewable at the option of the lessee for a period from the date originally incurred, of one (1) year or less; and

(iii) installment purchase or conditional sale contracts having an original term of one (1) year or less.

"Special Record Date" for the payment of any Defaulted Interest on Bonds means a date fixed by the Bond Trustee pursuant to the Trust Agreement.

"State" means the State of Vermont.

"Subordinated Indebtedness" means Indebtedness of a Member of the Obligated Group that by the terms thereof is specifically junior and subordinate to the Obligations with respect to payment of principal and interest thereon and that is evidenced by an instrument containing provisions substantially the same as those set forth in the Master Indenture.

"Supplement" means an indenture supplemental to, and authorized and executed pursuant to the terms of, the Master Indenture.

"Supplement No. 21" means Supplemental Indenture for Obligation No. 21, dated as of February 1, 2016, by and between the Corporation and the Master Trustee.

"Tax Certificate" means the Tax Certificate and Agreement, dated the Closing Date, concerning certain matters pertaining to the use and investment of proceeds of the Bonds executed by the Agency and the Corporation on the date of initial execution and delivery of the Bonds, including any and all exhibits attached thereto.

"Tax-Exempt Organization" means a Person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code and exempt from federal income taxes under Section 501(a) of the Code or corresponding provisions of federal income tax laws from time to time in effect.

"Term Bonds" means the Bonds, other than Serial Bonds, stated to be payable by their terms on one or more dates.

"Total Operating Revenues" means, with respect to the Obligated Group, as to any period of time, total operating revenues, as determined in accordance with generally accepted accounting principles consistently applied.

"Total Required Payments" means the sum of Loan Repayments and Required Payments under the Loan Agreement.

"Transfer" means any act or occurrence the result of which is to dispossess any Person of any asset or interest therein, including specifically, but without limitation, the forgiveness of any debt or the lease of any such asset.

"Trust Agreement" means the Trust Agreement securing the Bonds, dated as of February 1, 2016, by and between the Agency and the Bond Trustee, including any trust agreement amendatory thereof or supplemental thereto.

"Variable Rate Indebtedness" means any portion of Indebtedness the interest rate on which is not established at the time of incurrence at a fixed or constant rate.

SUMMARY OF THE MASTER INDENTURE

Authorization, Issuance and Terms of Obligations

There is no limit on the principal amount or number of Obligations that may be issued under the Master Indenture or Indebtedness that may be created under other documents, except as limited by the provisions of the Master Indenture or of any Supplement, but no Obligations may be issued unless the provisions of the Master Indenture are followed. Any Member of the Obligated Group proposing to incur Long Term Indebtedness or enter into Derivative Agreements, whether evidenced by Obligations issued under the Master Indenture or Indebtedness or Derivative Agreements created under any other documents, shall, at least seven (7) days prior to the date of the incurrence of such Long Term Indebtedness or Derivative Agreements, give written notice of its intention to incur such Long Term Indebtedness or enter into such Derivative Agreement, including in such notice the amount of Indebtedness or the notional amount of the Derivative Agreement to be incurred, to the other Members of the Obligated Group and, in the case of Long-Term Indebtedness in an amount exceeding $5,000,000 or a Derivative Agreement with a notional amount exceeding $5,000,000, to the Master Trustee. Each Member of the Obligated Group is jointly and severally liable for each and every Obligation.

Any Member of the Obligated Group and the Master Trustee may from time to time enter into a Supplement in order to evidence Indebtedness or Derivative Agreements under the Master Indenture. Such Supplement will, with respect to an Obligation evidencing Indebtedness created thereby, set forth the date thereof, and the date or dates on which the principal of, redemption premium, if any, and interest on such Obligation will be payable, and the form of such Obligation and such other terms and provisions as will conform with the provisions and conditions of the Master Indenture.

Particular Covenants

Security; Restrictions on Encumbering Property; Payment of Principal and Interest

(a) Any Obligation issued pursuant to the Master Indenture will be a general obligation of the issuer of such Obligation.

To secure the prompt payment of the principal of, redemption premium, if any, and the interest on the Obligations, and the performance by each Member of the Obligated Group of its other obligations under the Master Indenture, each Member of the Obligated Group pledges, assigns and grants to the Master Trustee a security interest in its Pledged Assets. Prior to its receipt of a request from the Master Trustee as described in subparagraph (d) below, any Member of the Obligated Group may sell, or incur Indebtedness secured by, all or any part of its Pledged Assets free of such security interest, subject to the limitations described under the subcaptions entitled "Limitation on Creation of Liens"; "Limitations on Indebtedness"; "Transfers of Property; Disposition of Cash and Investments; Sale of Accounts" and "Consolidation, Merger, Sale or Conveyance" of this "SUMMARY OF THE MASTER INDENTURE".

Prior to the delivery of the first Obligation under the Master Indenture, there were delivered to the Master Trustee duly executed financing statements evidencing the security interest of the Master Trustee in the Pledged Assets in the form required by the Vermont Uniform Commercial Code with copies sufficient in number for filing in the office of the Secretary of State in Montpelier, Vermont and in the office of the City Clerk of the City of Burlington, Vermont. Continuation statements are required to be filed to maintain the perfection of such security interest.

Without limiting the generality of the foregoing, such security interest will apply to all rights to receive Gross Receipts whether in the form of accounts receivable, contract rights or other rights, and to the proceeds thereof. The security interest will apply to all of the foregoing, whether now existing or hereafter coming into existence and whether now owned or held or hereafter owned or acquired by the Members of the Obligated Group.

To further secure the prompt payment of the principal of, redemption premium, if any, and the interest on the Obligations and the performance by each Member of the Obligated Group of its other obligations under the Master Indenture, the Corporation has executed and delivered to the Master Trustee the Mortgage.

(b) Each Member of the Obligated Group covenants that it will not pledge or grant a security interest in (except as provided in subparagraph (a) above and as may be otherwise provided in the Master Indenture) any of its Property.

(c) Each Obligation will be a joint and several general obligation of each Member of the Obligated Group. Each Member of the Obligated Group covenants to promptly pay or cause to be paid the principal of, premium, if any, and interest on each Obligation issued under the Master Indenture at the place, on the dates and in the manner provided in the Master Indenture, in the Supplement and in said Obligation according to the terms thereof whether at maturity, upon proceedings for redemption, by acceleration or otherwise.

(d) Each Member of the Obligated Group covenants that, if an Event of Default under the Master Indenture shall have occurred and be continuing, it will, upon request of the Master Trustee, deliver or direct to be delivered to the Master Trustee all Gross Receipts until such Event of Default has been cured.

Tax-Exempt Status

So long as the Master Indenture remains in effect, each Member of the Obligated Group which is a Tax-Exempt Organization at the time it becomes a Member of the Obligated Group agrees that, so long as all amounts due or to become due on any Related Bond have not been fully paid to the holder thereof, it will not take any action or fail to take any action which action or failure to act (including any action or failure to act which would result in the alteration or loss of its status as a Tax-Exempt Organization) would, in the Opinion of Bond Counsel, result in the interest on any Related Bond becoming included in the gross income of the holder thereof for federal income tax purposes.

Insurance

Each Member of the Obligated Group agrees that it will maintain, or cause to be maintained, such insurance with respect to the operation and maintenance of its Property (including one or more self-insurance programs considered by an Insurance Consultant to be reasonable and appropriate) of such type and in such amounts as are normally carried by hospital facilities of similar type and size and against such risks as are customarily insured against in connection with hospital operations and hospital facilities of similar type and size, including, but not limited to: (i) comprehensive general public liability insurance, including blanket contractual liability and automobile insurance including owned and hired automobiles (excluding collision and comprehensive coverage thereon), (ii) professional liability or medical malpractice insurance, (iii) fire, lightning, windstorm, hail, explosion, riot, riot attending a strike, civil commotion, damage from aircraft, smoke and uniform standard coverage and vandalism and

malicious mischief endorsements and business interruption insurance covering such periods, (iv) workers' compensation insurance and (v) boiler insurance.

The Obligated Group is required to retain an Insurance Consultant to review the insurance requirements of the Members of the Obligated Group from time to time (but not less frequently than biennially). If the Insurance Consultant makes recommendations for the increase of any coverage, the Obligated Group is required to increase or cause to be increased such coverage in accordance with such recommendations, subject to a good faith determination of the Obligated Group Representative that such recommendations, in whole or in part, are in the best interests of the Obligated Group. Notwithstanding anything in the Master Indenture to the contrary, each Member of the Obligated Group will have the right, without giving rise to an Event of Default solely on such account, (i) to maintain insurance coverage below that most recently recommended by the Insurance Consultant, if the Obligated Group furnishes to the Master Trustee a report of the Insurance Consultant to the effect that the insurance so provided affords either the greatest amount of coverage available for the risk being insured against at rates which in the judgment of the Insurance Consultant are reasonable in connection with reasonable and appropriate risk management, or the greatest amount of coverage necessary by reason of state or federal laws now or hereafter in existence limiting medical and malpractice liability, or (ii) to adopt alternative risk management programs which the Insurance Consultant determines to be reasonable, including, without limitation, to self-insure in whole or in part individually or in connection with other institutions, to participate in programs of captive insurance companies, to participate with other health care institutions in mutual or other cooperative insurance or other risk management programs, to participate in state or federal insurance programs, to take advantage of state or federal laws now or hereafter in existence limiting medical and malpractice liability, or to establish or participate in other alternative risk management programs; all as may be approved by the Insurance Consultant as reasonable and appropriate risk management by the Obligated Group. If any Member of the Obligated Group is self-insured for any coverage, the report of the Insurance Consultant mentioned above is required to state whether the anticipated funding of any self-insurance fund is actuarially sound, and if not, the required funding to produce such result and such coverage is required to be reviewed by such Consultant not less frequently than annually. If the Insurance Consultant determines that the anticipated funding of any self-insurance fund is not actuarially sound, the Obligated Group covenants that it will fund such self-insurance fund in the manner recommended by the Insurance Consultant.

Insurance and Condemnation Proceeds

Amounts that do not exceed 20% of the Net Book Value of the Property and Equipment of the Obligated Group received by any Member of the Obligated Group 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 prepayment of any Indebtedness in accordance with the terms thereof and of any pertinent Supplement.

Amounts that exceed 20% of the Net Book Value of the Property and Equipment of the Obligated Group received by any Member of the Obligated Group as insurance proceeds with respect to any casualty loss or as condemnation awards will be applied in such manner as the recipient may determine; provided, however, that the recipient is required to notify the Master Trustee and within twelve (12) months after the casualty loss or taking, deliver to the Master Trustee:

(i) (A) An Officer's Certificate certifying the expected Long-Term Debt Service Coverage Ratio for each of the two (2) full Fiscal Years following the date on which such proceeds or awards are expected to have been fully applied, which Long-Term Debt Service Coverage Ratio

for each such period is not less than 1.50, as shown by pro forma financial statements for each such period, accompanied by a statement of the relevant assumptions including assumptions as to the use of such proceeds or awards, upon which such pro forma statements are based, and (B) if the amount of such proceeds or awards received with respect to any casualty loss or condemnation exceeds thirty percent (30%) of the Net Book Value of the Property and Equipment of the Obligated Group, a written report of a Consultant confirming such certification; or

(ii) A written report of a Consultant stating the Consultant's recommendations, including recommendations as to the use of such proceeds or awards, to cause the Long-Term Debt Service Coverage Ratio for each of the periods described in clause (i) above to be not less than 1.10, or, if in the opinion of the Consultant the attainment of such level is impracticable, at the highest practicable level.

Each Member of the Obligated Group agrees that it will use such proceeds or awards, to the extent permitted by law, only in accordance with the assumptions described in clause (i), or the recommendations described in clause (ii), of the preceding paragraph.

Limitation 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 Pledged Assets or on Property now owned or hereafter acquired by it other than Permitted Liens.

(b) Permitted Liens will consist of the following:

(i) The Lien on the Pledged Assets created by the Master Indenture as described in subparagraph (a) under the subcaption above entitled "Security; Restrictions on Encumbering Property; Payment of Principal and Interest";

(ii) Liens arising by reason of good faith deposits with 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;

(iii) 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;

(iv) 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, unless the amount of such judgment lien is less than $5,000,000, in which case the execution thereon may be unstayed;

(v) (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, affecting any Property; (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 the amount or validity of which, are being contested and execution thereon is stayed or, with respect to Liens of mechanics, materialmen, laborers, suppliers or vendors have been due for fewer than ninety (90) days; (C) easements, rights-of-way, servitudes, restrictions, oil, gas or other mineral reservations 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;

(vi) Any Lien which is existing on the date of authentication and delivery of the first Obligation issued under the Master Indenture provided that no such Lien may be increased, extended, renewed or modified to apply to any Property of any Member of the Obligated Group not subject to such Lien on such date or to secure Indebtedness not Outstanding as of the date of the Master Indenture, unless such Lien as so increased, extended, renewed or modified otherwise qualifies as a Permitted Lien under the Master Indenture;

(vii) Any Lien on Property which is part of the Property and Equipment securing Indebtedness in a principal amount not exceeding fifteen percent (15%) of Total Operating Revenues as shown on the Audited Financial Statements of the prior Fiscal Year;

(viii) Any Lien on pledges, bequests, gifts or grants to be received in the future including any income derived from the investment thereof;

(ix) Any Lien on inventory securing Indebtedness which does not exceed twenty-five percent (25%) of the Net Book Value thereof;

(x) Any Lien in favor of a trustee on the proceeds of Indebtedness prior to the application of such proceeds;

(xi) Any Lien securing all Obligations on a parity basis;

(xii) Any Liens subordinate to the lien described in clause (xi) above required by a statute under which a Related Bond is issued;

(xiii) Liens on moneys deposited by patients or others with any Member of the Obligated Group as security for or as prepayment for the cost of patient care;

(xiv) 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;

(xv) Liens on Property due to rights of third party payors, including the federally funded health insurance programs, for recoupment of amounts paid to any Member of the Obligated Group;

(xvi) Rights of the United States of America under Title 42 United States Code Section 291i;

(xvii) Any Lien securing Non-Recourse Indebtedness permitted by the provisions of the Master Indenture described below in paragraph (g) under "Limitations on Indebtedness";

(xviii) Any Lien on Accounts that are sold pursuant to the provisions of the Master Indenture described below in paragraph (c) under the subcaption entitled "Transfers of Property; Disposition of Cash and Investments; Sale of Accounts" or that are pledged to secure Indebtedness permitted by the provisions of the Master Indenture described below in paragraph (g) under the subcaption entitled "Limitations on Indebtedness";

(xix) Any Lien on Property acquired by a Member of the Obligated Group if the Indebtedness secured by the Lien is additional Indebtedness permitted under the provisions of the Master Indenture described below under the subcaption entitled "Limitations on Indebtedness", and if an Officer's Certificate is delivered to the Master Trustee certifying that (A) the Lien and the Indebtedness secured thereby were created and incurred by a Person other than the Member of the Obligated Group, and (B) the Lien was not created for the purpose of enabling the Member of the Obligated Group to avoid the limitations of the Master Indenture on creation of Liens on Property of the Obligated Group; and

(xx) Any Lien on moveable equipment (as such term is defined under generally accepted accounting principles) securing Indebtedness incurred to purchase such moveable equipment, provided that the total of such Indebtedness does not exceed twenty-five percent (25%) of the Net Book Value of the Property of the Obligated Group as shown on the Audited Financial Statements of the prior Fiscal Year.

Limitations on Indebtedness

Each Member of the Obligated Group agrees that after the issuance and delivery of the first Obligation under the Master Indenture, it will not incur any Indebtedness if, after giving effect to all other Indebtedness incurred by the Obligated Group, such Indebtedness could not be incurred pursuant to the provisions of the Master Indenture described in paragraphs (a) through (i), inclusive, below. Any Indebtedness may be incurred only in the manner and pursuant to the terms set forth in the Master Indenture described in paragraphs (a) through (i) below.

(a) Long-Term Indebtedness may be incurred if prior to incurrence of the Long-Term Indebtedness one of the following conditions is met:

(i) there is delivered to the Master Trustee an Officer's Certificate certifying that, immediately after the incurrence of the proposed Long-Term Indebtedness, the aggregate principal amount of all Long-Term Indebtedness does not exceed sixty-seven percent (67%) of Capitalization; or

(ii) there is delivered to the Master Trustee an Officer's Certificate (accompanied by Audited Financial Statements) certifying that the Long-Term Debt Service Coverage Ratio, taking all Outstanding Long-Term Indebtedness and the Long-Term Indebtedness then proposed to be incurred into account as if it had been incurred at the beginning of such period, for the most recent Fiscal Year preceding the date of delivery of such Officer's Certificate for which the Audited Financial Statements are available, is not less than 1.25; or

(iii) there is delivered to the Master Trustee an Officer's Certificate certifying that the Long-Term Debt Service Coverage Ratio, taking into account the proposed Long-Term Indebtedness, for (A) in the case of Long-Term Indebtedness (other than a Guaranty) to finance capital improvements, each of the two (2) full Fiscal Years next succeeding the date on which such capital improvements are expected to be placed in operation or (B) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, each of the two (2) full Fiscal Years next succeeding the date on which the Indebtedness is incurred, is not less than 1.35; provided, however, that such Officer's Certificate must also certify, in the case of (A) above when interest on the proposed Long-Term Indebtedness has not been capitalized, that the Long-Term Debt Service Coverage Ratio for each of the two (2) full Fiscal Years next succeeding the date on which the Indebtedness is incurred is not less than 1.00; such Officer's Certificate is required to be accompanied by projected balance sheets, statements of revenues and expenses and statements of changes in cash flow for each such Fiscal Year and a statement of the assumptions upon which such projected financial statements are based; or

(iv) (A) there is delivered to the Master Trustee an Officer's Certificate (accompanied by Audited Financial Statements) certifying the Long-Term Debt Service Coverage Ratio, taking into account all Outstanding Long-Term Indebtedness, but not the Long-Term Indebtedness then to be incurred, for the most recent Fiscal Year preceding the date of delivery of the Officer's Certificate for which the Audited Financial Statements are available, is not less than 1.10; and (B) there is filed with the Master Trustee the report of a Consultant to the effect that the forecasted Long-Term Debt Service Coverage Ratio, taking the proposed Long-Term Indebtedness into account, for (I) in the case of Long-Term Indebtedness (other than a Guaranty) to finance capital improvements, each of the two (2) full Fiscal Years succeeding the date on which such capital improvements are expected to be placed in operation, or (II) in the case of Long-Term Indebtedness not financing capital improvements or in the case of a Guaranty, each of the two (2) full Fiscal Years succeeding the date on which the Indebtedness is incurred, is not less than 1.25; provided, however, that such Consultant's report must also show, in the case of (I) above when interest on the proposed Long-Term Indebtedness has not been capitalized, that the forecasted Long-Term Debt Service Coverage Ratio for each of the two (2) full Fiscal Years succeeding the date on which the Indebtedness is incurred is not less than 1.00, in each case as shown by forecasted balance sheets, statements of revenues and expenses and statements of changes in financial position for each such period, accompanied by a statement of the relevant assumptions upon which such forecasted statements are based; or

(v) without compliance with any of the tests mentioned in clause (i), (ii), (iii) or (iv) above, Long-Term Indebtedness may be incurred provided that there is delivered to the Master Trustee an Officer's Certificate of an Obligated Group Representative certifying that, immediately after giving effect to any Long-Term Indebtedness incurred pursuant to the provisions of the Master Indenture described in this clause (v), the aggregate of Long-Term Indebtedness incurred under the provisions of the Master Indenture described in this clause (v) does not exceed twenty-five percent (25%) of Total Operating Revenues for the most recent Fiscal Year for which Audited Financial Statements are available.

Notwithstanding any of the Long-Term Debt Service Coverage Ratios specified in clause (ii), (iii) or (iv) above, if the report of a Consultant states that Governmental Restrictions have been imposed or have taken effect which make it impossible for such coverage requirements to be met, then such coverage requirements will be reduced to the maximum coverage permitted by such Governmental Restrictions but in no event less than 1.00.

(b) Completion Indebtedness may be incurred without limitation; provided, however, that prior to the incurrence of Completion Indebtedness, the Obligated Group Representative is required to furnish to the Master Trustee the following: (i) a certificate of an architect estimating the costs of completing the facilities for which Completion Indebtedness is to be incurred; and (ii) a certificate of the chief financial officer of the Member of the Obligated Group for which Completion Indebtedness is to be incurred certifying that the amount of Completion Indebtedness to be incurred will be sufficient, together with other funds, if applicable, to complete construction of the facilities in respect of which Completion Indebtedness is to be incurred.

(c) Long-Term Indebtedness may be incurred for the purpose of refunding any Outstanding Long-Term Indebtedness without limitation if, prior to the incurrence of such Long-Term Indebtedness, there is delivered to the Master Trustee an Opinion of Counsel stating that upon the incurrence of such proposed Long-Term Indebtedness and application of the proceeds thereof (on the Cross-over Date, in the case of Cross-over Refunding Indebtedness), the Outstanding Long-Term Indebtedness to be refunded thereby will no longer be Outstanding.

(d) Short-Term Indebtedness may be incurred if immediately after the incurrence of such Indebtedness the aggregate Outstanding principal amount of all such Indebtedness does not exceed twenty-five percent (25%) of the Total Operating Revenues for the most recent Fiscal Year for which Audited Financial Statements are available; provided, however, that there must be a period of at least twenty (20) consecutive calendar days during each such Fiscal Year during which all Short-Term Indebtedness, other than Short-Term Indebtedness incurred pursuant to the provisions of the Master Indenture described below in paragraph (h) and Short-Term Indebtedness incurred to offset a temporary delay in the receipt of funds due from third-party payors, does not exceed three percent (3%) of such Total Operating Revenues; provided, further, that the aggregate of the principal amount of Indebtedness Outstanding under the provisions of the Master Indenture described in this paragraph (d) and the provisions of the Master Indenture described above in clause (v) of paragraph (a) must not at any time exceed twenty-five percent (25%) of Total Operating Revenues as reflected in the Audited Financial Statements of the Obligated Group for the most recent Fiscal Year for which Audited Financial Statements are available. At the election of the Obligated Group Representative, Indebtedness that constitutes Short-Term Indebtedness may be excluded from Short-Term Indebtedness for the purpose of meeting the requirements set forth in the proviso of the preceding sentence for any Fiscal Year if such Indebtedness is treated as Long-Term Indebtedness for the purpose of computing the Long-Term Debt Service Requirement for such Fiscal Year.

(e) Indebtedness may be incurred without limitation by any Member of the Obligated Group under a line of credit, letter of credit, standby bond purchase agreement or similar liquidity or credit enhancement facility established in connection with the issuance of any Obligations or Related Bonds; provided, however, if such liquidity facility is used or drawn upon to purchase, but not retire Obligations or Related Bonds, then the liability represented by such use or draw by the Member of the Obligated Group will be included in Indebtedness as of the date of such use or draw and the principal amount of the Obligations or Related Bonds so purchased will be excluded for all other purposes of the Master Indenture.

(f) Put Indebtedness may be incurred, if prior to the incurrence of such Put Indebtedness (i) the conditions described above in clause (i), (ii), (iii) or (iv) of paragraph (a) are met and (ii) a binding commitment from a bank or other financial institution exists to provide financing sufficient to pay the purchase price or principal of such Put Indebtedness on any date on which the owner of such Put Indebtedness may demand payment thereof pursuant to the terms of such Put Indebtedness.

Notwithstanding the provisions of the preceding sentence, clause (ii) of such sentence shall be effective only during any period when Related Bonds issued by the Agency that are rated lower than "AA" or "Aa" by any rating agency then rating such Related Bonds or that are not rated are outstanding and, during any such period, the provisions of clause (ii) of such sentence may be waived in writing by the Agency.

(g) Non-Recourse Indebtedness may be incurred without limitation.

(h) Indebtedness secured by Accounts may be incurred if prior to the incurrence of such Indebtedness there is delivered to the Master Trustee an Officer's Certificate of an Obligated Group Representative certifying that immediately after the incurrence of such Indebtedness, the amount of Accounts that have been pledged to secure Indebtedness that has been incurred pursuant to the provisions of the Master Indenture described in this paragraph (h) and is then Outstanding will not exceed 25% of the Obligated Group's net patients accounts, as shown on the Audited Financial Statements for the most recent Fiscal Year for which Audited Financial Statements are available; provided, however, that (A) the determination of whether a disposition of Accounts is a sale or loan shall be made in accordance with generally accepted accounting principles and (B) any Indebtedness incurred pursuant to the provisions of the Master Indenture described in this paragraph (h) will be considered to be Short-Term Indebtedness subject to the incurrence test set forth above in paragraph (d).

(i) Subordinated Indebtedness may be incurred without limitation.

(j) Indebtedness may be classified and incurred under any of the above-referenced paragraphs with respect to which the tests set forth in such paragraphs are met. Each Member may elect to have Indebtedness that was classified and incurred pursuant to one such paragraph, reclassified as having been incurred under another paragraph, by demonstrating compliance with such other paragraph on the assumption that such Indebtedness is being incurred on the date of delivery of any Officer's Certificate, report of a Consultant, Opinion of Counsel or Audited Financial Statements required to be delivered under such other paragraph. From and after such demonstration, such Indebtedness shall be deemed to have been incurred under the paragraph with respect to which such compliance has been demonstrated until any subsequent reclassification of such Indebtedness.

Long-Term Debt Service Coverage Ratio

(a) Each Member of the Obligated Group covenants to set rates and charges for its facilities, services and products such that the Long-Term Debt Service Coverage Ratio, calculated at the end of each Fiscal Year, will not be less than 1.10; provided, however, that in any case where Long-Term Indebtedness has been incurred to acquire or construct capital improvements, the Long-Term Debt Service Requirement with respect thereto will not be taken into account in making the foregoing calculation until the first Fiscal Year commencing after the occupation or utilization of such capital improvements unless the Long-Term Debt Service Requirement with respect thereto is required to be paid from sources other than the proceeds of such Long-Term Indebtedness prior to such Fiscal Year.

(b) If at any time the Long-Term Debt Service Coverage Ratio required by the provisions of the Master Indenture described above in paragraph (a) is less than 1.10, as derived from the most recent Audited Financial Statements for the most recent Fiscal Year, the Obligated Group covenants to retain a Consultant within thirty (30) days to make recommendations to increase such Long-Term Debt Service Coverage Ratio in the following Fiscal Year to the highest level attainable. Each Member of the Obligated Group agrees that it will, to the extent permitted by law, follow the recommendations of the Consultant. So long as a Consultant shall be retained and each Member of the Obligated Group shall

follow such Consultant's recommendations to the extent permitted by law, the provisions of the Master Indenture described under this caption shall be deemed to have been complied with even if the Long-Term Debt Service Coverage Ratio for the following Fiscal Year is below the required level; provided, however, the revenues of the Obligated Group shall not be less than the amount required to pay the total operating expenses of the Obligated Group and to pay the debt service on all Indebtedness of the Obligated Group for such Fiscal Year.

(c) If a report of a Consultant is delivered to the Master Trustee, which report shall state that Governmental Restrictions have been imposed or have taken effect which make it impossible for the coverage requirement described above in paragraph (a) to be met, then such coverage requirement shall be reduced to the maximum coverage permitted by such Governmental Restrictions but in no event less than 1.00, and thereafter, for so long as such Governmental Restrictions are in effect, a report of a Consultant stating that Governmental Restrictions which make it impossible for the coverage requirement described above in paragraph (a) to be met are still in effect shall be delivered to the Master Trustee biennially.

(d) If the Long-Term Debt Service Coverage Ratio shall be less than 1.00 for any Fiscal Year, it shall be an Event of Default.

Transfers of Property; Disposition of Cash and Investments; Sale of Accounts

(a) Each Member of the Obligated Group agrees that it will not Transfer in any Fiscal Year Property consisting of Property other than cash and securities except for Transfers as follows:

(i) Each Member of the Obligated Group may transfer Property to any other Member of the Obligated Group, without limit.

(ii) Each Member of the Obligated Group may transfer Property to any Person in the ordinary course of business.

(iii) Each Member of the Obligated Group may transfer Property to any Person for fair and adequate consideration on terms no less favorable to the Member than would be obtained in a comparable arm's-length transaction.

(iv) Each Member of the Obligated Group may transfer Property to any Person if, in the reasonable judgment of such Member, such Property has, or within the next succeeding twenty-four (24) calendar months is reasonably expected to, become inadequate, obsolete or worn out, or otherwise unsuitable, unprofitable, undesirable or unnecessary for the operation of the Member's primary business.

(v) Each Member of the Obligated Group may transfer Property to any Person, if such Property consists solely of assets which are specifically restricted by the donor or grantor to a particular purpose which is inconsistent with or otherwise unavailable for their use for payment of Long-Term Indebtedness of such Member.

(vi) Each Member of the Obligated Group may transfer Property to any Person if the Property to be transferred is not essential to such Member's primary business operations, and the proceeds of such transfer are used to acquire additional facilities, to repay the principal of Long-Term Indebtedness of such Member, or otherwise used in a productive manner to the benefit of such Member's business operations.

(vii) Each Member of the Obligated Group may transfer Property as part of a merger, consolidation, sale or conveyance permitted under the provisions of the Master Indenture described below under the subcaption entitled "Consolidation, Merger, Sale or Conveyance".

(viii) Each Member of the Obligated Group may transfer Property to any Person, provided that prior to such transfer the Master Trustee receives an Officer's Certificate certifying that, immediately after the proposed disposition, the Obligated Group could meet the conditions of the Master Indenture described above in subparagraphs (a)(i), (ii), (iii) or (iv) under the subcaption entitled "Limitations on Indebtedness" for the incurrence of one additional dollar of Long-Term Indebtedness after taking into account the effect of the proposed disposition, assuming for the purposes of any historical test that such transaction occurred at the beginning of the most recent Fiscal Year for which Audited Financial Statements are available (which Officer's Certificate must contain any demonstrations required to satisfy said conditions and must have attached the written report of a Consultant, if any, required to satisfy said conditions).

(b) Each Member of the Obligated Group agrees that it will not Transfer Property consisting of cash and securities in any Fiscal Year except for Transfers as follows:

(i) Each Member of the Obligated Group may Transfer Property consisting of cash and securities to any Member of the Obligated Group or any Affiliate, without limit; and

(ii) Each Member of the Obligated Group may Transfer Property consisting of cash and securities to any Person if there shall be filed with the Master Trustee an Officer's Certificate of an Obligated Group Representative, accompanied by and based upon Audited Financial Statements for the most recent Fiscal Year for which Audited Financial Statements are available, demonstrating that the Long-Term Debt Service Coverage Ratio for such Fiscal Year would not be reduced below 1.75 if the amount of investment income on the cash or securities that are the subject of the proposed Transfer were deducted from Income Available for Debt Service for such Fiscal Year.

(c) Each Member of the Obligated Group agrees that it will not Transfer Accounts; provided, however, that prior to its receipt of a request from the Master Trustee pursuant to the provisions of the Master Indenture described above in paragraph (d) under the subcaption entitled "Security; Restrictions on Encumbering Property; Payment of Principal and Interest", any Member of the Obligated Group will have the right to sell, in any Fiscal Year, its Accounts in an amount not to exceed the difference between (i) the Account Lien Amount and (ii) the amount of Accounts that have been pledged to secure Outstanding Indebtedness incurred by any Member of the Obligated Group pursuant to the provisions of the Master Indenture described above in paragraph (h) under the subcaption entitled "Limitations on Indebtedness", if such Member of the Obligated Group (i) receives as consideration for such sale cash, services or Property equal to the fair market value of the accounts receivable so sold, as certified to the Master Trustee in an Officer's Certificate of such Member of the Obligated Group and (ii) delivers to the Master Trustee a statement from the Obligated Group's independent certified public accountants that such sale of accounts receivable constitutes a "sale" under generally accepted accounting principles.

(d) Notwithstanding the foregoing provisions of the Master Indenture, nothing in the Master Indenture shall be construed as limiting the ability of any Member of the Obligated Group to purchase or sell Property or inventory 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.

Consolidation, Merger, Sale or Conveyance

(a) Each Member of the Obligated Group covenants that it will not merge into or consolidate with, or sell or convey all or substantially all of its assets to any Person that is not a Member of the Obligated Group unless:

(i) Either a Member of the Obligated Group will be the successor corporation or entity, or if the successor corporation or entity is not a Member of the Obligated Group such successor corporation or entity shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Master Trustee, containing the agreement of such successor corporation or entity to assume the due and punctual payment of the principal of, redemption premium, if any, and interest on all Outstanding Obligations issued under the Master Indenture according to their tenor and the due and punctual performance and observance of all the covenants and conditions of the Master Indenture and any Supplement thereto and granting to the Master Trustee a security interest in the Pledged Assets of such successor corporation or entity; 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 the conditions of the Master Indenture described above in subparagraphs (a)(i), (ii), (iii) or (iv) under the subcaption entitled "Limitations on Indebtedness" would be met for the incurrence of one additional dollar of Long-Term Indebtedness; and

(iii) If all amounts due or to become due on any Related Bond have not been fully paid to the holder thereof, the Master Trustee shall also receive an Opinion of Bond Counsel 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 exclusion from gross income for purposes of federal income taxation of interest payable on such Related Bond.

(b) In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation or entity, such successor corporation or entity shall succeed to and be substituted for its predecessor, with the same effect as if it had been named in the Master Indenture as such predecessor or had become a Member of the Obligated Group pursuant to the provisions of the Master Indenture described below under the subcaption entitled "Parties Becoming Members of the Obligated Group", as the case may be. Such successor corporation or entity thereupon may cause to be signed, and may issue in its own name Obligations issuable under the Master Indenture; and upon the order of such successor corporation or entity and subject to all the terms, conditions and limitations in the Master Indenture prescribed, the Master Trustee shall authenticate and shall deliver Obligations that such successor corporation or entity shall have caused to be signed and delivered to the Master Trustee. All Outstanding Obligations so issued by such successor corporation or entity under the Master Indenture shall in all respects have the same security position and benefit under the Master Indenture as Outstanding Obligations theretofore or thereafter issued in accordance with the terms of the Master Indenture as though all of such Obligations had been issued thereunder 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 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 the Master Indenture and that it is proper for the Master Trustee under the provisions of the Master Indenture to join in the execution of any instrument required to be executed and delivered under the provisions of the Master Indenture described under this caption.

Filing of Financial Statements, Certificate of No Default, Other Information

The Obligated Group covenants that it will:

(a) Within thirty (30) days after receipt of the Audited Financial Statements but in no event later than one hundred twenty (120) days 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, a copy of such Audited Financial Statements.

(b) Within thirty (30) days after receipt of the Audited Financial Statements but in no event later than one hundred twenty (120) days after the end of each Fiscal Year, file with the Master Trustee and with each Holder who may have so requested or in 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 the Fiscal Year and stating whether, to the best knowledge of the signers, any Member of the Obligated Group is in default in the performance of any covenant contained in the Master Indenture and, if so, specifying each such default of which the signers may have knowledge and whether each such default has been corrected. If any default has not been remedied, then such Officer's Certificate, to the best knowledge of the signer, shall identify what, if any, corrective action will be taken to cure such default.

(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 its consolidated or combined subsidiaries, including any Member of the Obligated Group) 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, subject to patient confidentiality and safety concerns.

(d) Within thirty (30) days after its receipt thereof, file with the Master Trustee a copy of each report which any provision of the Master Indenture requires to be prepared by a Consultant or an Insurance Consultant.

(e) Within thirty (30) days after the beginning of each Fiscal Year, file with the Master Trustee an Opinion of Counsel which shall state whether there are required to be filed in any office, within the period of twelve (12) full consecutive calendar months following the date of such Opinion of Counsel, financing statements, including continuation statements, in order to continue the perfection of the security interests granted under the Master Indenture.

Parties Becoming Members of the Obligated Group

Persons which are not Members of the Obligated Group may, with the written prior consent of the current Members of the Obligated Group, become Members of the Obligated Group, if:

(a) The Person which is becoming a Member of the Obligated Group shall execute and deliver to the Master Trustee an appropriate instrument, satisfactory to the Master Trustee containing the agreement of such Person (i) to become a Member of the Obligated Group under the Master Indenture and thereby become subject to compliance with all provisions of the Master Indenture pertaining to a Member of the Obligated Group, including the pledge and security interest provided for in the Master Indenture, the filing or recordation of all financing statements and continuation statements in such places as are required by law and the performance and observance of all covenants and obligations of a Member of the Obligated Group under the Master Indenture, and (ii) to guarantee, unconditionally and irrevocably, to the Master Trustee and each other Member of the Obligated Group that all Obligations issued and then Outstanding or to be issued and Outstanding under the Master Indenture will be paid in accordance with the terms of such Obligations and of the Master Indenture when due.

(b) Each instrument executed and delivered to the Master Trustee in accordance with the provisions of the Master Indenture described in paragraph (a) above 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 Person and constitutes a valid and binding obligation enforceable in accordance with its terms, except as enforceability may be limited by bankruptcy laws, insolvency laws, other laws affecting creditors' rights generally, equity principles and laws dealing with fraudulent conveyances.

(c) There is filed with the Master Trustee an Officer's Certificate demonstrating that, immediately following the admission of such Person as a Member of the Obligated Group, the Obligated Group could meet the conditions of the Master Indenture described above in subparagraphs (a)(i), (ii), (iii) or (iv) under the subcaption entitled "Limitations on Indebtedness" for the incurrence of one additional dollar of Long-Term Indebtedness.

(d) If all amounts due or to become due on any Related Bond have not been paid to the holders thereof, there shall be filed with the Master Trustee an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that the consummation of such transaction would not adversely affect the exclusion from gross income for purposes of federal income taxation of the interest on any such Related Bond.

(e) If such Person is not a non-profit corporation, the Obligated Group Representative shall have delivered to the Master Trustee an Opinion of Counsel to the effect that the addition of such Person to the Obligated Group will not necessitate the registration of any Obligations under the Securities Act of 1933, as amended, or cause the qualification of the Master Indenture or any Supplement under the Trust Indenture Act of 1939, as amended, to be required, or, if such registration or qualification is required, that all applicable registration and qualification provisions of said acts have been complied with.

Withdrawal from the Obligated Group

(a) No Member of the Obligated Group may withdraw from the Obligated Group unless, prior to the taking of such action, there is delivered to the Master Trustee:

(i) (A) An Officer's Certificate demonstrating that (I) all Obligations issued by such Member are no longer Outstanding or (II) an amount of cash or Defeasance Obligations sufficient to accomplish the requirement of clause (i)(A)(I) above has been paid by such Member to the Master Trustee or all Outstanding Obligations issued by such Member have been assumed by another Member of the Obligated Group, and (B), in either case, if all amounts due on any

Related Bond which bears interest which is not includable in the gross income of the recipient thereof under the Code 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 such Member's withdrawal from the Obligated Group, whether or not contemplated on any date of delivery of any Related Bond, would not cause the interest payable on such Related Bond to become includable in the gross income of the recipient thereof under the Code; and

(ii) An Officer's Certificate certifying that, immediately following the withdrawal of such Member of the Obligated Group, the Obligated Group could meet the conditions of the Master Indenture described above in subparagraphs (a)(i), (ii), (iii) or (iv) under the subcaption entitled "Limitations on Indebtedness" for the incurrence of one additional dollar of Long-Term Indebtedness.

(b) Upon the withdrawal of any Member from the Obligated Group, any guaranty by such Member pursuant to the provisions of the Master Indenture described above under the subcaption entitled "Parties Becoming Members of the Obligated Group" will be released and discharged in full and all liability of such Member of the Obligated Group with respect to all Obligations Outstanding under the Master Indenture shall cease.

Replacement Master Indenture

The Corporation, acting in its capacity as Obligated Group Representative, has covenanted in Supplement No. 21 that, so long as any Series 2016A Bonds are Outstanding, the Obligated Group will make no substitution of the Master Indenture without the consent of a majority of the Holders of the then Outstanding Series 2016A Bonds.

Each Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds will surrender such Obligation to the Master Trustee and each Related Bond Trustee for Related Bonds will, with the prior written consent of the bond insurer or credit facility provider, if any, for such Related Bonds and with the consent of a majority of the Series 2016A Holders (so long as the Series 2016A Bonds are Outstanding), surrender any Obligation issued to secure such Related Bonds to the Master Trustee, upon presentation to the Holder or the Related Bond Trustee, as the case may be, of the following:

(a) an original replacement note or similar obligation (the "Substitute Obligation") duly authenticated and issued under and pursuant to an existing or new master trust indenture, trust agreement, bond order, bond resolution or similar instrument (the "Replacement Master Indenture") by which the party or parties purported to be obligated thereby (the "New Group") have agreed to be bound; provided, however, that:

(i) the trustee serving as master trustee under such Replacement Master Indenture (the "New Trustee") shall be an independent corporate trustee (which may be the Master Trustee or the Related Bond Trustee) meeting the eligibility requirements of the Master Trustee as set forth in the Master Indenture; and

(ii) for so long as any Related Bonds issued by the Agency are outstanding, the Replacement Master Indenture shall have been approved by the Agency, unless the Replacement Master Indenture is an existing master trust indenture, trust agreement, bond order, bond resolution or similar instrument by which any member of the New Group is already bound and the issuance of

bonds secured thereby has already been authorized or approved by the Agency, in which case the consent of the Agency will not be required;

(b) an original counterpart or certified copy of the Replacement Master Indenture pursuant to which each member of the New Group has agreed (i) to become a member of the New Group and thereby to become subject to compliance with all provisions of the Replacement Master Indenture and (ii) unconditionally and irrevocably (subject to the right of such Person to cease its status as a member of the New Group pursuant to the terms and conditions of the Replacement Master Indenture) to jointly and severally make payments upon each note and obligation, including the Substitute Obligation, issued under the Replacement Master Indenture at the times and in the amounts provided in each such note or obligation;

(c) an Opinion of Counsel addressed to the Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds or to the Related Bond Trustee, as the case may be, and the Obligated Group Representative to the effect that: (1) the Replacement Master Indenture has been duly authorized, executed and delivered or has been duly adopted, as the case may be, by each member of the New Group, the Substitute Obligation has been duly authorized, executed and delivered by the Obligated Group, and the Replacement Master Indenture and the Substitute Obligation are each a legal, valid and binding obligation of each member of the New Group, enforceable in accordance with their terms, subject in each case to customary exceptions for bankruptcy, insolvency, fraudulent conveyance and other laws generally affecting enforcement of creditors' rights and application of general principles of equity; (2) all requirements and conditions to the issuance of the Substitute Obligation set forth in the Replacement Master Indenture have been complied with and satisfied; and (3) the registration of the Substitute Obligation under the Securities Act of 1933, as amended, and the qualification of the Replacement Master Indenture 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;

(d) an Officer's Certificate certifying that (i) the New Group could, after giving effect to the Substitute Obligation, meet the conditions of the Master Indenture for the incurrence of one dollar of additional Long-Term Indebtedness as described above in paragraph (a) under the subcaption entitled "Limitations on Indebtedness", as demonstrated in such certificate, and (ii) the New Group would not be in default under the provisions of the Master Indenture described above under the subcaption entitled "Limitation on Creation of Liens";

(e) an Opinion of Bond Counsel that the surrender of the Obligation and the acceptance by the Bond Trustee of the Substitute Obligation will not adversely affect the validity of any Related Bonds or any exemption for the purposes of federal or state income taxation to which interest on any Related Bonds would otherwise be entitled;

(f) evidence that (i) written notice of such substitution, together with a copy of such Replacement Master Indenture, has been given by the New Group to each rating agency then maintaining a rating on any Obligation or Related Bonds and (ii) the then current rating category on each such Obligation or Related Bonds will not be withdrawn or reduced (without regard to any rating refinement or gradation by numerical modifier or otherwise) by any such rating agency as a result of such substitution;

(g) evidence that written notice of such substitution and rating confirmation, together with a copy of such Replacement Master Indenture, has been given by the New Group to each Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds or to the Related Bond Trustee under

each Related Bond Indenture, as the case may be, not less than forty-five (45) days prior to the execution and delivery of the Replacement Master Indenture; and

(h) such forecasts and other opinions and certificates as the Agency may require and such other opinions and certificates as the Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds or the Related Bond Trustee, as the case may be, the Master Trustee or the bond insurer or credit facility provider, if any, may reasonably require, together with such reasonable indemnities as the Holder of an Obligation evidencing and securing Indebtedness other than Related Bonds or the Related Bond Trustee, as the case may be, the Master Trustee, the Agency or the bond insurer or credit facility provider, if any, may request.

Notwithstanding such provisions of the Master Indenture, no Substitute Obligation may extend the stated maturity of or time for paying interest on any Obligation surrendered to the Master Trustee or reduce the principal amount of or the redemption premium or rate of interest payable on such Obligation without the consent of each Holder of such Obligation evidencing and securing Indebtedness other than Related Bonds or the registered owners of all Related Bonds then outstanding, as the case may be.

Defaults and Remedies

Events of Default

An Event of Default under the Master Indenture is any of the following events: (a) the failure by the Members of the Obligated Group to make any payment of the principal of, the premium, if any, or interest on any Obligations issued and Outstanding under the Master Indenture when due and payable, whether at maturity, by proceedings for redemption, by acceleration or otherwise in accordance with the terms of such Obligations, of the Master Indenture or of any Supplement; (b) the failure by any Member of the Obligated Group to perform, observe or comply with any covenant or agreement under the Master Indenture and such failure continues for a period of thirty (30) days after written notice of such failure, requiring the same to be remedied, shall have been given to the Members of the Obligated Group by the Master Trustee or to the Members of the Obligated Group and the Master Trustee by the Holders of at least twenty-five percent (25%) in aggregate principal amount of Obligations then Outstanding; provided, however, that if said failure is such that it cannot be corrected within such 30-day period but can reasonably be expected to be fully remedied, no Event of Default shall exist if corrective action is instituted within such 30-day period and diligently pursued until the event of default is corrected; (c) an Event of Default under a Related Bond Indenture or upon a Related Bond occurs and continues beyond any applicable cure period provided for therein; (d) failure by any Member of the Obligated Group to make any required payment of any Indebtedness except Non-Recourse Indebtedness (other than Obligations issued and Outstanding under the Master Indenture), whether such Indebtedness now exists or shall hereafter be created, and any applicable grace period 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, which event of default shall not have been waived by the holder of such mortgage, indenture or instrument, and as a result of such failure to pay or other event of default such Indebtedness shall have been accelerated; provided, however, that such default shall not constitute an Event of Default under the Master Indenture for so long as such payment shall be contested in good faith if within thirty (30) days written notice is delivered to the Master Trustee, signed by the Obligated Group Representative, that such Member of the Obligated Group is contesting the payment of such Indebtedness and the amount of such Indebtedness is less than one-half of one percent (0.5%) of Income Available for Debt Service for the immediately preceding Fiscal Year, or if such Indebtedness is equal to or greater than one-half one

percent (0.5%) of Income Available for Debt Service of the immediately preceding Fiscal Year, within the time allowed for service of a responsive pleading if a proceeding to enforce payment of the Indebtedness is commenced, any Member of the Obligated Group in good faith shall commence proceedings to contest the obligation to pay or alleges the nonexistence or payment of such Indebtedness; (e) the entry of a decree or order by a court having jurisdiction in the premises for an order for relief against any Member of the Obligated Group, or approving as properly filed a petition seeking reorganization, arrangement, adjustment or composition of or in respect of such Member under the United States Bankruptcy Code or any other applicable federal or state law, or appointing a receiver, liquidator, custodian, assignee, or sequestrator (or other similar official) of such Member 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; and (f) the institution by any Member of the Obligated Group of proceedings for an order for relief, or the consent by it to an order for relief against it, or the filing by it of a petition or answer or consent seeking reorganization, arrangement, adjustment, composition or relief under the United States 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, custodian, assignee, trustee or sequestrator (or other similar official) of such Member of the Obligated Group 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.

Acceleration; Annulment of Acceleration

Upon the occurrence and during the continuation of any Event of Default under the Master Indenture, the Master Trustee may and, upon the written request of (i) the Holders of not less than twenty-five percent (25%) in aggregate principal amount of Obligations Outstanding or (ii) any Person properly exercising the right given to such Person under any Supplement to require acceleration of the Obligations issued pursuant to such Supplement, shall, by notice to the Members of the Obligated Group, declare all Obligations Outstanding immediately due and payable, whereupon such Obligations shall become and be immediately due and payable, anything in the Obligations or in the Master Indenture to the contrary notwithstanding; provided, however, that if the terms of any Supplement give a Person the right to consent to acceleration of the Obligations issued pursuant to said Supplement, the Obligations issued pursuant to such Supplement may not be accelerated by the Master Trustee unless such consent is properly obtained pursuant to the terms of such Supplement. In the event Obligations are accelerated, there will be due and payable on such Obligations an amount equal to the total principal amount of all such Obligations, plus all interest accrued thereon to the date of acceleration and, to the extent permitted by applicable law, which accrues to the date of payment all interest which accrues thereon from the date of acceleration to the date of payment.

If, at any time after the principal of the Obligations has been so declared due and payable and before the entry of final judgment or decree in any suit, action or proceeding instituted on account of such default, (i) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee money or Defeasance Obligations 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 Obligations Outstanding; (ii) the Obligated Group has paid or caused to be paid or deposited with the Master Trustee money sufficient to pay the charges, compensation, expenses, disbursements, advances, fees and liabilities of the Master Trustee; (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 Obligations then due only because of

such declaration) shall have been remedied, then the Master Trustee may, and upon the written request of Holders of not less than twenty-five percent (25%) in aggregate principal amount of the Obligations Outstanding shall, annul such declaration and its consequences with respect to any 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 twenty-five percent (25%) in aggregate principal amount of the Obligations Outstanding, together with indemnification of the Master Trustee to its satisfaction, shall, proceed forthwith to protect and enforce its rights and the rights of the Holders by such suits, actions or proceedings as the Master Trustee, being advised by counsel, shall deem expedient.

Regardless of the happening of an Event of Default, the Master Trustee, if requested in writing by the Holders of not less than twenty-five percent (25%) in aggregate principal amount of the Obligations then Outstanding, shall, when indemnified to its satisfaction, institute and maintain such suits and proceedings necessary or expedient to prevent any impairment of the security under the Master Indenture by any acts which may be unlawful or in violation of the Master Indenture, or to preserve or protect the interests of the Holders, provided that such request and action are not in conflict with any applicable law or the Master Indenture and, in the Master Trustee's sole judgment, are not unduly prejudicial to the interest of the Holders not making such request.

Application of Gross Receipts and Other Moneys After Default

During the continuance of an Event of Default all Gross Receipts and other moneys received by the Master Trustee, after payment of (i) 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 and (ii) in the sole discretion of the Master Trustee, the payment of the expenses of operating any Member of the Obligated Group, shall be applied as follows:

(a) Unless the principal of all Outstanding 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 Obligations in the order of the maturity of such installments, and, if the amount available shall not be sufficient to pay in full all installments maturing on the same date, then to the payment thereof ratably, according to the amounts due, without discrimination or preference; and Second: to the payment to the Persons entitled thereto of the unpaid principal installments of any Obligations then due, whether at maturity or by call for redemption, in the order of their due dates, and if amounts available shall not be sufficient to pay in full all Obligations due on any date, then to the payment thereof ratably, according to the amounts of principal installments due on such date, without any discrimination or preference.

(b) If the principal of all Outstanding Obligations shall have become or have been declared due and payable, to the payment of the principal and interest then due and unpaid upon 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 Obligation over any other Obligation, ratably, according to the amounts due respectively for principal and interest, without any discrimination or preference.

(c) If the principal of all Outstanding Obligations shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled under the provisions of the Master Indenture, then, subject to the provisions of clause (b) above in the event that the principal of all Outstanding Obligations shall later become due or be declared due and payable, the moneys shall be applied in accordance with the provisions of clause (a) above.

Moneys to be applied by the Master Trustee during a continuance of an Event of Default shall be applied as the Master Trustee shall determine, having due regard for the amount available and the likelihood of additional moneys becoming available in the future. Whenever the Master Trustee applies 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 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 Obligation until such Obligation is presented to the Master Trustee for appropriate endorsement of any partial payment or for cancellation if fully paid.

Holders' Control of Proceedings

If an Event of Default shall have occurred and be continuing, the Holders of not less than a majority in aggregate principal amount of Obligations then Outstanding shall have the right, subject to the terms of the Master Indenture, to direct the method and place of conducting any enforcement proceedings.

Waiver of Event of Default

No delay or omission of the Master Trustee or of any Holder to exercise any right or power accruing upon any Event of Default shall impair any such right or power or shall be construed to be a waiver of any such Event of Default or an acquiescence therein. Every power and remedy given to the Master Trustee and the Holders, respectively, may be exercised from time to time and as often as may be deemed expedient by them. The Master Trustee may waive any Event of Default which in its opinion shall have been remedied before the entry of final judgment or decree in any suit, action or proceeding instituted by it under the provisions of the Master Indenture or before the completion of the enforcement of any other remedy under the Master Indenture. The Master Trustee, upon the written request of the Holders of not less than a majority in aggregate principal amount of Obligations then Outstanding, shall waive any Event of Default under the Master Indenture and its consequences, except payment defaults which have not been cured, which may be waived only by written consent of the Holders of all the Obligations (with respect to which such payment default exists) then Outstanding. In case of a waiver by the Master Trustee of an Event of Default under the Master Indenture, all parties shall be restored to their former positions and rights under the Master Indenture, respectively, but no such waiver shall extend to any subsequent or other Event of Default or impair any right consequent thereon.

Appointment of Receiver

Upon the occurrence of any Event of Default, the Master Trustee shall be entitled to the appointment of a receiver or receivers of the Property of the Obligated Group with such powers as the court shall confer.

Notice of Default

The Master Trustee shall, within ten (10) days after it has knowledge of the occurrence of an Event of Default, mail to all Holders as the names and addresses of such Holders appear upon the books of the Master Trustee, notice of such Event of Default known to the Master Trustee, unless such Event of Default shall have been cured or properly waived before the giving of such notice; provided that, except in the case of default in the payment of the principal of or premium, if any, or interest on any of the Obligations and the Events of Default specified above in clauses (e) and (f) under the caption entitled "Defaults and Remedies - Events of Default", the Master Trustee shall be protected in withholding such notice if and so long as the board of directors, the executive committee, or a trust committee of directors or a responsible officer of the Master Trustee in good faith determines that the withholding of such notice is in the interests of the Holders.

Supplements and Amendments

Supplements Not Requiring Consent of Holders

The Master Indenture may be supplemented or amended without the consent of or notice to any of the Holders for one or more of the following purposes: to cure an ambiguity or formal defect or omission therein; to correct or supplement any provision which may be inconsistent with any other provision, or to make any other provisions with respect to matters or questions arising under the Master Indenture and which shall not materially and adversely affect the interests of the Holders; to grant or confer ratably upon all Holders any additional rights, remedies, powers or authority that may lawfully be granted or conferred upon them; 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; to create and provide for the issuance of Indebtedness as permitted under the Master Indenture; to obligate a successor to any Member of the Obligated Group; and to comply with any state or federal securities law.

Supplements Requiring Consent of Holders

Other than supplements referred to under the preceding subcaption, the Holders of not less than 51% in aggregate principal amount of the Obligations then Outstanding shall have the right to approve the execution of Supplements modifying, altering, amending, adding to or rescinding, in any particular, the Master Indenture except a Supplement which would:

(i) Effect a change in the times, amounts or currency of payment of the principal of, premium, if any, and interest on any Obligation or a reduction in the principal amount or redemption price of any Obligation or the rate of interest thereon, without the consent of the Holder of such Obligation;

(ii) Permit the preference or priority of any Obligation over any other Obligation, without the consent of the Holders of all Obligations then Outstanding; or

(iii) Reduce the aggregate principal amount of Obligations then Outstanding the consent of the Holders of which is required to authorize such Supplement without the consent of the Holders of all Obligations then Outstanding.

All Supplements executed pursuant to the Master Indenture will be binding on all Holders of Obligations.

Satisfaction and Discharge of Master Indenture

If (i) the Obligated Group Representative shall deliver to the Master Trustee for cancellation all Obligations theretofore authenticated and not theretofore cancelled, or (ii) all Obligations not theretofore cancelled or delivered to the Master Trustee for cancellation shall have become due and payable and money sufficient to pay the same shall have been deposited with the Master Trustee, or (iii) all Obligations that have not become due and payable and have not been cancelled or delivered to the Master Trustee for cancellation shall be Defeased Obligations, and if in all cases the Members of the Obligated Group shall also pay or cause to be paid all other sums payable 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.

Evidence of Acts of Holders

In the event that any request, direction or consent is requested or permitted under the Master Indenture of the Holders, the registered owners of Related Bonds then outstanding shall be deemed to be such Holders for the purpose of any such request, direction or consent in the proportion that the aggregate principal amount of Related Bonds then outstanding held by each such owner of Related Bonds bears to the aggregate principal amount of all Related Bonds then outstanding.

Removal of the Master Trustee

The Master Trustee may resign on its own motion or may be removed at any time by a written instrument signed by the Holders of not less than a majority of the principal amount of Obligations then Outstanding, or so long as no Event of Default has occurred and is continuing, by an instrument in writing signed by the Obligated Group Representative.

SUMMARY OF THE TRUST AGREEMENT

The following is a summary of certain provisions of the Trust Agreement.

Various Funds and Accounts Created by the Trust Agreement

The Trust Agreement creates the following funds:

1. the Issuance Fund,

2. the Bond Fund, and

3. the Redemption Fund.

The Trust Agreement also creates two separate accounts in the Bond Fund, which accounts are designated the "Interest Account" and the "Principal Account."

The money in each of the aforementioned funds and accounts will be held in trust and will be subject to a lien and charge in favor of the Holders of the Bonds and for the further security of such Holders until paid out or transferred as provided in the Trust Agreement.

Issuance Fund

All issuance costs, within the meaning of Section 147(g) of the Code, incurred in connection with the Bonds to be paid from the initial proceeds of the Bonds will be paid only from the Issuance Fund (collectively, "Issuance Costs"). All money received by the Agency from any source for Issuance Costs will be deposited immediately upon its receipt to the credit of the Issuance Fund.

Deposits to the Bond Fund

The Bond Trustee will deposit all amounts received as Loan Repayments and Required Payments under the Loan Agreement in the following order, subject to the credits provided in the Trust Agreement:

(i) into the Interest Account, on May 25, 2016, and on the 25th day of each May and November thereafter, the entire amount of interest payable on the Bonds on the next ensuing Interest Payment Date; and

(ii) into the Principal Account, on November 25, 2016, and on each November 25 thereafter, the entire amount of principal of all Serial Bonds due on the next ensuing December 1.

If, after giving effect to the credits specified below, any installment of Total Required Payments is insufficient to enable the Bond Trustee to make the deposits required above, the Bond Trustee will notify the Corporation and request it increase each future installment of the Total Required Payments to make up any previous deficiency in any of the required payments and to make up any deficiency or loss in any of the above-mentioned accounts and funds.

To the extent that investment earnings are credited to the Interest Account or the Principal Account in accordance with the Trust Agreement, or amounts are credited thereto as a result of the application of Bond proceeds or a transfer of investment earnings on any other fund or account held by the Bond Trustee, or otherwise, future deposits to such accounts will be reduced by the amount so credited, and the Loan Repayments due following the date of the credit will be reduced by the amounts so credited.

All amounts received by the Bond Trustee as principal of or interest accruing on the Bonds to be redeemed as a result of a prepayment of Obligation No. 21 will be deposited in the Redemption Fund and the Interest Account, respectively, when received. All amounts received by the Bond Trustee as redemption premiums will be deposited in the Redemption Fund when received.

Bond Fund Accounts

If the Bonds are not in a Book-Entry System, not later than 1:00 p.m. on each Interest Payment Date, or date for the payment of Defaulted Interest, or date upon which Bonds are to be redeemed, the Bond Trustee will withdraw from the Interest Account and remit by mail, or, to the extent permitted by the Trust Agreement, by wire transfer, to each Holder which is not a Securities Depository Nominee the amount required for paying interest on such Bonds when due and payable.

If the Bonds are in a Book-Entry System, at such time as to enable the Bond Trustee to make payments of interest on the Bonds in accordance with any existing agreement between the Bond Trustee and any Securities Depository, the Bond Trustee will withdraw from the Interest Account and remit by wire transfer, in Federal Reserve or other immediately available funds, the amounts required to pay to any Holder which is a Securities Depository Nominee interest on the Bonds on the next ensuing Interest

Payment Date or date for the payment of Defaulted Interest or date upon which Bonds are to be redeemed; provided, however, that in no event will the Bond Trustee be required to make such wire transfer prior to the Business Day next preceding each Interest Payment Date or date for the payment of Defaulted Interest or date upon which Bonds are to be redeemed, and provided further that such wire transfer will be made not later than 1:00 p.m. on each Interest Payment Date or date for the payment of Defaulted Interest or date upon which Bonds are to be redeemed.

In the event the balance in the Interest Account on the second Business Day next preceding an Interest Payment Date or date on which Bonds are to be redeemed, is insufficient for the payment of interest becoming due on the Bonds on the next ensuing Interest Payment Date or date upon which Bonds are to be redeemed, the Bond Trustee shall notify the Corporation of the amount of the deficiency. Upon notification, the Corporation shall immediately deliver to the Bond Trustee an amount sufficient to cure the same.

If the Bonds are not in a Book-Entry System, not later than 1:00 p.m. on each December 1, the Bond Trustee shall withdraw from the Principal Account and remit by mail, or, to the extent permitted by the Trust Agreement, by wire transfer, to each Holder which is not a Securities Depository Nominee the amount required for paying the principal of all Bonds maturing on such December 1.

If the Bonds are in a Book-Entry System, at such time as to enable the Bond Trustee to make payment of the principal of all Bonds maturing on such December 1 in accordance with any existing agreement between the Bond Trustee and any Securities Depository, the Bond Trustee shall withdraw from the Principal Account and remit by wire transfer, in Federal Reserve or other immediately available funds, the amounts required to pay to any Holder which is a Securities Depository Nominee the principal of all Bonds maturing on such December 1; provided, however, that in no event shall the Bond Trustee be required to make such wire transfer prior to the Business Day next preceding each such December 1, and provided further that such wire transfer shall be made not later than 1:00 p.m. on each such December 1.

In the event that the balance in the Principal Account on the second Business Day next preceding December 1 is insufficient for the payment of principal of all Bonds becoming due on such December 1, the Bond Trustee shall notify the Hospital of the amount of the deficiency. Upon notification, the Hospital shall immediately deliver to the Bond Trustee an amount sufficient to cure the same.

Redemption Fund

Money or Available Moneys held for the credit of the Redemption Fund will be applied to the purchase or redemption of Bonds as provided in the Trust Agreement. The expenses in connection with the purchase or redemption of Bonds are required to be paid by the Corporation as part of the Required Payments under the Loan Agreement.

Investment of Money

Money held for the credit of all funds and accounts will be continuously invested and reinvested by the Bond Trustee in Investment Obligations. Any such Investment Obligations shall mature not later than the respective dates when the money held for the credit of such funds or accounts will be required for the purposes intended

No Investment Obligations in any fund or account may mature beyond the latest maturity date of any Bonds Outstanding at the time such Investment Obligations are deposited.

Investment Obligations acquired with money and credited to any fund or account established under the Trust Agreement will be held by or under the control of the Bond Trustee and will be deemed at all times to be part of such fund or account in which such money was originally held, and the interest accruing thereon and any profit or loss realized upon the disposition or maturity of such investment shall be credited to or charged against such fund or account. The Bond Trustee will sell at the best price obtainable or reduce to cash a sufficient amount of such Investment Obligations whenever it is necessary to provide money to make any payment or transfer of money from any such fund or account. The Bond Trustee will not be liable or responsible for any loss resulting from any such investment.

Valuation

For the purpose of determining the amount on deposit in any fund or account, Investment Obligations in which money in such fund or account is invested will be valued (a) at face value if such Investment Obligations mature within six months from the date of valuation thereof, and (b) if such Investment Obligations mature more than six months after the date of valuation thereof, at the price at which such Investment Obligations are redeemable by the holder at his option if so redeemable, or, if not so redeemable, at the lesser of (i) the cost of such Investment Obligations minus the amortization of any premium or plus the amortization of any discount thereon and (ii) the market value of such Investment Obligations.

The Bond Trustee will value the Investment Obligations in the funds and accounts established under the Trust Agreement two Business Days prior to each Interest Payment Date. In addition, the Investment Obligations will be valued by the Bond Trustee at any time requested by the Agency Representative on reasonable notice to the Bond Trustee (which period of notice may be waived or reduced by the Bond Trustee), except that the Bond Trustee will not be required to value the Investment Obligations more than once in any calendar month.

Events of Default

Each of the following events is an Event of Default:

(a) payment of any installment of interest on any Bond shall not be made when the same shall become due and payable; or

(b) payment of the principal or the redemption premium, if any, of any Bond shall not be made when the same shall become due and payable, whether at maturity or by proceedings for redemption or otherwise; or

(c) default in the due and punctual performance of any other of the covenants, conditions, agreements and provisions contained in the Trust Agreement or any agreement supplemental thereto and such default shall continue for thirty (30) days or such further time as may be granted in writing by the Bond Trustee after receipt by the Corporation or the Agency , as the case may be, of a written notice from the Bond Trustee specifying such default and requiring the same to be remedied; or

(d) an "Event of Default" shall have occurred under the Loan Agreement, and such "Event of Default" shall not have been remedied or waived.

Remedies on Default

Upon the happening and continuance of any Event of Default under the Trust Agreement, the Bond Trustee may, and shall upon the written request of the Holders of not less than twenty-five percent (25%) in aggregate principal amount of Bonds then Outstanding, by notice in writing to the Agency and the Corporation, declare the principal of all Bonds then Outstanding (if not then due and payable) to be due and payable immediately, and upon such declaration the same shall become and be immediately due and payable, anything contained in the Bonds or in the Trust Agreement to the contrary notwithstanding; provided, however, that if at any time after the principal of Bonds 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, or before the completion of the enforcement of any other remedy under the Trust Agreement, money shall have accumulated in the Bond Fund sufficient to pay the principal of all matured Bonds and all arrears of interest, if any, upon all Bonds then Outstanding (except the principal of any Bonds not then due and payable by their terms and the interest accrued on such since the last interest payment date), and the charges, compensations, expenses, disbursements, advances and liabilities of the Bond Trustee and all other amounts then payable by the Agency under the Trust Agreement shall have been paid or a sum sufficient to pay the same shall have been deposited with the Bond Trustee or whenever applicable, and every other default known to the Bond Trustee in the observance or performance of any covenant, condition or agreement contained in the Bonds or in the Trust Agreement (other than a default in the payments of the principal of such Bonds then due only because of a declaration under the Trust Agreement) shall have been remedied to the satisfaction of the Bond Trustee, then and in every such case, the Bond Trustee may, and upon the written request of the Holders of not less than twenty-five percent (25%) in aggregate principal amount of Bonds not then due and payable by their terms (Bonds then due and payable only because of a declaration under the Trust Agreement shall not be deemed to be due and payable by their terms) and then Outstanding, shall, by written notice to the Agency and the Corporation, rescind and annul such declaration and its consequences, but no such rescission or annulment shall extend to or affect any subsequent Event of Default or impair any right consequent thereon.

Upon the happening and continuance of any Event of Default under the Trust Agreement, then and in every such case the Bond Trustee may, and upon the written request of the Holders of not less than twenty-five percent (25%) in aggregate principal amount of Bonds then Outstanding, shall, proceed, subject to the indemnification provisions of the Trust Agreement, to protect and enforce its rights and the rights of the Holders under the laws of the State or under the Trust Agreement by such suits, actions or special proceedings in equity or at law, or by proceedings in the office of any board or officer having jurisdiction, either for the specific performance of any covenant or agreement contained in the Trust Agreement or in aid or execution of any power therein granted or for the enforcement of any proper legal or equitable remedy, as the Bond Trustee, being advised by counsel chosen by the Bond Trustee, shall deem most effectual to protect and enforce such rights.

No Holder may institute any suit, action or proceeding in equity or at law on any Bonds for any remedy under the Trust Agreement unless he previously has given to the Bond Trustee written notice of the Event of Default under the Trust Agreement on account of which suit, action or proceeding is to be instituted, and unless the Holders of not less than twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding have requested in writing the Bond Trustee to act and have furnished the Bond Trustee reasonable security and indemnity as required in the Trust Agreement and the Bond Trustee has refused or neglected to comply with such request within a reasonable time; except that the Holders of not less than 25% in aggregate principal amount of the Bonds then Outstanding may institute any such suit, action or proceeding in their own names for the benefit of all Holders. Except as

provided in the Trust Agreement, no Holder will have any right in any manner whatever to enforce any right thereunder, and any individual rights given to such Holders by law are restricted by the Trust Agreement to the rights and remedies therein granted.

Notice to Bondholders

The Bond Trustee will, upon notice of an Event of Default, immediately notify the Agency and the Corporation of such Event of Default. The Bond Trustee will mail to all Holders at their addresses as they appear on the registration books written notice of the occurrence of any Event of Default under the Trust Agreement, within ten (10) days after the Bond Trustee has notice of the same, that any such Event of Default has occurred; provided that, except upon the happening of an Event of Default with respect to the payment of the principal of and interest on or redemption premium on Bonds when due, the Bond Trustee may withhold such notice from the Holders if in its opinion such withholding is in the interest of the Holders; and provided further that the Bond Trustee will not be subject to any liability to any Holder by reason of its failure to mail any such notice.

Payment of Bond Trustee's and Bond Registrar's Fees

If the Agency fails to cause required payments to be made to the Bond Trustee or the Bond Registrar for compensation and expenses, the Bond Trustee or the Bond Registrar may make such payment from any money in its possession and will be entitled to a preference therefor over any Bonds Outstanding.

Holders of Obligation No. 21

In the event that any request, direction or consent is requested or permitted by the Master Indenture of the registered owners of Obligations issued thereunder, including Obligation No. 21, the Holders of Bonds then Outstanding, acting by and through the Bond Trustee, shall be deemed to be registered owners of Obligation No. 21 for the purpose of any such request, direction or consent in the proportion that the aggregate principal amount of Bonds then Outstanding held by each such Holder of Bonds bears to the aggregate principal amount of all Bonds then Outstanding.

Modification of the Trust Agreement

The Agency and the Bond Trustee may from time to time execute such supplemental trust agreements as shall be consistent with the terms and provisions of the Trust Agreement and the Loan Agreement and, in the opinion of the Bond Trustee, who may rely conclusively on a written Opinion of Counsel, will not materially and adversely affect the Holders: to cure any ambiguity or formal defect or omission, to correct or supplement any inconsistent provision, or to make any other provisions with respect to matters or questions arising under the Trust Agreement; 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; to add other conditions, limitations and restrictions thereafter to be observed; to add other covenants and agreements to be observed by the Agency or to surrender any right or power reserved to or conferred upon the Agency; to comply with any federal or state securities law; or to provide for the issuance of Bonds in bearer form; to provide for the maintenance of Bonds under a book-entry system.

The Trust Agreement may be amended in any particular, with the consent of the Holders of not less than a majority in aggregate principal amount of the Bonds Outstanding; provided, that nothing

contained in the Trust Agreement will permit (a) any extension of the maturity of principal or interest of any Bonds without the consent of the Holders of such Bonds, (b) a reduction in the principal amount of or the redemption premium or the rate of interest on any Bonds without the consent of the Holders of such Bonds, (c) the creation of a pledge of receipts and revenues to be received by the Agency under the Loan Agreement superior to the pledge created under the Trust Agreement without the consent of the Holders of all Bonds Outstanding, (d) a preference or priority or any Bonds over any other Bonds without the consent of the Holders of all Bonds Outstanding, or (e) a reduction in the aggregate principal amount of Bonds required for consent to such supplemental trust agreement without the consent of the Holders of all Bonds Outstanding.

Defeasance

When (a) the Bonds secured by the Trust agreement shall have become due and payable in accordance with their terms or as provided in the Trust Agreement, and (b) the whole amount of the principal and the interest and premium, if any, so due and payable upon all Bonds shall be paid or if the Trustee or the Bond Registrar shall hold, sufficient money or Defeasance Obligations the principal of and the interest on which, when due and payable, will provide sufficient money to pay the principal of, and the interest and redemption premium, if any, on all Bonds then Outstanding to the maturity date or dates of such Bonds or to the date or dates specified for redemption if Bonds are to be redeemed, irrevocable instructions to call the Bonds for redemption shall have been given by the Agency to the Bond Trustee, and (c) sufficient funds shall also have been provided or provision made for paying all other obligations payable under the Trust Agreement by the Agency, then and in that case the right, title and interest of the Trustee in the funds and accounts mentioned in this Trust Agreement shall thereupon cease, terminate and become void and, on demand of the Agency and upon being furnished with an opinion, in form and substance satisfactory to the Bond Trustee, of counsel approved by the Trustee, to the effect that all conditions precedent to the release of the Trust Agreement have been satisfied, the Bond Trustee shall release the Trust Agreement and shall execute such documents to evidence such release as may be reasonably required by the Agency and the Hospital and shall turn over to the Agency, for the benefit of the Corporation, any surplus in, and all balances remaining in, all funds and accounts, other than money held for the redemption or payment of Bonds. Otherwise, the Trust Agreement shall be, continue and remain in full force and effect; provided, that, in the event Defeasance Obligations shall be deposited with and held by the Bond Trustee or the Bond Registrar as hereinabove provided, (i) in addition to the requirements set forth in the Trust Agreement, the Bond Trustee, within thirty (30) days after such Defeasance Obligations shall have been deposited with it, shall cause a notice signed by the Bond Trustee to be mailed, first class, postage prepaid, to all Holders, setting forth (a) the date or dates, if any, designated for the redemption of the Bonds, (b) a description of the Defeasance Obligations so held by it, and (c) that the Trust Agreement has been released, and (ii) (a) the Bond Trustee shall nevertheless retain such rights, powers and privileges under the Trust Agreement as may be necessary and convenient in respect of the Bonds for the payment of the principal, interest and any premium for which such Defeasance Obligations have been deposited, and (b) the Bond Registrar shall retain such rights, powers and privileges under the Trust Agreement as may be necessary and convenient for the registration of transfer and exchange of Bonds.

Recourse Against the Agency

The members, officers and employees of the Agency are not personally liable for any costs, losses, damages or liabilities caused or incurred by the Agency in connection with the Trust Agreement, or for the payment of any sum or for the performance of any obligation under the Trust Agreement.

SUMMARY OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement.

Loan Repayments; Required Payments Under the Loan Agreement

The Corporation is required to make Total Required Payments under the Loan Agreement when due. Loan Repayments and Required Payments under the Loan Agreement relating to deposits to the Reserve Fund are to be paid, when due and payable, directly to the Bond Trustee or, in the name of the Bond Trustee, to any Depositary for deposit in the Bond Fund or the Redemption Fund. All other Required Payments under the Loan Agreement are to be paid by the Corporation directly, when due and payable, to the persons, firms, governmental agencies and other entities entitled thereto.

The Loan Repayment is due and payable as follows:

(a) to the credit of the Interest Account beginning May 25, 2016, and on each May 25 and November 25 thereafter, the entire amount of the interest payable on the Bonds on the next Interest Payment Date;

(b) to the credit of the Principal Account, beginning November 25, 2016 and on each November 25 thereafter, that amount which is sufficient to pay the principal of all Bonds maturing on the next ensuing December 1; and

(c) any amount that may from time to time be required to enable the Agency to pay redemption premiums as and when Bonds are called for redemption.

Loan Repayments are required to be sufficient in the aggregate to repay the Loan and interest thereon and to pay in full all Bonds when due (whether by maturity, redemption, acceleration or otherwise) together with the total interest and redemption premium, if any, thereon. The Corporation is required to repay the Loan in installments as provided in the Loan Agreement, each installment being deemed a Loan Repayment. The Corporation may prepay all or any part of the Loan as provided in the Loan Agreement.

The Corporation shall also pay, when due and payable, as Required Payments under the Loan Agreement, the following costs and expenses, exclusive of costs and expenses payable from the proceeds of the Bonds:

(i) the fees and other costs payable to the Bond Registrar, the Bond Trustee and the Master Trustee;

(ii) all costs incurred in connection with the purchase or redemption of Bonds to the extent money is not otherwise available therefor;

(iii) the fees and other costs incurred for services of such attorneys, management consultants, insurance advisers, and accountants as are employed to make examinations, provide services, render opinions or prepare reports required under the Loan Agreement, the Master Indenture, or the Trust Agreement; and

(iv) reasonable fees and other costs that the Corporation is obligated to pay, not otherwise paid under the Loan Agreement or the Trust Agreement, incurred by the Agency in connection with its administration and enforcement of, and compliance with, the Loan Agreement or the Trust Agreement, including, but not limited to, the initial administration fee of the Agency, and the annual administration fee presently imposed by the Agency, which the Corporation acknowledges may be increased from time to time, in an annual amount not to exceed 1/10 of 1% of the original aggregate principal amount of the Bonds and is payable on February 1 of each calendar year commencing February 1, 2017, and reasonable attorney's fees.

Absolute Obligation to Make Total Required Payments

The obligation of the Corporation to make the Loan Repayments and to make all other Required Payments under the Loan Agreement and Obligation No. 21 and to perform the other agreements contained in the Loan Agreement is absolute and unconditional and will not be abated, diminished or subject to deduction (whether for taxes or otherwise) regardless of any cause or circumstance whatsoever including, without limitation, any defense, setoff, recoupment or counterclaim that the Corporation may have against the Agency or the Bond Trustee or any other person.

Security for the Loan

As collateral security for repayment of the Loan and the performance by the Corporation of its obligations under the Loan Agreement, the Corporation has executed and delivered to the Agency Obligation No. 21 which the Agency has assigned to the Bond Trustee. Obligation No. 21 is issued under and secured by the Master Indenture and Supplement No. 21. The Master Indenture provides that any Member of the Obligated Group may issue additional indebtedness or enter into Derivative Agreements secured by the security for Obligation No. 21 on a pari passu basis for the purposes, under the terms and conditions and to the extent described in the Master Indenture.

Covenants of the Corporation

The Loan Agreement provides that the Corporation will comply with each covenant, condition and agreement in the Master Indenture and the Loan Agreement. The Loan Agreement also sets forth certain other agreements of the Corporation with respect to: merger, sale and transfer of assets; examination of books and records of the Corporation by the Bond Trustee, and the Agency; furnishing to the Agency, the Bond Trustee and the registered owners of the Bonds, financial statements and certain other information required to be furnished under the Master Indenture to the Master Trustee; the execution and delivery of supplements, amendments and other corrective instruments as may reasonably be required with respect to the performance of the Loan Agreement; and the filing and recording of financing statements and other instruments relating to the rights of the Bond Trustee as against other creditors of, or purchasers for value from, the Agency or the Corporation.

Secondary Market Disclosure

The Corporation covenants for the benefit of the persons who from time to time are the owners of the Bonds for federal income tax purposes (the "beneficial owners"):

(a) (x) to file within 60 days after the end of each quarter of each Fiscal Year, beginning with the Fiscal Year ending on June 30, 2016, with the Electronic Municipal Market Access ("EMMA") system administered by the Municipal Securities Rulemaking Board ("MSRB") and to any Vermont state

information depository, its unaudited quarterly financial statements and (y) to file within 180 days after the end of each Fiscal Year, beginning with the Fiscal Year ending on September 30, 2016, with EMMA core financial information for such Fiscal Year, including (i) the Audited Financial Statements and (ii) the financial and statistical data of the type generally included in the Official Statement for the Bonds, including financial and statistical data under the following headings in Appendix A to the Official Statement for the Bonds to the extent that such data are not included in the Audited Financial Statements referred to in clause (i) above:

(1) "Medical Staff – Medical Staff Profile and – Statistics";

(2) "Service Area Characteristics and Market Position – Market Share and Trends";

(3) "Statement of Operations";

(4) "Utilization Statistics";

(5) "Net Revenue Payer Mix";

(6) "Liquidity Position – Unrestricted Cash and Investments";

(7) "Total Debt to Capitalization"'

(8) "Debt Service Coverage";

(9) "Summary of Swap Agreements";

(10) "Investment Positions";

(11) "Unrestricted Board-Designated Assets – Asset Allocation"; and

(12) "Historical Financial Performance" (including the tables contained therein)

(b) to file in a timely manner, with EMMA (or such successor system administered by the MSRB), notice of any failure of the Hospital to comply with paragraph (A) above and notice of any of the following events with respect to the Bonds:

(i) principal and interest payment delinquencies;

(ii) non-payment related defaults, if material;

(iii) unscheduled draws on debt service reserves reflecting financial difficulties;

(iv) unscheduled draws on credit enhancements reflecting financial difficulties;

(v) substitution of credit or liquidity providers, or their failure to perform;

(vi) 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;

(vii) modifications to rights of security holders, if material;

(viii) bond calls, if material, and tender offers;

(ix) defeasances;

(x) release, substitution, or sale of property securing repayment of the Bonds, if material;

(xi) rating changes;

(xii) bankruptcy, insolvency, receivership or similar event of the Hospital[1];

(xiii) the consummation of a merger, consolidation, or acquisition involving the Borrower or the sale of all or substantially all of the assets of the Borrower, 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

(xiv) the appointment of a successor or additional trustee or the change of name of a trustee, if material.

No beneficial owner may institute any suit, action or proceeding at law or in equity ("Proceeding") for the enforcement of any covenant in paragraph (a) above (the "Disclosure Covenant") or for any remedy for breach thereof, unless such owner shall have filed with the Corporation written notice of and request to cure such breach, and the Corporation shall have refused to comply within a reasonable time; provided, however, that failure to comply with the Disclosure Covenant shall not be an event of default under the Loan Agreement, shall not give rise to a claim for monetary damages in any amount and shall not result in any acceleration of payment of the Bonds. All Proceedings shall be for the equal benefit of all beneficial owners of the outstanding Bonds benefited by the same or a substantially similar covenant, and no remedy shall be sought or granted other than specific performance of the Disclosure Covenant at issue. Notwithstanding the foregoing, no challenge to the adequacy of the information provided in accordance with the filings mentioned in paragraph (a) above may be prosecuted

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

by any beneficial owner except in compliance with the remedial and enforcement provisions of the Loan Agreement.

Any amendment or modification to the Disclosure Covenant may only take effect if:

(1) the amendment or modification is 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 the Corporation;

(2) the information to be provided, as modified, would have complied with the requirements of Rule 15c2-12 issued under the Securities Exchange Act of 1934 ("Rule 15c2-12") as of the date of the Official Statement, after taking into account any amendments or interpretations of Rule 15c2-12, as well as any changes in circumstances; and

(3) any such amendment or modification does not materially impair the interests of the beneficial owners, as determined either by parties unaffiliated with the Corporation (such as the Bond Trustee or bond counsel), or by approving vote of the registered owners of not less than a majority in principal amount of the Bonds then Outstanding pursuant to the terms of the Trust Agreement, as it may be amended from time to time.

In the case of any amendment, the annual financial information containing the amended operating data or financial information shall explain, in narrative form, the reasons for the amendment and the impact of the change in the type of operating data or financial information being provided.

These provisions of the Loan Agreement shall terminate upon payment, or provision having been made for payment in a manner consistent with Rule 15c2-12, in full of the principal of and interest on all of the Bonds.

Defaults and Remedies

Events of Default are defined in the Loan Agreement to include: (a) failure of the Corporation to make any payment under the Loan Agreement (including, but not limited to, Loan Repayments) or Obligation No. 21 when due, whether at maturity, redemption, acceleration or otherwise, (b) failure of the Corporation to perform, observe or comply with any covenant, condition or agreement on its part under the Loan Agreement (other than a failure to make any Loan Repayment or Required Payment under the Loan Agreement), including any covenant, condition or agreement in the Master Indenture applicable to any Member of the Obligated Group and incorporated by reference in the Loan Agreement, and such failure continues for a period of 30 days after the date on which written notice of such failure, requiring the same to be remedied, shall have been given to the Corporation by the Bond Trustee or to the Corporation and the Bond Trustee by the Holders of at least 25% in aggregate principal amount of the Bonds then Outstanding; provided, however, that if such performance, observation or compliance requires work to be done, action to be taken or conditions to be remedied, which by their nature cannot reasonably be done, taken or remedied, as the case may be, within such 30-day period, no Event of Default shall be deemed to have occurred or to exist if, and so long as the Corporation shall commence such performance, observation or compliance within such period and shall diligently and continuously prosecute the same to completion, or (c) an Event of Default described under the caption "SUMMARY OF THE MASTER INDENTURE – Defaults and Remedies -- Events of Default" above shall have occurred and be continuing or the Master Trustee shall have declared the aggregate principal amount of Obligation No. 21

and all interest due thereon immediately due and payable in accordance with the provisions of the Master Indenture described in the first paragraph under the caption "SUMMARY OF THE MASTER INDENTURE – Defaults and Remedies -- Acceleration; Annulment of Acceleration" above.

Whenever any Event of Default under the Loan Agreement shall have happened and be continuing, the Agency may take the following remedial steps: (i) in the case of an Event of Default described in (a) in the preceding paragraph, the Agency may take whatever action at law or in equity is necessary or desirable to collect the payments then due under Obligation No. 21; (ii) in the case of an Event of Default described in (b) in the preceding paragraph, the Agency may take whatever action at law or in equity is necessary or desirable to enforce the performance, observance or compliance by the Corporation with any covenant, condition or agreement by the Corporation under the Loan Agreement; and (iii) in the case of an Event of Default described in (c) in the preceding paragraph, the Agency may take such action, or cease such action, as the Master Trustee directs, but only to the extent such directions are consistent with the provisions of the Master Indenture.

Notwithstanding any other provision of the Loan Agreement or any right, power or remedy existing at law or in equity or by statute, the Agency shall not under any circumstances declare the entire unpaid aggregate amount of the Loan to be immediately due and payable except in accordance with the directions of the Master Trustee in the event that the Master Trustee shall have declared the aggregate principal amount of Obligation No. 21 and all interest due thereon immediately due and payable in accordance with the Master Indenture.

Prepayment of Loan

The Corporation has the option to prepay, together with accrued interest, all or any portion of the unpaid aggregate amount of the Loan in accordance with the terms and provisions of the Trust Agreement. Such prepayment shall be made by the Corporation taking, or causing the Agency to take, the actions required (i) for payment of the Bonds, whether by redemption or purchase prior to maturity or by payment at maturity, or (ii) to effect the purchase, redemption or payment at maturity of less than all of the Bonds according to their terms.

Subject to the provisions of the Master Indenture, the Corporation shall have the option to prepay all or a portion of the unpaid aggregate amount of the Loan, together with accrued interest to the date of prepayment, from amounts received by the Corporation or another Member of the Obligated Group as insurance proceeds with respect to any casualty loss or failure of title or as condemnation awards, provided that such prepayment shall not be less than $100,000, upon the occurrence of the following event:

> Damage to or destruction of all or any part of the Property and Equipment by fire or casualty, or loss of title to or use of all or any part of the Property and Equipment as a result of the failure of title or as a result of Eminent Domain proceedings or proceedings in lieu thereof (if such damage, destruction, loss of title or loss of use causes such Property and Equipment to be impracticable to operate, as evidenced by an Officer's Certificate filed with the Agency and the Bond Trustee).

Subject to the provisions of the Master Indenture, the Loan Agreement shall not be construed to prohibit the Corporation from applying insurance proceeds with respect to any casualty loss or condemnation awards or payments in lieu thereof to the optional prepayment in part of the Loan in accordance with the provisions of the Loan Agreement.

To make a prepayment as described in the preceding paragraphs under this caption, the Hospital Representative must give written notice to the Agency and the Bond Trustee which will specify therein (i) the date of the intended prepayment of the Loan, (ii) the aggregate principal amount of the Bonds to be purchased, redeemed or paid at maturity and the date or dates on which the purchase, redemption or payment is to occur, (iii) the source of the money that will be used by the Corporation to make such prepayment of the Loan and (iv) subject to the requirements of the Trust Agreement the maturities of the Bonds to be called.

The Corporation has the right to revoke any notice of prepayment given pursuant to the Loan Agreement if, on or prior to the tenth (10th) Business Day preceding any date fixed for redemption of Bonds pursuant to the Trust Agreement, the Hospital Representative notifies the Bond Trustee in writing that the Corporation has elected to revoke its election to redeem such Bonds because it has determined that the source of money for such redemption specified in the notice given by the Hospital Representative pursuant to the Loan Agreement is not available.

Amendments to Agreement

The Loan Agreement may, without the consent of or notice to any of the Holders, be amended, from time to time, to:

(a) cure any ambiguity or formal defect or omission in the Loan Agreement or in any supplement thereto;

(b) correct or supplement any provisions in the Loan Agreement which may be inconsistent with any other provisions in the Loan Agreement or make any other provisions with respect to matters which do not materially or adversely affect the interest of the Holders;

(c) 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; or

(d) add conditions, limitations and restrictions on the Corporation to be observed thereafter.

Any other amendments to the Loan Agreement require the consent of the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding.

Exclusion from Gross Income Covenant

The Corporation covenants that it will not take, and will cause each other Member of the Obligated Group not to take, any action which will, or fail to take, or allow any other Member of the Obligated Group to fail to take, any action which failure will, cause interest on the Bonds to become includable in the gross income of the Holders for federal income tax purposes pursuant to the provisions of the Code.

Members, Officers and Employees of the Agency and the Corporation Not Liable

Neither the members, officers and employees of the Agency nor the members of the Board of Trustees or the officers and employees of the Corporation shall be personally liable for any costs, losses, damages or liabilities caused or subsequently incurred by the Corporation or any officer, director or agent thereof in connection with or as a result of the Loan Agreement.

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APPENDIX D

FORM OF OPINION OF BOND COUNSEL

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APPENDIX D

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BEIJING HONG KONG SAN FRANCISCO
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DALLAS NEW YORK TOKYO
GENEVA PALO ALTO WASHINGTON, D.C.

FOUNDED 1866

February __, 2016

Vermont Educational and Health
Buildings Financing Agency
Winooski, Vermont

As bond counsel to Vermont Educational and Health Buildings Financing Agency (the "Board"), a body corporate and politic constituting a public instrumentality of the State of Vermont (the "Agency"), we have examined Title 16, Chapter 131, Sections 3851-3862, Vermont Statutes Annotated, as amended (the "Act"), and certified copies of the proceedings of the Board of the Agency, authorizing the issuance of revenue bonds of the Agency hereinafter described and other proofs submitted relative to the issuance of the following described bonds (the "Bonds"):

$176,375,000
VERMONT EDUCATIONAL AND HEALTH BUILDINGS FINANCING AGENCY
REVENUE BONDS
(THE UNIVERSITY OF VERMONT MEDICAL CENTER PROJECT)
SERIES 2016A

Dated, maturing, bearing interest and subject to redemption all as provided in the Trust Agreement.

The Bonds are issued under and pursuant to the Act and a Trust Agreement, dated as of February 1, 2016 (the "Trust Agreement"), between the Agency and People's United Bank, N.A., as trustee (the "Trustee"), for the purpose of providing funds, together with other available funds, to (i) refund the Refunded Bonds (as defined in the hereinafter defined Loan Agreement) and (ii) pay certain expenses incurred in connection with the authorization and issuance of the Bonds. The Bonds are issuable in fully registered form in denominations of $5,000 and integral multiples thereof.

The Agency will lend the proceeds of the Bonds to The University of Vermont Medical Center Inc. (the "Corporation") under a Loan Agreement, dated as of February 1, 2016 (the "Loan Agreement"), between the Agency and the Corporation. The Bonds are secured by, among other things, payments to be made by the Corporation on its Obligation No. 21, dated as of February 1, 2016 ("Obligation No. 21"), issued by the Corporation under an Amended and Restated Master Trust Indenture, dated as of March 1, 2004, as supplemented (the "Master Trust Indenture"), between the Corporation and People's United Bank, as successor master trustee (the "Master Trustee"), as such Master Trust Indenture is further supplemented by Supplemental Indenture for Obligation No. 21, dated as of February 1, 2016 (the "Supplemental Indenture"

and, together with the Master Trust Indenture, the "Master Indenture"), between the Corporation and the Master Trustee. Obligation No. 21 is being delivered to the Agency as evidence of the Corporation's obligations to repay the loan of the proceeds of the Bonds, and assigned by the Agency to the Trustee as security for the payment of the Bonds. Obligation No. 21 is a direct, general and unconditional obligation of the Corporation secured by, among other things, a security interest in Pledged Assets (as defined in the Master Indenture) and a mortgage on substantially all of the real property of the Corporation at its Medical Center Campus. The Bonds are additionally secured by funds held by the Trustee under the Trust Agreement, income from the investment thereof and, under certain circumstances, proceeds of insurance and condemnation awards.

We have also examined a Bond as executed and authenticated.

Based upon such examination, we are of the opinion that:

1. The Bonds have been duly authorized, executed and issued.

2. The Trust Agreement has been duly authorized and executed by the Agency and is a valid, binding and enforceable agreement in accordance with its terms.

3. The Bonds are a valid and binding limited obligation of the Agency payable in accordance with its terms from payments to be made by the Corporation pursuant to Obligation No. 21 and the Loan Agreement, funds held by the Trustee and money attributable to the proceeds of the Bonds and the income from the investment thereof, and, under certain circumstances, proceeds of insurance, condemnation awards and remedial action taken pursuant to the Master Indenture, the Trust Agreement or the Loan Agreement.

4, The Loan Agreement has been duly authorized and executed by the Agency and is a valid, binding and enforceable agreement in accordance with its terms.

5. The Bonds shall not be deemed to constitute a debt or liability of the State of Vermont, and neither the faith and credit nor the taxing power of the State of Vermont is pledged for the payment of the principal of or the interest on the Bonds.

6. Based on current law and assuming compliance by the Corporation and the Agency with certain requirements of the Internal Revenue Code of 1986, as amended (the "Code"), and their respective covenants in the Trust Agreement and the Loan Agreement regarding use, expenditure and investment of proceeds of the Bonds and the timely payment of certain investment earnings to the United States Treasury, interest on the Bonds is not includible in gross income of the owners thereof for federal income tax purposes under current law. Interest on the Bonds will not be treated as an item of tax preference for purposes of the federal individual or corporate alternative minimum tax. Failure by the Agency or the Corporation to

comply with their respective covenants to comply with the provisions of the Code regarding the use, expenditure, and investment of proceeds of the Bonds and the timely payment of certain investment earnings to the Treasury of the United States may cause interest on the Bonds to become included in gross income for federal income tax purposes retroactive to their date of issuance. The covenant of the Agency does not require the Agency to make any financial contribution for which it does not receive funds from the Corporation. The opinion expressed in this paragraph may not be relied upon to the extent that the exclusion from gross income of the interest on the Bonds for federal income tax purposes is adversely affected as a result of any action taken, or not taken, in reliance on the advice or opinion of counsel other than this firm. Other than as described herein, we have not addressed and we are not opining on the tax consequences to any investor of the investment in, or receipt of any interest on, the Bonds.

The Act provides that the Bonds and the income therefrom shall at all times be exempt from taxation in the State of Vermont, except for transfer and estate taxes.

The enforceability of the Trust Agreement and the Loan Agreement and the obligations of the aforementioned parties with respect to such documents and the security interest described above are subject to bankruptcy, insolvency and other laws affecting creditors' rights generally. To the extent that the remedies under the Trust Agreement and the Loan Agreement require enforcement by a court of equity, the enforceability thereof may be limited by such principles of equity as the court having jurisdiction may impose.

In rendering the opinions in paragraph 6 above, we have relied upon the representations made by the Corporation with respect to certain material facts within its knowledge, which facts and representations we have not independently verified, and the opinions of Dinse, Knapp & McAndrew, P.C., Burlington, Vermont, counsel to the Corporation, that the Corporation is an organization described in Section 501(c)(3) of the Code and exempt from tax under section 501(a) of the Code, or corresponding provisions of prior law, and that to such counsel's knowledge, the Corporation has done nothing to impair such status or cause the use of property financed or refinanced with the proceeds of the Bonds to constitute an unrelated trade or business under Section 513(a) of the Code in excess of any allowable amount permitted by Section 145(a) of the Code.

In rendering the above opinions we have also relied, without independent investigation, upon the opinions of Dinse, Knapp & McAndrew, P.C., Burlington, Vermont, counsel to the Corporation, with respect to the due organization and valid existence of the Corporation, its power and authority with respect to the transactions contemplated by, and its due authorization, execution and delivery of, the Supplemental Indenture, Obligation No. 21 and the Loan Agreement.

Respectfully submitted,

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THE
University of Vermont
HEALTH NETWORK

Mixed Sources
Product group from well managed forests, controlled sources and recycled wood or fiber.

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