PRELIMINARY OFFICIAL STATEMENT DATED _____, 2020

NEW ISSUE - BOOK ENTRY ONLY

Rating: S&P: "__"
See "RATING" herein

In the opinion of Dinsmore & Shohl LLP, Bond Counsel, assuming continuing compliance by the Louisville/Jefferson County Metro Government, Kentucky, Louisville Medical Center, Inc., and other contractually-bound parties with certain covenants in the financing documents herein described and subject to the limitations and exceptions set forth under the caption "TAX TREATMENT," (i) interest on the Bonds is included in gross income for federal income tax purposes, (ii) under the Constitution and laws of the Commonwealth of Kentucky and official interpretations thereof, interest on the Bonds is subject to income taxation by the Commonwealth, and (iii) the Bonds are exempt from ad valorem taxation by the Commonwealth and its political subdivisions. See "TAX TREATMENT" herein.

$20,100,000*
LOUISVILLE/JEFFERSON COUNTY METRO GOVERNMENT, KENTUCKY
TAXABLE REVENUE BONDS, SERIES 2020
(LOUISVILLE MEDICAL CENTER STEAM AND CHILLED WATER PLANT PROJECT)

Dated: Date of Delivery **Due: as shown on inside front cover**

Interest on the captioned Bonds (herein the "Bonds") will be payable from the dated date, on May 1 and November 1, commencing November 1, 2020, and the Bonds mature on each May 1, as shown above.

The Bonds are special limited obligations of the Louisville/Jefferson County Metro Government, Kentucky (the "Issuer") being issued pursuant to an Ordinance of the Legislative Council of the Issuer and pursuant to the Indenture described and defined herein between the Issuer and U.S. Bank National Association, Nashville, Tennessee, as Trustee (the "Trustee"). The proceeds of the Bonds, together with other funds, will be used to finance the costs of improvements to the Louisville Medical Center, Inc.'s (the "Corporation") steam and chilled water plant in Louisville, Kentucky. See "PLAN OF FINANCE."

The Bonds are subject to optional redemption prior to their stated maturities and are subject to extraordinary optional and mandatory sinking fund redemption as described herein. See "THE BONDS – Redemption Provisions."

The Bonds will be initially issued as fully registered bonds in book entry form in the name of The Depository Trust Company ("DTC") or its nominee. There will be no distribution of Bonds to owners of book entry interests. DTC will receive all payments of principal and interest with respect to the Bonds from the Trustee. DTC is required by its rules and procedures to remit such payments to participants in DTC for subsequent disbursement to the owners of book entry interests. So long as DTC or its nominee is the registered owner of the Bonds, references herein to the Holders or registered owners (other than under the caption "TAX TREATMENT" or "CONTINUING DISCLOSURE") shall mean DTC or its nominee, and not the owners of book entry interest in the Bonds. See "THE BONDS – Book Entry Only System."

Payment of the principal of the Bonds, the premium, if any, and the interest thereon are secured by and payable solely from (i) revenues of the projects financed by the Bonds, (ii) revenues, proceeds, receipts and payments made by the Corporation pursuant to the Loan Agreement described herein between the Issuer and the Corporation, (iii) monies and securities held in the funds and accounts established under the Indenture, and income from the investment thereof, and (iv) the proceeds of the Bonds.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER AND DO NOT CONSTITUTE A DEBT, GENERAL OBLIGATION, PLEDGE OF FAITH AND CREDIT OR LIABILITY OF THE ISSUER, THE COMMONWEALTH OF KENTUCKY OR OF ANY AGENCY OR POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE CONSTITUTION OR STATUTES OF THE COMMONWEALTH OF KENTUCKY, AND THE BONDS ARE PAYABLE SOLELY FROM THE FUNDS AND PROPERTY PLEDGED THEREFOR.

The Bonds are offered when, as and if issued by the Issuer and received by the Robert W. Baird & Co. Incorporated (the "Underwriter"), subject to the approval of legality by Dinsmore & Shohl LLP, Louisville, Kentucky, Bond Counsel, and to the approval of certain matters for the Corporation by Dinsmore & Shohl LLP, Louisville, Kentucky, for the Issuer by Michael J. O'Connell, Esq., County Attorney, and for the Underwriter by Frost Brown Todd LLC, Louisville, Kentucky. It is expected that the Bonds in definitive form will be available for delivery through the facilities of DTC in New York, New York on or about July __, 2020.

*Preliminary; subject to change

LOUISVILLE/JEFFERSON COUNTY METRO GOVERNMENT, KENTUCKY
TAXABLE REVENUE BONDS, SERIES 2020
(LOUISVILLE MEDICAL CENTER STEAM AND CHILLED WATER PLANT PROJECT)

DUE MAY 1*	AMOUNT*	INTEREST RATE	YIELD	PRICE	CUSIP**
2023	$395,000				
2024	405,000				
2025	420,000				
2026	435,000				
2027	450,000				
2028	465,000				
2029	485,000				
2030	500,000				
2031	520,000				
2032	545,000				
2033	565,000				
2034	590,000				
2035	615,000				
2036	640,000				
2037	670,000				
2038	700,000				
2039	735,000				
2040	765,000				
2041	805,000				
2042	845,000				
2043	885,000				
2044	925,000				
2045	975,000				
2046	1,025,000				
2047	1,075,000				
2048	1,130,000				
2049	1,190,000				
2050	1,255,000				

$_____,000 __% Term Bonds due May 1, 20__ – Yield ___% – CUSIP _____***

* Preliminary, subject to change.

** CUSIP is a registered trademark of the American Bankers Association ("ABA"). CUSIP data is provided by CUSIP Global Services, managed by S&P Global market Intelligence on behalf of ABA. The CUSIP numbers listed above are being provided solely for the convenience of bondholders only at the time of issuance of the Series 2020 Bonds and neither the Issuer nor the Underwriter nor the Corporation makes any representation with respect to such numbers or undertake any responsibility for their accuracy now or at any time in the future.

*** Term Bond subject to mandatory sinking fund redemption. See "THE BONDS –Redemption Provisions" herein.

Regarding Use of this Official Statement

IN CONNECTION WITH THIS PUBLIC OFFERING, THE UNDERWRITER MAY OVER ALLOT OR EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE BONDS AT LEVELS ABOVE THOSE THAT MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

No dealer, broker, salesman or other person has been authorized by the Issuer, the Corporation or the Underwriter to give any information or to make any representations other than as contained in this Official Statement, including the appendices hereto, in connection with the offering described herein, and if given or made, such other information or representation 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 a solicitation of an offer to buy any securities other than those identified on the cover page or an offer to sell or a solicitation of an offer to buy such securities in any jurisdiction in which it is unlawful to make such offer, solicitation or sale. The Issuer neither has nor assumes any responsibility as to the accuracy or completeness of the information contained in this Official Statement, other than that appearing under the captions "THE ISSUER" and "LITIGATION – The Issuer".

Certain information contained in this Official Statement has been obtained from the Corporation, DTC and other sources that are believed to be reliable. No representation or warranty is made by the Issuer or the Underwriter, however, as to the accuracy or completeness of such information, and nothing contained in this Official Statement is, or may be relied on as, a promise or representation by the Issuer or the Underwriter. The information herein relating to the Issuer has been provided by the Issuer, and neither the Corporation nor the Underwriter makes any representation with respect to or warrants the accuracy of such information. This Official Statement is distributed in connection with the sale of the securities described herein and may not be used, in whole or in part, for any other purpose. The information and expression of opinions set forth 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 persons referred to above since the date hereof.

This Official Statement should be considered in its entirety. No one factor should be considered more or less important than any other by reason of its position in this Official Statement. Where statutes, ordinances, reports or other documents are referred to in this Official Statement, reference should be made to them for more complete information regarding their subject matter.

The Bonds have risk characteristics which require careful analysis and consideration before a decision to purchase is made. See "BONDHOLDERS' RISK" and "APPENDIX A – FINANCIAL AND OPERATING DATA REGARDING THE PLANT". The Bonds should only be purchased by investors who have adequate experience to evaluate the merits and the risks of the Bonds and who are able to bear the risk of loss of all or a portion of their investment in the Bonds. Each prospective investor should consult its own counsel, accountant and other advisors as to financial, legal, and related matters concerning the investment described in this Official Statement.

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 a part of, its responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

THIS OFFICIAL STATEMENT CONTAINS STATEMENTS THAT ARE "FORWARD-LOOKING STATEMENTS" AS THAT TERM IS DEFINED IN THE SECURITIES ACT OF 1933, AS

AMENDED, AND THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED. WHEN USED IN THIS OFFICIAL STATEMENT, THE WORDS "ESTIMATE," "BUDGET," "EXPECT," "PROJECT," "INTEND," "ANTICIPATE," "BELIEVE," "MAY," "WILL," "CONTINUE" AND SIMILAR EXPRESSIONS ARE INTENDED TO IDENTIFY FORWARD-LOOKING STATEMENTS. FORWARD-LOOKING STATEMENTS ARE SUBJECT TO RISKS AND UNCERTAINTIES, SOME OF WHICH ARE DISCUSSED IN THIS OFFICIAL STATEMENT, THAT COULD CAUSE ACTUAL RESULTS TO DIFFER MATERIALLY FROM THOSE CONTEMPLATED IN SUCH FORWARD-LOOKING STATEMENTS. INVESTORS AND PROSPECTIVE INVESTORS ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON FORWARD-LOOKING STATEMENTS, WHICH SPEAK ONLY AS OF THE DATE OF THIS OFFICIAL STATEMENT. ALL FORWARD-LOOKING STATEMENTS INCLUDED IN THIS OFFICIAL STATEMENT HAVE BEEN PROVIDED BY THE CORPORATION.

TABLE OF CONTENTS

OFFICIAL STATEMENT
$20,100,000*
LOUISVILLE/JEFFERSON COUNTY METRO GOVERNMENT, KENTUCKY
TAXABLE REVENUE BONDS, SERIES 2020
(LOUISVILLE MEDICAL CENTER STEAM AND CHILLED WATER PLANT PROJECT)

INTRODUCTION

The purpose of this Official Statement, including the cover page and the appendices hereto, is to provide information in connection with the offering by Louisville/Jefferson County Metro Government, Kentucky (the "Issuer") of its $20,100,000* Taxable Revenue Bonds, Series 2020 (Louisville Medical Center Steam and Chilled Water Plant Project) (the "Bonds"). The Bonds will be issued pursuant to a Bond Trust Indenture dated as of July 1, 2020 (the "Indenture" or "Bond Indenture"), by and between the Issuer and U.S. Bank National Association, with its designated corporate trust office in Nashville, Tennessee, as Trustee (the "Trustee" or "Bond Trustee"). The Bonds are to be issued in accordance with the provisions of the Indenture, an ordinance adopted by the Issuer on June 11, 2020 (the "Ordinance") and the Industrial Buildings for Cities and Counties Act, as amended, Sections 103.200 to 103.285 of the Kentucky Revised Statutes (the "Act").

The Issuer will be obligated to pay the principal or redemption price of and interest on the Bonds solely from the revenues and funds pledged for their payment as provided in the Indenture, including, with respect to the Bonds, moneys paid to the Trustee by Louisville Medical Center, Inc. (the "Corporation") under the Loan Agreement dated as of July 1, 2020 (the "Loan Agreement") between the Corporation and the Issuer. See "THE BONDS" and "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS; ADDITIONAL BONDS."

The Bonds are being issued on the basis of parity as to security and source of payment with the Issuer's outstanding (i) Refunding Revenue Bonds, Series 2012A (Louisville Medical Center, Inc. Steam and Chilled Water Plant Project) issued in the original principal amount of $7,510,000 (the "Series 2012 Bonds"), and (ii) Taxable Refunding Revenue Bonds, Series 2016 (Louisville Medical Center Steam and Chilled Water Plant Project) issued in the original principal amount of $7,550,000 (the "Series 2016 Bonds") and will be payable from the gross income and revenues derived from the operation of the Corporation's steam and chilled water plant located at 235 Abraham Flexner Way in Louisville, Kentucky (the "Plant").

As more specifically described under "PLAN OF FINANCE" herein, the proceeds of the Bonds will be loaned by the Issuer to the Corporation (the "Loan") to (a) pay all or a portion of the costs of converting the Corporation's Plant to a wholly-natural gas powered steam generating facility, including without limitation the acquisition, construction, installation, and equipping of (i) three new, higher capacity boilers designed to combust natural gas and fuel oil in replacement of the existing boilers identified as Boilers B-1, B-2, and B-3, (ii) new boiler control systems, (iii) a new fuel oil storage and supply system for the steam generating facilities of the Plant, and (iv) other real property improvements, machinery, and equipment necessary and related to any of the foregoing (the "Project"); and (b) pay costs of issuance of the Bonds. A more detailed description of the application of the proceeds of the Bonds is contained in "ESTIMATED SOURCES AND USES OF FUNDS."

Under the Loan Agreement, the Corporation will have an unconditional obligation to provide for the repayment of the Loans at such times and in such amounts so as to provide for the payment of the principal or redemption price of and interest on the Bonds when due. The Loan Agreement will remain in full force and effect until such time as the principal or redemption price of and interest on the Bonds and any other amounts owed under the Loan Agreement have been fully paid or provision for such payment has been made as required by the Indenture.

*Preliminary; subject to change

The Issuer will assign to the Trustee, for the benefit of the Holders, all of the Issuer's rights under the Loan Agreement (except for rights to certain notices and payments relating to fees, indemnification and administrative expenses), including the right to receive payments with respect to the Loans.

The obligation of the Corporation to make payments under the Loan Agreement will be secured, on a parity with other Plant Bonds (as hereinafter defined), by a pledge of the gross income and revenues derived from the operation of the Plant. The Corporation agrees in the Loan Agreement that, except for Permitted Encumbrances (as defined in **Appendix H** hereto), it shall not mortgage or grant a security interest in any of the Plant property unless such mortgage and security interest also secures the Series 2012A Bond, the Series 2016 Bonds and the Bonds on a *pari passu* basis. To further secure its obligations under the Loan Agreement and the Loan Agreement securing the Series 2012A Bonds and Series 2016 Bonds the Corporation has granted a first lien mortgage on the Plant pursuant to the Plant Mortgage as hereinafter defined.

The definitions of certain capitalized terms used in this Official Statement, together with summaries of certain documents related to the Bonds, are set forth under the heading "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF LEGAL DOCUMENTS" in **Appendix H**. Such summaries are qualified in their entirety by, and should be read only in conjunction with, the documents themselves. Copies of such documents are also available from the Corporation and the Trustee.

THE ISSUER

Except for the information under this heading, the Issuer has not participated in the preparation of this Official Statement and assumes no responsibility as to the accuracy or completeness of any information in this Official Statement.

The Issuer is a consolidated local government and political subdivision of the Commonwealth of Kentucky. The Issuer is governed by a Mayor and a Metro Council (Legislative Council) consisting of twenty-six (26) elected Councilmembers. The Mayor is the chief executive officer of the Issuer and oversees the Issuer's services.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER AND DO NOT CONSTITUTE A DEBT, GENERAL OBLIGATION, PLEDGE OF FAITH AND CREDIT OR LIABILITY OF THE ISSUER, THE COMMONWEALTH OF KENTUCKY OR OF ANY AGENCY OR POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE CONSTITUTION OR STATUTES OF THE COMMONWEALTH OF KENTUCKY, AND THE BONDS ARE PAYABLE SOLELY FROM THE FUNDS AND PROPERTY PLEDGED THEREFOR. NEITHER THE CREDIT NOR THE TAXING POWER OF THE ISSUER, THE COMMONWEALTH OF KENTUCKY OR ANY AGENCY OR POLITICAL SUBDIVISION THEREOF IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE BONDS.

THE CORPORATION AND THE COMMISSION

[TO BE UPDATED]

The Corporation is a nonstock, nonprofit corporation organized and existing under the laws of the Commonwealth of Kentucky (the "Commonwealth") and is exempt from federal income taxation by virtue of Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation was created in 1950 when leaders of the University of Louisville (the "University"), Louisville General Hospital, Children's Hospital and Jewish Hospital established an organization to assist in the development of a comprehensive medical center to serve the Louisville metropolitan region. The institutions which currently are members of the Corporation include the University, Kentucky

Community & Technical College System ("KCTCS"), Norton Healthcare, Inc. ("Norton"), University Medical Center, Inc. ("UofL Hospital"), and UofL Health-Louisville, Inc. ("UofL Health").

Currently, the Corporation owns the Plant, which is operated and managed by the Medical Center Commission of Louisville/Jefferson County Metro Government (the "Commission"), a public agency of the Issuer, and the Plant is utilized by Norton, KCTCS, UofL Hospital, UofL Health and the University (collectively, the "Plant Users"). While the Commission is an agency of the Issuer and the representatives on the Board of Commissioners of the Commission are formally appointed by the Issuer, the individuals serving on the Board of Directors of the Corporation also serve for like terms on the Board of Commissioners.

The Plant serves an area known as the "Louisville Medical Center Area," which is generally considered to be an approximately 24 square block area in downtown Louisville, Kentucky bounded on the North by Jefferson Street, on the East by Clay Street, on the South by Broadway and on the West by First Street. The University's Health Sciences Center (which includes the medical school, dental school and three research buildings), KCTCS, JHSMH Hospital, Kosair Children's Hospital, Norton Hospital, Norton Medical Pavilion, Norton Cancer Institute and the University of Louisville Hospital are all located within the Louisville Medical Center Area. Other major facilities or institutions located within this area are the Kentucky Lions Eye Research Institute, J. Graham Brown Cancer Center (a part of the University of Louisville Hospital), Frazier Rehab Institute, the Rudd Heart and Lung Center, the Kosair Charities Building, several medical research facilities, and several outpatient care facilities.

Further information about the Corporation, the management and operation of the Plant is contained in **Appendices A and B**.

THE PLANT USERS

[TO BE UPDATED]

The University, UofL Health, Norton, UofL Hospital and KCTCS are the Plant Users. The following sets forth certain brief descriptions of each of the Plant Users.

Norton Healthcare, Inc.

Norton, is a Kentucky nonstock, nonprofit corporation and is exempt from federal income taxation by virtue of Sections 501(a) and 501(c)(3) of the Code. Norton is a holding company that controls a group of corporations that collectively operate a diversified health care system headquartered in Louisville, Kentucky, providing healthcare and related services in Kentucky and Southern Indiana. Norton includes five acute care hospitals with 1,422 staffed beds, 13 immediate care centers, seven outpatient centers, four stand-alone radiology and two cardiology diagnostic centers, over 760 employed medical providers and more than 13,000 employees providing care at more than 210 locations throughout Louisville and Southern Indiana.

Pediatric and Adult Hospital Services. Norton owns and operates five hospitals located in Jefferson County with over 1,800 licensed beds, including: (1) Kosair Children's Hospital located in the Louisville Medical Center area, with 267 staffed beds, which is Kentucky's only full service, stand-alone pediatric hospital; (2) Norton Hospital and Norton Medical Pavilion, both located in the Louisville Medical Center Area, which together have 383 staffed beds and offer a full array of adult inpatient hospital services; (3) Norton Audubon Hospital located in Jefferson County, Kentucky, with 302 staffed beds; (4) Norton Women's Hospital & Kosair Children's Hospital – St. Matthews (formerly known as Norton Suburban Hospital) Hospital, an acute care facility located in eastern Jefferson County, with 346

staffed beds; and (5) Norton Brownsboro Hospital, located in northeastern Jefferson County, Kentucky with 124 staffed beds.

Outpatient Services. Kosair Children's Medical Center – Brownsboro provides ambulatory surgery services, diagnostic services, laboratory services and emergency services that are uniquely suited for the pediatric population. Adult oriented diagnostic services are also provided in four stand-alone radiology and two cardiology diagnostic centers. In addition, employed primary and specialty physician practices employ 458 physicians and 150 mid-level providers and thirteen immediate care centers provide extended hours and walk in treatment for non-emergent conditions located in Norton's primary service area.

Audited financial statements for Norton as of and for the years ended December 31, 2018 and 2019 are set forth in **Appendix C**.

UofL Health-Louisville, Inc.

UofL Health-Louisville, Inc. ("UofL Hospital") is a Kentucky nonstock, nonprofit corporation and is exempt from federal income taxation by virtue of Sections 501(a) and 501(c)(3) of the Code. As of January 1, 2012, KentuckyOne Health ("KentuckyOne Health"), a Kentucky non-profit corporation, became the member of JHSMH as a result of a Sponsorship and Consolidation Agreement between JHSMH Catholic Health Initiatives and Jewish Hospital Healthcare Services, Inc. and certain other entities. Neither KentuckyOne Health nor any of its affiliates, other than JHSMH and UMC, has any obligations with respect to the User Contract.

JHSMH owns and operates the following facilities:

Jewish Hospital is a 462-bed regional medical center facility providing primary and secondary care services and is a tertiary care and quaternary regional referral center. Jewish Hospital's specialties include hand and microsurgery, heart and lung care, rehabilitation medicine (including sports medicine and orthopedics), neuroscience, occupational health, organ transplantation, plastic and aesthetic surgery and primary care. Jewish Hospital is located on the Louisville Medical Center complex.

Sts. Mary and Elizabeth Hospital, a 298-bed primary care hospital located in south Louisville. Sts. Mary and Elizabeth offers, among other services, treatment in cancer, cardiac care, lung disease, orthopedics, vascular and general surgery and emergency services.

Jewish Hospital Shelbyville, a 70-bed community hospital provides inpatient and outpatient services to the residents of Shelby, Henry and Spencer counties, located 30 minutes east of downtown Louisville.

Our Lady of Peace is one of the largest behavioral health hospitals in the country with 396 acute psychiatric beds. Our Lady of Peace operates a full continuum of behavioral health and substance use services for patients from young children to adults. Within Our Lady of Peace is the Kosair Charities Children's Peace Center, which provides specialty programs for children and adolescents who have complex treatment needs, such as intellectual or developmental disabilities; forensic issues for females; and/or co-occurring substance use issues.

Frazier Rehab and Neuroscience Center is a 15-story, 135-bed acute rehab hospital opened in 2007 that offers physical, occupational and speech therapies, therapeutic recreation and psychological and neuropsychological testing services in both inpatient and outpatient settings. Frazier Rehab Institute also operates over twenty community-based outpatient rehab sites in Kentucky and southern Indiana, and

manages Southern Indiana Rehab Hospital, a 60-bed freestanding rehab hospital located in New Albany, Indiana owned in partnership with Floyd Memorial Hospital and Health Services and Clark Memorial Hospital.

JHSMH also owns and operates a number of outpatient and emergency care facilities located in the Louisville, Kentucky area, including Jewish Hospital Medical Center East, Jewish Hospital Medical Center Northeast, Jewish Hospital Medical Center South and Jewish Hospital Medical Center Southwest.

Unaudited financial information for UofL Health as of and for the years ended June 30, 2018 and June 30, 2019 are set forth in **Appendix D**.

University of Louisville

The University is an urban, public university that has had close historical and legal ties with Louisville-Jefferson County. The University was founded in 1798 as the Jefferson Seminary, later known as Louisville College, and in 1846 became the University of Louisville by legislative charter. The University became a member of Kentucky's public higher education system on July 1, 1970, and amended its charter to reflect its status as a state institution, subject to the administration and control of the Board of Trustees of the University (the "Board" or "Board of Trustees") which was constituted a public body corporate, with the usual corporate powers, and possessing all the authorities, immunities, rights, privileges, and franchises normally attached to the governing bodies as Kentucky public higher education institutions.

The University has three campuses. The Belknap Campus is three miles from downtown Louisville and houses eight of the University's twelve colleges and schools. The Health Sciences Center is situated in downtown Louisville's medical complex and houses the University's health related programs and the University of Louisville Hospital (Hospital). On the Shelby Campus, located in eastern Jefferson County, are the National Crime Prevention Institute, the Center for Predictive Medicine regional biosafety lab, and the Division of Distance and Continuing Education. In recent years, the University has also offered expanded campus courses at both off-site and international locations. The University had a full-time equivalent enrollment of 18,453 in the Fall of 2015.

The University has established or designated independent components for the following divisions: the College of Arts & Sciences, School of Dentistry, J.B. Speed School of Engineering, School of Music, School of Medicine, The Brandeis School of Law, College of Education & Human Development, School of Public Health and Information Sciences, School of Nursing, College of Business, Kent School of Social Work, and Undergraduate Studies. The University as a whole is a member of, or is accredited by, the following agencies: The American Council on Education, the Association of American Colleges, the Association of Urban Universities, the American Association of University Women, the Southern University Conference, the Southern Association of Colleges and Secondary Schools, the University of the State of New York and the Kentucky State Department of Education.

The School of Medicine is accredited by the Liaison Committee on Medical Education, a joint effort of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) for the MD Degree, and the residency programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). The School of Dentistry, including the Dental Hygiene Program, is accredited by the Commission on Dental Education of the American Dental Association. The School of Nursing is accredited by the Commission on Collegiate Nursing Education (CCNE). The College of Arts and Sciences is a member of, or is accredited by, Section on Paralegal Education of the American Bar Association, National Association of Schools of Public Affairs and Administration, American Psychological Association, American Chemical Society, National Association of Schools and Theater,

Foundation for the Interior Design Education Research, the Association of American Colleges, the Southern Association of Colleges and Secondary Schools, the Kentucky Association of Colleges and Secondary Schools, and the Kentucky State Department of Education. The School of Music is accredited by the National Association of Schools of Music. The J.B Speed School of Engineering is accredited by the Computer Science Accreditation Commission of the Computer Sciences Accreditation Board, Computing Accreditation Commissions of ABET, Inc., Engineering Accreditation Commission of the Accrediting Board for Engineering and Technology (ABET/EAC). The College of Education & Human Development is accredited by the National Council for Accreditation of Teacher Education, the American Psychological Association, the Sport Management Program Review Council, and the American Art Therapy Association. The Kent School of Social Work is accredited by the Commission on Accreditation for Marriage and Family Therapy Education, Commission on Accreditation of the Council on Social Work Education. The School of Public Health and Information Sciences is accredited by the Council on Education for Public Health (CEPH). The Brandeis School of Law is accredited by a Section of Legal Education and Admissions to the Bar of the American Bar Association; Association of American Law Schools. The College of Business is accredited by the American Assembly of Collegiate Schools of Business.

The University of Louisville School of Medicine, founded in 1837, is part of the University of Louisville Health Sciences Center (the "Health Sciences Center") and is located in the Louisville Medical Center. Immediately east of the school is the University of Louisville Hospital ("U of L Hospital") U of L Hospital, the principal teaching hospital of U of L, and within a few blocks are Jewish Hospital, Kosair Childrens Hospital, Norton Hospital and Norton Medical Pavilion. The center of activity for pre-clinical students is the Instructional Building which is a functional and modern three-story structure designed on the unit laboratory concept for teaching pre-clinical disciplines connected to the Instructional Building are the School of Dentistry and a fourteen-floor tower building housing the Medical School's departments of Anatomical Sciences and Neurobiology, Biochemistry, Microbiology and Immunology, Pharmacology and Toxicology, and Physiology and Biophysics and the administrative offices of the Departments of Psychiatry and Behavioral Sciences and Neurology. Also connected is the Commons Building which houses the Health Sciences Library, an auditorium seating 500 and a café.

As the lease of the U of L Hospital campus by UofL Health from the University and the Commonwealth of Kentucky may expire or terminate prior to maturity of the Bonds, the University has agreed in the User Contract to assume UofL Health's obligations under the User Contract upon the expiration or termination of the lease.

Pursuant to an Executive Order issued by the Governor of the Commonwealth of Kentucky on March 31, 2016, the April 1, 2016 allotments of the budget appropriations to each of the state universities was ordered reduced by 4.5% of the 2015-16 appropriation, resulting in a reduction of the April 1, 2016 installment of the 2015-16 appropriation to the University from $28,083,200 to $21,824,700. On April 11, 2016, the Attorney General of the Commonwealth of Kentucky filed a Complaint in Franklin Circuit Court against the Office of the Governor for a Declaration of Rights and a Permanent Injunction alleging the actions of the Governor in reducing the allotments to the state universities violated the doctrine of the separation of powers and the duty of the Governor to faithfully execute the law as mandated by the Kentucky Constitution. Such Complaint seeks declaratory and injunctive relief (i) declaring the actions of the Governor, the Finance Secretary, the state Budget Director and the Treasurer in withholding the allotments to the state universities illegal, (ii) permanently enjoining the Governor, the Finance Secretary, the state Budget Director and the Treasurer from reducing or withholding appropriations to the state universities or any other state agency, and (iii) ordering the Governor, the Finance Secretary, the state Budget Director and the Treasurer to provide the full appropriation to the state universities. On April 19, 2016 the Governor directed that a portion of the reductions ordered to be undertaken on March 31, 2016 be restored, resulting in $3,477,000 being remitted to the University on April 19, 2016 and reducing the net

overall reduction of the 2015-16 appropriation to the University to $2,781,500. On April 29, 2016, pursuant to an Order from Franklin Circuit Judge Thomas Wingate, $2,781,500 from the University's fourth quarter allotment was disbursed and placed in a trust account pending a further order from the Court. That amount represents two percent (2%) of the University's FY 2016 General Fund appropriation. Judge Wingate's decision in the case (Franklin Circuit Court No. 16-CI-0389, Commonwealth of Kentucky, *ex rel.* Andy Beshear, Attorney General v. Commonwealth of Kentucky, Office of the Governor, *ex rel.* Matthew G. Bevin, *et al.*) is currently on appeal to the Kentucky Supreme Court; oral arguments are scheduled for Thursday, August 18. Pending the outcome of the litigation surrounding the Complaint, no assurance can be given that future budgeted appropriations will not be similarly reduced by executive order.

Audited financial statements for the University as of and for the years ended June 30, 2018 and June 30, 2019 are set forth in **Appendix E**.

University Medical Center, Inc. ("UofL Health")

University Medical Center, Inc. d/b/a University of Louisville Hospital ("UofL Health") is a Kentucky, nonstock, nonprofit corporation and is exempt from federal income taxation by virtue of Sections 501(a) and 501(c)(3) of the Code. Neither KentuckyOne Health nor any of its affiliates, other than JHSMH and UMC, has any obligations with respect to the User Contract.

UofL Health operates the University of Louisville Hospital, a tertiary and quaternary care hospital with 404 licensed beds providing a full range of diagnostic, therapeutic, emergency and surgical services. It is the principal adult teaching hospital of U of L and is used for teaching, research and clinical care programs. Its clinical programs and services include, among others, medical and radiological oncology, digestive health, stroke and heart care, high risk obstetrics and trauma services. As the only Adult Level I Trauma Center, and the primary emergency hospital in the region, UofL Health receives the majority of trauma cases from a metropolitan population of over one million, as well as referred cases from outlying rural areas,

UofL Health's campus consists of five structures: a 9-story hospital facility known as the Concentrated Care Building, a 4-story cancer center known as the James Graham Brown Cancer Center; a 4-story facility known as the Ambulatory Care Building; a 6-story parking garage and central services facility known as the Institutional Services Center; and a 2-story facility known as the Lampton which houses certain administrative and support functions.

Each of the facilities is owned by the Commonwealth and leased to and operated by UofL Health pursuant to the Affiliation Agreement and a Lease Agreement among the Commonwealth, as lessor, UofL Health, as lessee, and the University. As its lease may expire or terminate prior to maturity of the Bonds, the University has agreed in the User Contract to assume UofL Health's obligations under the User Contract upon the expiration or termination of the lease.

On March 1, 2013, KentuckyOne Health, UofL Health, and the University of Louisville entered into a joint operating agreement and academic affiliation agreement (the "Agreements") pursuant to which KentuckyOne Health: (a) oversees most of the day to day operations of UofL Health and (b) committed to provide financial support to the University over a period of time. UofL Health retained ownership of its assets and operates certain excluded operations. The Agreements have a 20-year term.

Unaudited financial information for UofL Health as of and for the years ended June 30, 2018 and June 30, 2019 are set forth in Appendix F.

Kentucky Community and Technical College System

KCTCS operates the public community and technical colleges throughout the Commonwealth of Kentucky, including Jefferson Community and Technical College ("JCTC"), which was founded in 1967. JCTC is located in the Louisville Medical Center Area with expansion locations in downtown Louisville, southwest Jefferson County, Carroll County, Shelby County and Bullitt County and is the largest public, comprehensive community college under the governance of the KCTCS. JCTC offers an array of programs and services to meet the needs of Louisville, Jefferson and surrounding counties, and through distance education, the needs of the Commonwealth. There are currently approximately 18,000 students enrolled at JCTC pursuing more than 70-degree, diploma and certificate and degree programs. Through these programs and courses, JCTC awards associate degrees, certificates and continuing education units consistent with the comprehensive nature of the institution. JCTC also has an extensive workforce program that provides customized development and training programs for over 530 companies and in excess of 9,450 employees each year. The approximately 240 full-time and 360 part-time faculty and the approximately 3335 staff and administrators assist students in accomplishing educational and career goals.

On March 31, 2016, the Governor issued an Executive Order reducing the remainder of Fiscal Year 2015 and 2016 public higher education institutions' appropriations by 4.5 percent. For KCTCS, the amount of the reduction was $8,557,300. On April 19, 2016, the Governor issued an executive order revising the March 31, 2016 reduction downward to 2.0 percent of 2015-2016 appropriations. At its March 10, 2016 meeting, the KCTCS Board, in anticipation of the budget reduction, authorized up to $8,557,300 to be moved from KCTCS' Budget Reserve into its operating budget to address the reduction. The budget reduction is currently in litigation as the Kentucky State Attorney General on April 11, 2016 filed a lawsuit which questioned the Governor's authority to impose the budget reduction. On April 20, 2016, the Governor restored some state funding to public colleges and universities through revision of the executive order cuts from 4.5 percent by 2.5 percent, for a total adjustment of 2 percent. Pending the outcome of the litigation, no assurance can be given that future budgeted appropriations will not be similarly reduced by executive order.

Audited financial statements for KCTCS, including JCTC, for the years ended June 30, 2018 and June 30, 2019 are set forth in **Appendix G.**

THE USER CONTRACT

[TO BE UPDATED]

April 23, 2002, the County of Jefferson, Kentucky, the Corporation, Jewish Hospital and St. Mary's Healthcare, Inc. ("JHSMH"), KCTCS, Norton, UofL, and UofL Hospital entered into a User Contract (the "Original User Agreement") for the purpose of providing for the operation of the Plant and to require JHSMH, KCTCS, Norton, UofL, and UofL Hospital to collectively pay the costs of operating the Plant, including any debt service related to bonds issued to finance improvements to or expansions of the Plant in exchange for the agreement of the Corporation to provide JHSMH, KCTCS, Norton, UofL, and UofL Hospital steam and chilled water from the Plant. The Original User Agreement was amended on October 1, 2011, October 1, 2012 and again on November 1, 2019 when UofL Health acquired all of the facilities owned by JHSMH that are serviced by the Plant. The parties entered into an Amended and Restated Steam and Chilled Water Plant User Agreement dated as of _____, 2020 (the "Amended and Restated User Agreement") which amends and restates the Original User Agreement, as amended, to revise certain provisions consistent with the parties' then current desires and expectations. The Original User Contract, as amended and restated in its entirety by the Amended and Restated User Agreement is referred to herein as the "User Contract".

General Overview

The User Contract requires the Corporation and the Commission to provide steam and chilled water to the Plant Users for the purposes of heating and/or cooling certain of their facilities located within the Louisville Medical Center Area (each, a "Plant Facility" and collectively, the "Plant Facilities"). In exchange, each of the Plant Users is required to purchase exclusively from the Corporation and the Commission all of the steam and chilled water necessary to heat and/or cool the Plant Facilities and to collectively pay the costs of operating the Plant, including but not limited to the debt service related to the Series 2012A Bonds, the Series 2016 Bonds and the Bonds as well as any additional parity bonds issued for the benefit of the Plant pursuant to the requirements of the User Contract, to the Corporation and the Commission.

If the Issuer determines, in its sole discretion, that the continued existence of the Commission and the participation of the Commission in the operation and management of the Plant is unnecessary and that such operation and management can be adequately performed by the Corporation alone, the Issuer may dissolve the Commission and terminate the rights, obligations and responsibilities of the Commission under the User Contract by providing the Corporation and each Plant User no less than sixty (60) days prior written notice of such dissolution and termination. Upon the provision of such written notice, the rights, obligations and responsibilities of the Commission under the User Contract shall terminate as of the date of termination identified in such written notice and all of the rights, obligations and responsibilities previously held by the Commission thereunder shall automatically vest in and become rights, obligations and responsibilities of the Corporation.

Addition of Future Plant Facilities

If a Plant User constructs a new building in the future for which (i) it is economically feasible on a life cycle cost analysis basis to use steam or chilled water produced and supplied by the Plant for purposes of providing heating or cooling the building and (ii) the Plant is reasonably capable of providing steam or chilled water to the building for the foregoing purpose, the new building shall constitute a Plant Facility pursuant to the User Contract and the related Plant User shall be required to purchase steam or chilled water from the Corporation and the Commission for such purpose. If a Plant User, the Corporation and the Commission disagree regarding whether it is economically feasible for the Plant to furnish steam and/or chilled water to a new building, the decision shall be made by an engineer or engineering firm with a recognized reputation for expertise in matters pertaining to steam and chilled water facilities who is acceptable to the manager of the Plant and the Plant Users (a "Qualified Plant Engineer") and shall be binding upon all the parties thereto.

Payment for Purchases of Steam and Chilled Water

The User Contract requires the manager of the Plant (the "Plant Manager"), on behalf of Corporation and the Commission, to invoice each Plant User for the Plant User's proportionate share of the Operating Costs of the Plant (as defined below) for each calendar month occurring during the term of the User Contract within fifteen (15) days after the last day of such calendar month. Each Plant User shall pay each invoice before the last day of the calendar month during which the invoice was received. Except as otherwise provided in the User Contract, all amounts payable thereunder must be made without setoff or counterclaim and without any deduction or withholding.

Calculation and Allocation of the Operating Costs of the Plant Among the Plant Users

The User Contract requires the Plant Users to collectively pay the operating costs of the Plant (the "Operating Costs of the Plant"), which are defined as the aggregate costs and expenses incurred by

the Corporation and the Commission in the course of operating the Plant and producing steam and chilled water thereby, including (i) employment-related costs and expenses, including those attributable to salaries, benefits, pensions, retirement contributions and training, (ii) costs and expenses incurred with respect to professional services, including engineering, architectural, legal, accounting services and laboratory fees, (iii) costs of energy, material and supplies consumed in the production of steam and chilled water, including coal, gas, electricity, water and water treatment chemicals, (iv) repairs and maintenance costs, (v) costs of insuring the Plant, including fire, vandalism, boiler and business interruption insurance, (vi) costs of materials, supplies, machinery, equipment and tools necessary for the Plant's continued operation, (vii) costs incurred with respect to the debt service related to the Series 2012A Bonds, the Series 2016 Bonds, the Bonds and any additional parity bonds issued for the benefit of the Plant pursuant to the requirements of the User Contract (collectively, "Plant Bonds"), and all payments and fees payable to trustees, paying agents, bond registrars, bond insurers and other parties related thereto, (viii) interest costs incurred other than with respect to Plant Bonds, (ix) costs of funding any depreciation or similar fund to provide for extensions, improvements additions and replacements of all or portions of the Plant, and (x) all other costs necessary for the operation of the Plant in accordance with sound operational and accounting practices.

The User Contract requires the Plant Manager to calculate and invoice each Plant User's proportionate share of the Operating Costs of the Plant for a calendar month in accordance with the following procedure:

Step 1: The Plant Manager shall determine the total Operating Costs of the Plant attributable to the production of steam and the total Operating Costs of the Plant attributable to the production of chilled water for the current Calculation Period (as defined below), which together shall equal the total Operating Costs of the Plant for such Calculation Period;

Step 2: The Plant Manager shall determine the total steam provided to each Plant User during such Calculation Period and the total steam provided to all Plant Users during such Calculation Period based upon meter readings attributable to each Plant Facility;

Step 3: The Plant Manager shall determine the total chilled water provided to each Plant User during such Calculation Period and the total chilled water provided to all Plant Users during such Calculation Period based upon meter readings attributable to each Plant Facility;

Step 4: The Plant Manager shall divide the total steam provided to each Plant User during such Calculation Period by the total steam provided to all Plant Users during such Calculation Period;

Step 5: The Plant Manager shall divide the total chilled water provided to each Plant User during such Calculation Period by the total chilled water provided to all Plant Users during such Calculation Period;

Step 6: The Plant Manager shall multiply the percentage determined in Step 4 by the total Operating Costs of the Plant attributable to the production of steam for such Calculation Period determined in Step 1;

Step 7: The Plant Manager shall multiply the percentage determined in Step 5 by the total Operating Costs of the Plant attributable to the production of chilled water for such Calculation Period determined in Step 1;

Step 8: The Plant Manager shall invoice each Plant User for a calendar month in an amount equal to the total of the amounts determined in Steps 6 and 7 less the aggregate amounts invoiced to each Plant User for steam and chilled water for the previous calendar months during the current fiscal year of the Corporation. If a Plant User's proportionate share of the Operating Costs of the Plant for a Calculation Period is less than the amount previously invoiced to the Plant User during the current fiscal year of the Corporation, the Plant Manager shall apply the difference as a credit against any amounts due with respect to the Plant User's current monthly invoice.

For purposes of the foregoing discussion, "Calculation Period" means a period of time beginning on the first day of a fiscal year of the Corporation and ending on the last day of the calendar month for which the Plant Manager must determine a Plant User's proportionate share of the Operating Costs of the Plant.

If the completion of the annual audited financial statements of the Corporation and the Commission for a fiscal year requires an adjustment to the allocation of the Operating Costs of the Plant among the Plant Users based upon the procedure described above, the User Contract requires the Plant Manager to add or deduct the amount of the adjustment to or from the affected Plant Users' next monthly invoices and shall explain the reason for the adjustment therein.

Remedy for Late Payment

On the first day of each calendar month the Plant Manager shall assess a late fee against each Plant User in an amount equal to the unpaid balance of any invoice due but unpaid as of such date multiplied by two percent (2.0%). The late fee shall be added to the next invoice provided to a Plant User.

Remedies for Nonpayment

If a Plant User (a "Delinquent Plant User") fails to pay an invoice for more than three (3) months after its date, the User Contract requires the Plant Manager to allocate the unpaid balance (excluding late fees) among the Remaining Plant Users (as defined below) based upon their proportionate share of the Operating Costs of the Plant for the calendar months during which the charges were incurred and to add the charges to the Remaining Plant Users' next monthly invoices. For purposes of the proceeding sentence, the Plant Manager shall exclude the amount of steam and chilled water provided to the Delinquent Plant User when allocating the unpaid balance among the Remaining Plant Users. For purposes of this paragraph, "Remaining Plant Users" means all of the Plant Users except a Delinquent Plant User.

The User Contract permits the Plant Manager to exercise all remedies available under applicable law to collect an unpaid balance, including the costs of collection thereof, from a Delinquent Plant User. Upon the collection of such balance and costs from a Delinquent Plant User, the Plant Manager must apply a credit to the balances invoiced to the Remaining Plant Users in the same proportion the related costs were previously assessed against the same by the Plant Manager.

Operating Budget

The User Contract requires the Plant Manager to prepare an annual operating budget for the Plant for each fiscal year of the Corporation based on estimates of steam and chilled water provided to the Plant Manager by each of the Plant Users. Although the annual operating budget is used by the Corporation and the Commission for purposes of managing and operating the Plant, the volume of steam and/or chilled

water estimated to be required by each Plant User and incorporated therein does not establish a minimum purchasing volume for each Plant User. Regardless of the volume of steam and chilled water incorporated in the annual operating budget, the User Contract requires the Plant Users to only purchase the amount of steam and chilled water actually needed to heat and cool their Plant Facilities.

Admission of New Plant Users as Parties to the User Contract

The User Contract permits other entities to become parties to the User Contract and to participate on an equal and parity basis therein (each, a "New Plant User") if (i) in the opinion of the Plant Manager and the Corporation's Board of Directors, the addition of a New Plant User would be beneficial to the overall function of the Plant, (ii) the proposed New Plant User is an organization organized and operating for public or nonprofit purposes, (iii) the Plant has sufficient capacity to satisfy the increased demand caused by the admission of the New Plant User, (iv) the revenues to be received by the Corporation and the Commission as a result of the addition of the New Plant User will be sufficient to pay the debt service on any additional Plant Bonds issued to finance improvements made to the Plant to create such increased capacity, (v) the existing parties to the User Contract and the New Plant User, collectively, execute an amendment to the User Contract acknowledging the addition of the New Plant User and binding the New Plant User to the terms and conditions of the User Contract and (vi) the Corporation obtains an opinion of counsel, recognized favorably on a national basis in such matters, that the interest on any tax-exempt Plant Bonds will not become taxable for purposes of federal or Commonwealth income tax purposes as a result of the addition of the New Plant User.

Issuance of Additional Plant Bonds

The Corporation may issue additional Plant Bonds ("Additional Plant Bonds") only upon the prior approval of the Board of Directors of the Corporation and the prior written consent of all Plant Users, the latter of which shall be obtained before any such Additional Plant Bond is sold. The Corporation may effect the issuance of refunding bonds with the prior approval of the Board of Directors of the Corporation but without the prior written consent of any Plant User if, (A) for refunded and refunding revenue bonds having the same general dates of maturities, the aggregate debt service owed by the Corporation for the refunding bonds is less than the aggregate debt service of the refunded bonds, (B) for refundings of revenue bonds with bullet maturities, the average annual debt service owed by the Corporation for the refunding bonds as a result of such refunding is equal to or less than the average aggregate debt service owed by the Corporation for the refunded bonds during the previous three years, or (C) the refunding results in a present value debt service savings for the Corporation. For the issuance of any other refunding bond, the Corporation must obtain the prior written approval of all Plant Users before such refunding bond is sold to any purchaser thereof.

The User Contract permits the Corporation and the Commission to request a governmental issuer to issue additional Plant Bonds for the purpose of refunding one or more outstanding series of Plant Bonds without obtaining the prior approval of each then current Plant User so long as such refunding is reasonably expected to decrease the remaining debt service and other remaining financing costs that would otherwise be paid by the Corporation and the Commission to such an extent as to cause the refunding to be economically desirable.

Upon the satisfaction of the requirements set forth above and upon the issuance of such Additional Plant Bonds, the debt service required to pay principal of, premium, if any, interest on and all related expenses incurred by the Corporation and the Commission shall constitute Operating Costs of the Plant under the User Contract.

Additional Plant Bonds which are issued pursuant to the provisions discussed in the preceding paragraphs will be issued on a parity as to payment and security in all respects with the Series 2012A Bonds, the Series 2016 Bonds, the Bonds and any other Additional Plant Bonds then outstanding and constituting parity bonds pursuant to the User Contract.

Impact of Casualty, Condemnation or Economic Unfeasibility on the Plant Users' Obligations Under the User Contract

Notwithstanding any other provision of the User Contract, if a Plant User incurs a Plant Casualty Event, Plant Condemnation Event or Plant Event of Economic Unfeasibility (each defined below) with respect to a Plant Facility and desires to stop purchasing steam or chilled water from the Corporation and the Commission with respect to such Plant Facility, the User Contract permits the Plant User to provide the Plant Manager written notice of such Plant Casualty Event, Plant Condemnation Event or Plant Event of Economic Unfeasibility and of the Plant User's desire to terminate its purchase of steam or chilled water with respect to such Plant Facility under the User Contract. Within sixty (60) days of the date of such notice, the Plant User shall pay to the Plant Manager on behalf of the Corporation and the Commission a termination fee equal to the product of the Share of Operating Expenses (as defined below) and the Remaining Multiplier (as defined below). Upon the payment of such fee in lawful money of the United States of America in immediately available funds, the User Contract provides that the Plant User's obligation to purchase steam and chilled water with respect to the Plant Facility shall terminate.

For purposes of the foregoing paragraph, (i) "Plant Casualty Event" means a casualty loss incurred by a Plant User with respect to a Plant Facility to such an extent as to make repairing or rebuilding the Plant Facility economically unfeasible after the application of insurance proceeds received by the Plant User as a result of such casualty, (ii) "Plant Condemnation Event" means the condemnation of a Plant Facility by an authorized governmental authority to such an extent as to make repairing or rebuilding the Plant Facility economically unfeasible after the application of insurance proceeds received by the Plant User as a result of such condemnation, (iii) "Plant Event of Economic Unfeasibility" means a change in the operations or industry of a Plant User that renders the Plant User's operation of a Plant Facility economically unfeasible, (iv) "Number of Years Elapsed" means the number of calendar years elapsed after the effective date of the Second Supplemental User Contract and before the calendar year of a Plant Casualty Event, Plant Condemnation Event or Plant Event of Economic Unfeasibility, as applicable, (v) "Number of Years Remaining" means the number of calendar years after the calendar year in which the effective date of the Second Supplemental User Contract occurred and including the calendar year in which the last maturity date of all Plant Bonds then outstanding occurs, (vi) "Share of Operating Expenses" equals the dollar amount of a Plant User's total share of the Operating Costs of the Plant for the immediately preceding calendar year attributable to a Plant Facility, and (vii) "Remaining Multiplier" means the greater of (a) the Number of Years Remaining less the Number of Years Elapsed or (b) zero.

For each fiscal year of the Corporation that occurs during the time period represented by a Remaining Multiplier used to calculate a termination fee under the User Contract, the Plant Manager shall use a portion of the termination fee to pay Operating Costs of the Plant for such fiscal year in an amount equal to the Share of Operating Expenses determined with respect to such termination payment. The Plant Manager shall allocate such Share of Operating Expenses among the calendar months occurring during such fiscal year on a pro-rata basis and shall allocate any remaining Operating Costs of the Plant for the applicable Calculation Period among the Plant Users using the procedure described under the heading "THE USER CONTRACT - Calculation and Allocation of the Operating Costs of the Plant Among the Plant Users".

Notwithstanding the foregoing, the User Contract provides that it shall not be a basis for a Plant User being released from its obligations hereunder that there is an alternative source available to such

Plant User for obtaining steam and chilled water, which such Plant User considers more advantageous because of cost savings or other benefits.

Termination of the User Contract

The Issuer agrees in the User Contract that upon full retirement of all of its Plant Bonds (including all Plant Bonds hereafter issued to refund or refinance such Plant Bonds), all of the Issuer's obligations shall cease thereunder, and the Corporation shall assume and carry out the obligations theretofore imposed upon the Issuer to provide continuing and adequate supply of steam and chilled water to the Plant Users.

The User Contract does not contain a stated term, but instead states that the parties' obligations shall continue so long as any Plant Bonds remain outstanding. Upon the payment and discharge of all Plant Bonds, all of the rights and responsibilities of the Issuer and the Commission under the User Contract shall terminate and the Corporation shall assume all of the Issuer and the Commission's obligations regarding the operation and management of the Plant thereunder.

THE BONDS

General

The Bonds will be dated their date of initial issuance and delivery and will bear interest from such date payable on May 1 and November 1, commencing November 1, 2020, at the rates, and will mature on the dates and in the amounts, set forth on the inside cover page of this Official Statement.

The Bonds will be issued as fully registered bonds without coupons and will be available initially in book-entry form only registered in the name of Cede & Co., as nominee for The Depository Trust Company ("DTC"), New York, New York, in denominations of $5,000 and integral multiples of $5,000. Purchasers of beneficial ownership interests in the Bonds (the "Beneficial Owners") will not receive certificates representing their interests. Transfers of Bonds and payments of principal or redemption price of and interest on the Bonds will be affected as described below. If the book-entry system is discontinued, bond certificates will be delivered as described in the Indenture and the Beneficial Owners will become registered owners of the Bonds. So long as Cede & Co., as nominee for DTC, is the sole Holder, references in this Official Statement to the "Holder" mean Cede & Co. and do not mean the Beneficial Owners.

Special and Limited Obligations

The Bonds will be special and limited obligations of the Issuer as more fully described in "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS; ADDITIONAL BONDS – Special and Limited Obligations."

Book-Entry Only System

The description which follows of the procedures and record-keeping with respect to beneficial ownership interests in the Bonds, payments of principal, premium, if any, and interest on the Bonds to DTC, its nominee, the Participants (defined below), or the Beneficial Owners (defined below), confirmation and transfer of beneficial ownership interests in the Bonds and other bond-related transactions by and between DTC, Participants and Beneficial Owners is based solely on information furnished by DTC.

The Bonds initially will be issued solely in book-entry form to be held in the book-entry-only system maintained by The Depository Trust Company ("DTC"), New York, New York. So long as such book-entry system is used, only DTC will receive or have the right to receive physical delivery of Bonds and, except as otherwise provided herein with respect to Beneficial Owners of beneficial ownership interests, each actual purchaser of each Bond (a "Beneficial Owner") will not be or be considered to be, and will not have any rights as, owner or holder of the Bonds under the Indenture.

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

DTC will act as securities depository for the Bonds. The Securities 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 maturity of the Bonds in the respective aggregate principal amounts thereof and will be deposited with DTC.

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

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

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be

requested by an authorized representative of DTC. The deposit of Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not affect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

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

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

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

Redemption proceeds, distributions, and interest payments on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Trustee, 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 Bonds held for the accounts of customers in bearer form or registered in "street name" and will be the responsibility of such Participant and not of DTC or its nominee, the Trustee or the Issuer, subject to any statutory or regulatory requirements as may be in effect from time to tune. Payment of redemption proceeds, distributions, and interest payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Issuer or the Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

A Beneficial Owner shall give notice to elect to have its Bonds purchased or tendered, through its Participant, to the Trustee and shall effect delivery of such Bonds by causing the Direct Participant to transfer the Participant's interest in the Bonds, on DTC's records, to the Trustee. The requirement for physical delivery of Bonds in connection with an optional tender or a mandatory purchase will be deemed satisfied when the ownership rights in the Bonds are transferred by Direct Participants on DTC's records and followed by a book-entry credit of tendered Bonds to the Trustee's DTC account.

NEITHER THE ISSUER NOR THE TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO ANY DIRECT PARTICIPANT, INDIRECT PARTICIPANT OR ANY

BENEFICIAL OWNER OR ANY OTHER PERSON NOT SHOWN ON THE REGISTRATION BOOKS OF THE TRUSTEE AS BEING A HOLDER WITH RESPECT TO: (1) THE BONDS; (2) THE ACCURACY OF ANY RECORDS MAINTAINED BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT; (3) THE PAYMENT BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY AMOUNT DUE TO ANY BENEFICIAL OWNER IN RESPECT OF THE PURCHASE PRICE OF TENDERED BONDS OR THE PRINCIPAL OR REDEMPTION PRICE OF OR INTEREST ON THE BONDS; (4) THE DELIVERY BY ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY NOTICE TO ANY BENEFICIAL OWNER WHICH IS REQUIRED OR PERMITTED UNDER THE TERMS OF THE ORDINANCE TO BE GIVEN TO HOLDERS; (5) THE SELECTION OF THE BENEFICIAL OWNERS TO RECEIVE PAYMENT IN THE EVENT OF ANY PARTIAL REDEMPTION OF THE BONDS; OR (6) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC AS HOLDER.

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

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

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

DTC may determine to discontinue providing its service as securities depository with respect to the Bonds at any time by giving notice to the Issuer and discharging its responsibilities with respect thereto under applicable law. In such event, the Ordinance provides for issuance of fully registered Bonds ("Replacement Bonds") directly to the Beneficial Owners of Bonds, other than DTC or its nominee, only in the event that DTC resigns or is removed as the securities depository for the Bonds. Upon the occurrence of this event, the Issuer and the Trustee may appoint another qualified depository. If the Issuer and the Trustee fail to appoint a successor depository, the Bonds shall be withdrawn from DTC and issued in fully registered form, whereupon the Issuer shall execute and the Trustee, as authenticating agent, shall authenticate and deliver Replacement Bonds in the denomination of $5,000 or integral multiples thereof. The Corporation will pay for all costs and expenses of printing, executing and authenticating the Replacement Bonds.

THE INFORMATION IN THIS SECTION CONCERNING DTC AND DTC'S BOOK-ENTRY SYSTEM HAS BEEN OBTAINED FROM SOURCES THAT THE CORPORATION BELIEVES TO BE RELIABLE, BUT THE CORPORATION TAKES NO RESPONSIBILITY FOR THE ACCURACY THEREOF.

Redemption Provisions

The Bonds are subject to redemption prior to maturity only as follows.

Optional Redemption. The Bonds maturing on and after May 1, 20__* are subject to redemption prior to maturity, in whole or in part from any source of funds, at the option of the Issuer on any day on and after May 1, 20__* at the redemption price of par plus accrued interest to the date of redemption.

Extraordinary Optional Redemption of Bonds. The Corporation shall have, subject to the conditions hereinafter imposed, the option to direct an extraordinary optional redemption of the Bonds, at the principal amount of the Bonds to be redeemed, without premium, plus accrued but unpaid interest on the Bonds to the date of redemption upon the occurrence of any of the following events (each an "Extraordinary Optional Redemption Event"):

Casualty Loss. The Plant shall have been damaged or destroyed to such an extent that the Plant reasonably cannot be expected to be restored, within a period of three months, to the condition thereof immediately preceding such damage or destruction or normal use and operation of the Plant is reasonably expected to be prevented for a period of three consecutive months.

Eminent Domain. Title to, or the temporary use of, all or a significant part of the Plant shall have been taken under the exercise of the power of eminent domain to such extent that the Plant cannot reasonably be expected to be restored within a period of three months to a condition of usefulness comparable to that existing before the taking or as a result of the taking and normal use and operation of the Plant reasonably is expected to be prevented for a period of three consecutive months. If title to or the temporary use of a portion of the Plant is taken under the exercise of power of eminent domain, even if the taking is not of such nature as to permit the exercise of the extraordinary optional redemption, the Corporation may direct the redemption, at a redemption price of 100% of the principal amount thereof, plus accrued interest to the date of redemption, of that part of the outstanding principal balance of the Bonds as may be payable from the net proceeds received in the eminent domain proceeding; provided, that the Corporation shall furnish to the Issuer and the Trustee a certificate of a licensed engineer stating that the property comprising the part of the Plant taken is not essential to continued operations of the Plant in the manner existing before that taking, the Plant has been restored to a condition substantially equivalent to that existing before the taking, or other improvements have been acquired or made which are suitable for the continued operation of the Plant.

Change in Law. As a result of any changes in the Constitution of the Commonwealth of Kentucky, the Constitution of the United States of America, or state or federal laws, or a result of legislative or administrative action or by final decree, judgment or order of any court or administrative body, the Indenture or the Loan Agreement shall have become void or unenforceable or impossible of performance in accordance with its intent and purpose, or if unreasonable burdens or excessive liabilities shall have been imposed with respect to the Plant or the operation thereof, as determined by the Corporation in good faith.

Change in Economics. Changes in the economic availability of raw materials, operating supplies, energy sources or supplies, or facilities necessary for the operation of the Plant shall have occurred or technological or other changes shall have occurred, which the Corporation cannot reasonably overcome or control, and which, in the Corporation's reasonable judgment, render the operation of the Plant uneconomic.

To exercise an extraordinary optional redemption of Bonds, the Corporation, within ninety (90) days following the event authorizing the exercise of that option or at any time during the continuation of the change in economic condition referred to above, shall give notice to the Issuer and the Trustee specifying the date of redemption, which date shall not be more than ninety (90) days from the date that

notice is mailed, and shall make arrangements satisfactory to the Trustee for the giving of the required notice of redemption.

Mandatory Sinking Fund Redemption. The Bonds maturing on May 1, 20__ are subject to mandatory sinking fund redemption in part at a redemption price of 100% of the principal amount of the Bonds to be redeemed plus accrued interest to the redemption date, on May 1 of the years and in the amounts set forth below:

Redemption Date	Principal Amount*

(1) final maturity

The Bonds maturing on May 1, 20__ are subject to mandatory sinking fund redemption in part at a redemption price of 100% of the principal amount of the Bonds to be redeemed plus accrued interest to the redemption date, on May 1 of the years and in the amounts set forth below:

Redemption Date	Principal Amount*

(1) final maturity

The principal amount of the Bonds, otherwise required to be redeemed may be reduced by the principal amount of such Bonds that have been delivered to the Trustee in lieu of cash payments under the Loan Agreement or purchased by the Trustee out of money in the Sinking Accounts established under the Indenture to the extent such Bonds have not previously been applied as a credit against any sinking fund installment. In no event may any Bond be purchased in lieu of redemption unless such Bond is presented to the Trustee for cancellation and the Trustee cancels such Bond upon receipt.

Payment of Redemption Price and Accrued Interest. If (i) unconditional notice of redemption has been duly given or duly waived by the holders of the Bonds called for redemption or (ii) conditional notice of redemption has been so given or waived and the redemption moneys have been duly deposited with the Trustee, then in either case the Bonds or portions thereof called for redemption shall be payable on the redemption date at the applicable redemption price plus accrued interest, if any, to the redemption date. Payment of the redemption price together with accrued interest shall be made by the Trustee to or upon the order of the holders of the Bonds called for redemption upon surrender of such Bonds. The redemption price, including accrued interest, the expenses of giving notice and any other expense of redemption shall be paid from funds provided to the Trustee by the Corporation for that purpose, as and to the extent provided in the Indenture.

Selection of Bonds for Redemption. If less than all of the Bonds of the same maturity of a series are to be redeemed upon any redemption of Bonds hereunder, the Trustee shall select the Bonds of such maturity to be redeemed by lot in such manner as the Trustee may determine. In making such selection, the Trustee shall treat each Bond as representing that number of Bonds of the lowest authorized

denomination as is obtained by dividing the principal amount of such Bond by such denomination. Notwithstanding the foregoing, so long as any Bonds are registered in the name of a securities depository or its nominee, the redemption of such Bonds (or portions thereof) shall be made in a manner consistent with the practice of such securities depository.

Notice of Redemption. Excluding a mandatory sinking fund redemption, Bonds shall be redeemed only by written notice (which may be for a conditional call) from the Corporation, on behalf of the Issuer, to the Trustee. That notice shall specify the redemption date and the principal amount of each maturity and series of Bonds to be redeemed, and shall be given at least forty-five (45) days before the redemption date or such shorter period as shall be acceptable to the Trustee. No notice is required to be given by the Corporation or the Issuer to the Trustee with respect to a mandatory Sinking Account redemption.

The Trustee shall mail, via first class mail, notice of any redemption of Bonds not less than thirty (30) nor more than sixty (60) days before the date set for redemption (except in the case of an Extraordinary Mandatory Redemption Event, in which case such notice shall be given at least five (5) days and not more than fifteen (15) days before the date fixed for redemption). If less than all such Bonds are to be redeemed, the Bonds to be redeemed shall be identified by reference to the issue and series designation, date of issue, serial numbers and maturity dates. The notice shall be mailed to each holder of a Bond to be so redeemed at the address shown on the Bond Register, but failure to receive such notice or any defect therein shall not be a condition precedent to, nor shall such failure affect the validity of the proceedings for, the redemption of any Bond.

If at the time of mailing of notice of any optional redemption there shall not have been deposited with the Trustee moneys in an amount sufficient to redeem all the Bonds called for redemption, such notice shall state that it is conditional in that it is subject to the deposit of such moneys with the Trustee not later than the redemption date, and such notice shall be of no effect unless such moneys are so deposited.

Effect of Redemption. If the Corporation makes available to the Trustee cash and noncallable Government Obligations that, when due, will be sufficient together with the income to be earned thereon to pay the principal or redemption price of and interest on any Bonds at maturity or on a date irrevocably fixed for their redemption, then interest on such Bonds shall cease to accrue on such maturity or redemption date, and from the date of such deposit the holders of such Bonds shall be restricted to the funds so deposited as provided in the Indenture.

PLAN OF FINANCE

The proceeds of the Bonds, after payment of costs of issuance of the Bonds, will be loaned to the Corporation under the Loan agreement and will used to pay all or a portion of the costs of converting the Corporation's Plant to a wholly-natural gas powered steam generating facility, including without limitation the acquisition, construction, installation, and equipping of (i) three new, higher capacity boilers designed to combust natural gas and fuel oil in replacement of the existing boilers identified as Boilers B-1, B-2, and B-3, (ii) new boiler control systems, (iii) a new fuel oil storage and supply system for the steam generating facilities of the Plant, and (iv) other real property improvements, machinery, and equipment necessary and related to any of the foregoing (the "Project).

ESTIMATED SOURCES AND USES OF FUNDS

Sources of Funds:

Par Amount of the Bonds	$_____
Original Issue [Discount] [Premium]	$_____
Total Sources	$_____
Uses of Funds:	
Deposit to Construction Fund	$_____
Costs of Issuance*	$_____
Total Uses	$_____

*Underwriter's discount, fees of the Issuer and the Trustee, rating agency fees, attorneys' fees, legal fees and expenses, printing costs, and other miscellaneous expenses related to the issuance of the Bonds.

SECURITY AND SOURCES OF PAYMENT FOR THE BONDS; ADDITIONAL BONDS

The Loan Agreement

The Bonds will be special and limited obligations of the Issuer payable solely from the money and investments in funds held by the Trustee under the Indenture and from amounts paid by the Corporation pursuant to the Loan Agreement. Under the Loan Agreement, the Corporation will have an unconditional obligation to provide for the repayment of the loans evidenced by the Loan Agreement at such times and in such amounts so as to provide for the payment of the principal or redemption price of and interest on the Bonds when due.

To secure the payment and performance of its obligations under the Loan Agreement, the Corporation pledges and grants to the Trustee, as assignee of the Issuer, a first priority lien on and security interest in the gross income and revenues of the Plant on a parity with the Series 2012A Bonds, the Series 2016 Bonds, the Bonds and additional Plant Bonds that may be issued in the future under the provisions of the Indenture and the User Contract. The Corporation does not anticipate having funds, other than the gross income and revenues derived from the Plant, available for the payment of the principal of, premium, if any, and interest on the Bonds. The obligations of the Plant Users under the User Contract are not a guaranty of payment of the principal of, premium, if any, and interest on the Bonds. The Loan Agreement will remain in full force and effect until such time as the principal of, premium, if any, and interest on the Bonds and any other amounts owed under the Loan Agreement have been fully paid or provision for such payment has been made as required by the Indenture.

The Issuer will assign to the Trustee, for the benefit of Holders, all of the Issuer's rights under the Loan Agreement (except for rights to certain notices and payments relating to fees, indemnification and administrative expenses), including the right to receive payments with respect to the Loan Agreement.

Except for Permitted Encumbrances and as described under the heading "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS; ADDITIONAL BONDS - Plant Mortgage" herein, the Corporation will not mortgage or grant a security interest in the Plant, unless such mortgage or security interest also secures *pari passu* the Plant Bonds.

Plant Mortgage

To further secure the obligations of the Corporation under the Loan Agreement the Corporation has granted a first mortgage lien on the Plant pursuant to the Amended And Restated Mortgage And Security Agreement dated as of July 1, 2020 by and between the Corporation and the Trustee (the "Plant Mortgage"), which amended and restated a Mortgage and Security Agreement dated as of May 29, 2002 by and between the Corporation and the Trustee, as amended and restated by the Amended and

Supplemental Mortgage and Security Agreement dated as of August 31, 2009, as amended and restated by the Amended and Restated Mortgage and Security Agreement dated as of December 1, 2011, as amended and restated by the Amended and Restated Mortgage and Security Agreement dated as of November 1, 2012, as amended and restated by the Amended and Restated Mortgage and Security Agreement dated as of May 1, 2014 and as amended and restated by the Amended and Restated Mortgage and Security Agreement dated as of September 1, 2016. In addition to securing the Bonds, the Plant Mortgage also serves to further secure the obligations of the Corporation under the Loan Agreement securing the Series 2012A Bonds, Series 2016 Bonds and the Bonds and provides that it shall further secure the obligations of the Corporation under any additional Loan Agreement entered into between the Corporation and the Trustee with respect to any Additional Plant Bonds issued pursuant to the requirements of the Indenture, the bond trust indentures securing the Series 2012A Bonds and the Series 2016 Bonds and the User Contract. See "USER CONTRACT - Issuance of Additional Plant Bonds" herein for a discussion of the requirements governing the issuance of Additional Plant Bonds pursuant to the User Contract.

Additional Bonds

The Indenture permits the issuance of Additional Plant Bonds ranking on a parity as to security and source of payment with the Series 2012A Bonds, Series 2016 Bonds and the Bonds for the purposes and subject to the conditions and restrictions contained in the User Contract, as amended or supplemented from time to time. See "USER CONTRACT - Issuance of Additional Plant Bonds" herein for a discussion of the requirements governing the issuance of Additional Plant Bonds pursuant to the User Contract.

Defeasance

When the interest on, and the principal or redemption price of, all Bonds have been paid, or there has been deposited with the Trustee an amount of cash or non-callable Government Obligations sufficient to pay when due all such principal or redemption price and interest, then all right, title and interest of the Trustee in the security provided by the Indenture shall cease and the collateral thereunder shall be released.

Special and Limited Obligations

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE ISSUER AND DO NOT CONSTITUTE A DEBT, GENERAL OBLIGATION, PLEDGE OF FAITH AND CREDIT OR LIABILITY OF THE ISSUER, THE COMMONWEALTH OF KENTUCKY OR OF ANY AGENCY OR POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE CONSTITUTION OR STATUTES OF THE COMMONWEALTH OF KENTUCKY, AND THE BONDS ARE PAYABLE SOLELY FROM THE FUNDS AND PROPERTY PLEDGED THEREFOR. NEITHER THE CREDIT NOR THE TAXING POWER OF THE ISSUER, THE COMMONWEALTH OF KENTUCKY OR ANY AGENCY OR POLITICAL SUBDIVISION THEREOF IS PLEDGED TO THE PAYMENT OF THE PRINCIPAL OF, PREMIUM, IF ANY, OR INTEREST ON THE BONDS.

BONDHOLDERS'RISKS

[TO BE UDPATED]

The discussion herein of risks to the owners of the Bonds is not intended as dispositive, comprehensive or definitive, but rather is to summarize certain matters which could affect payment on the Bonds. Other sections of this Official Statement, as cited herein, should be referred to for a more detailed

description of risks described in this section, which descriptions are qualified by reference to any documents discussed therein. Copies of all such documents are available for inspection at the designated corporate trust office of the Trustee.

General

Except as noted herein, the Bonds will be payable solely from the payments on the Loan Agreement to be made by the Corporation, which are entirely dependent on payments received under the User Contract from the Plant Users.

No representation or assurance can be made that revenues will be realized by the Corporation in amounts sufficient to pay the principal and redemption price of, premium, if any, and interest on the Bonds. The realization of future revenues and the expenses of the Corporation are dependent upon, among other things, the capabilities of the management of the Corporation ("Management") and future economic and other conditions which are unpredictable and which may affect revenues and, in turn, the ability to pay such principal and redemption price, premium, if any, and interest. The Corporation cannot assure that the revenues of the Corporation or the utilization of the Plant will not decrease.

None of the provisions of the Indenture or the Loan Agreement that have been heretofore described nor any other provisions, covenants, terms and conditions of the Indenture or the Loan Agreement will afford the Trustee any assurance that the principal and interest owing on the Bonds will be paid as and when due, if the financial condition of the Corporation, or one or more of the Plant Users deteriorates to a point where the Corporation or such Plant User or Users are unable to pay their debts as they come due or otherwise become insolvent.

The practical realization of any rights upon any default under the Loan Agreement and the Indenture will depend upon the exercise of various remedies specified in these instruments, as restricted by federal and state laws. The federal bankruptcy laws may have an adverse effect on the ability of the Trustee and the owners of the Bonds to enforce their respective claims under the Loan Agreement and the Indenture.

The operations of education and health care organizations and the ownership and organization of educational and health care facilities and services, including those of the Corporation and the Plant Users, have been subject to increasing scrutiny by federal, state and local governmental agencies. In response to perceived abuses and actual violations, these agencies have increased their audit and enforcement activities, and federal and state legislation has been considered or enacted providing for or expanding existing civil and criminal penalties against certain activities. In addition, federal, state and local agencies have increased their scrutiny of transactions involving not-for-profit, tax-exempt organizations and are focusing in particular upon limitations on the use of charitable assets and revenues.

The User Contract contains few limitations or conditions upon transactions involving the Plant Users. A governmental agency may determine that a transaction may have violated applicable laws and may proceed to enjoin the transaction or impose civil or criminal penalties, notwithstanding the fact that the transaction may have been permitted, or not prohibited, by the User Contract. Violations of these laws may have a material adverse effect on the operations and financial condition of the Corporation and the Plant Users.

Certain of the factors that could affect the Bonds and the future financial condition of the Corporation and the Plants Users are described below. This discussion of risk factors is not, and is not intended to be, exhaustive. Neither the Underwriter nor the Issuer has made any independent investigation

of the extent to which any of these factors could have an adverse impact on the revenues of the Corporation and the Plant Users.

Enforceability of the User Contract

The practical realization of any rights upon any default by the Issuer, the Commission, the Corporation or a default by a Plant User under the User Contract will depend upon the exercise of various remedies specified in such instruments, as restricted by federal and state laws. The federal bankruptcy laws may have an adverse effect on the ability of the Trustee and the owners of the Bonds to enforce their claims granted by the Indenture or the User Contract. The obligations of Norton, UofL Hospital and UofL Health (collectively, the "Health Care Users") under the User Contract will be limited to the same extent as the obligations of debtors by bankruptcy, reorganization, insolvency, fraudulent conveyance, moratorium, or other similar laws affecting the enforcement of creditors' rights and by the availability of equitable remedies. Additionally, the obligations of the University and KCTCS under the User Contract are subject to the appropriation of funds by the Commonwealth of Kentucky to pay the operating expenses of the University and KCTCS.

The remedies available to the Trustee, the Issuer or the owners of the Bonds upon events of default under the Indenture or the User Contract can be dependent upon judicial actions which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, the bankruptcy laws, the remedies provided in the Indenture and the User Contract may not be readily available or may be limited.

In addition, there exists common law authority and authority under Kentucky statutes for the power of courts to terminate the existence of a nonprofit corporation or to 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 action may arise on a court's own motion or through a petition of Kentucky's Attorney General or other persons pursuant to the power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

Impact of Disruptions in the Credit Markets and General Economic Factors

The domestic and international financial crises of recent years has had, and may continue to have, negative repercussions upon the global, national and Kentucky economies, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, increase in interest rates, reduced business activity, increased consumer bankruptcies and increased business failures and bankruptcies. The Federal Reserve Board and other agencies of the federal government and foreign governments took action designed to enhance liquidity, improve the performance and efficiency of credit markets and generally stabilize securities markets.

As the domestic and international financial crises have ebbed, the Federal Reserve Board has reversed some of its earlier actions designed to enhance liquidity and stability in financial markets, such as scaling back its mortgage-backed bond buying program. In addition, in response to the disruption in the markets caused by the financial crises, in 2010 Congress enacted and the President approved the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"). Additional legislation is under active consideration by Congress and regulatory action is being considered by various federal agencies, the Federal Reserve Board and foreign governments which legislation is intended to increase the regulation of financial institutions and domestic and global credit and securities markets. It is widely expected that one consequence of these actions could be to generally raise the level of short-term and long-term interest rates. In response to statutory or regulatory efforts to increase capital reserve

requirements on banks and other financial institutions, such banks and financial institutions may reduce lending, or may discontinue providing certain financial products such as letters of credit. The Federal Reserve Board is also widely expected to take action to increase short-term interest rates in the near future, although the precise timing and amount of any such increase(s) cannot be predicted. The effects of these legislative regulatory and other governmental actions, including the Dodd-Frank Act, upon the Corporation and the Plant Users and, in particular, their access to capital markets and their investment portfolios, cannot be predicted.

The financial crises have had a particularly acute impact upon the financial sector in recent years, and have caused many banks and other financial institutions to seek additional capital, to merge, and in some cases, to fail. A continued weakening or delayed recovery of the economy could have a material adverse effect upon the Corporation and the Plant Users.

The Plant Users have significant holdings in a broad range of investments. Market fluctuations have affected and will continue to affect materially the value of those investments and those fluctuations may be and historically have been material. Investment income (including both realized and unrealized gains on investments) can contribute significantly to the Corporation's and Plant Users' financial results. Future market fluctuations may have a material positive or negative effect on the Corporation's and Plant Users' financial results.

For many years, health care providers have been under increasing economic pressure from various third-party payors, both governmental (particularly Medicare and Medicaid) and private (e.g., health insurance companies). Shifts in third-party payor policies and the need for providers to adapt to changing and complex payment arrangements have had and will continue to have a significant impact upon the economic performance of some of the Plant Users. The financial condition of the Corporation and Plant Users is also threatened by particular pressures resulting from the current economic environment and the recent financial crisis, including risks of: increased inflation; increased pressure on the federal government to decrease Medicare funding, on the federal and state governments to decrease Medicaid funding and on employers to reduce healthcare coverage and increase deductibles; increased unemployment, uncompensated care and bad debt; and decrease in return on investments. These developments may have a material adverse impact on the Corporation and some of the Plant Users.

Potential Effects of Bankruptcy

If the Corporation were to file a petition for relief under the federal Bankruptcy Code, the filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against the Corporation and its property. If the bankruptcy court so ordered, the Corporation's property could be used for the benefit of the Corporation, despite the claims of its creditors (including the Trustee).

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

Tax Exemption for Not-For-Profit Corporations

Loss of tax-exempt status by one or more of the Health Care Users could result in loss of the tax exemption of tax-exempt debt issued for the benefit of the Health Care Users. Such an event also could have material adverse consequences on the financial condition of the Health Care Users. Management is not aware of any transactions or activities currently ongoing that are likely to result in the revocation of the tax-exempt status of any of the Health Care Users.

The maintenance by a Health Care User of its status as an organization described in Section 501(c)(3) of the Code is contingent upon compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and educational purposes and their avoidance of transactions that may cause their assets to inure to the benefit of private individuals. The IRS' interpretation of and position on these rules as they affect the organization and operation of health care organizations (for example, with respect to providing charity care, joint ventures, physician and executive compensation, physician recruitment and retention, etc.) is constantly evolving. The IRS reserves the power to, and in fact occasionally does, alter or reverse its positions concerning tax-exemption issues, even concerning long-held positions upon which tax-exempt health care organizations have relied.

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

Section 4958 of the Code imposes excise taxes on "excess benefit transactions" between "disqualified persons" and tax-exempt organizations such as the Health Care Users. According to the legislative history and regulations associated with Section 4958, these excise taxes may be imposed by the IRS either in lieu of or in addition to revocation of exemption. The legislation is potentially favorable to taxpayers because it provides the IRS with a punitive option short of revocation of exempt status to deal with incidents of private inurement. However, the standards for tax-exemption have not been changed, including the requirement that no part of the net earnings of an exempt entity inure to the benefit of any private individual. Consequently, although the IRS has only infrequently revoked the tax exemption of nonprofit health care corporations in the past, the risk of revocation remains and there can be no assurance that the IRS will not direct enforcement activities against a Health Care User.

In 1990, the Employee Plans and Exempt Organizations Division of the IRS expanded the Coordinated Examination Program (referred to as "CEP") of the IRS to tax-exempt health care organizations. CEP audits are conducted by teams of revenue agents. The CEP audit teams consider a wide range of possible issues, including the community benefit standard, private inurement and private benefit, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, tax-exempt bond financing, political contributions and unrelated business income.

A Health Care User could be audited by the IRS. Because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, a CEP audit could result in additional taxes, interest and penalties. A CEP audit could ultimately affect the tax-exempt status of a Health Care User.

In 2004, the IRS announced an enforcement effort (referred to as the "Tax Exempt Compensation Enforcement Project") to identify and curb abuses by charities that pay excessive compensation and benefits to officers and other insiders. The IRS implemented this new effort by contacting nearly 2,000 charities about their compensation practices and procedures. The project's goals were to address the compensation of specific individuals, influence how organizations set compensation, and learn about existing practices. The inquiry involved both large and small charities, and also included the investigation of insider transactions, including loans, leases and other transfers of income and assets to officers and insiders. As a result of such inquiry, the IRS could seek to use the entire range of its enforcement activities, including penalties for filing incorrect information, intermediate sanctions, and revocation of the organization's exempt status.

Loss of tax-exempt status by a Health Care User could have material adverse consequences on the future financial condition and results of its operations. Additionally, the loss of federal tax-exempt status by a Health Care User could adversely affect its access to future tax-exempt financing.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Act") places additional requirements on tax-exempt hospitals for them to receive and maintain their Section 501(c)(3) federal tax-exempt status. One significant new requirement is that tax-exempt hospitals must perform a community health needs assessment every three years and develop an implementation strategy to meet the identified needs. Any tax-exempt hospital that fails to satisfy the community health needs assessment requirement for any taxable year will be subject to an excise tax penalty of $50,000. Furthermore, the United States Secretary of the Treasury or that individual's delegate is to review the community benefit activities of each tax-exempt hospital at least every three years, as well as 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. Another major element of the Health Care Reform Act relating to tax-exempt status of hospitals involves charges. A hospital must limit the amounts charged for emergency room or other medically necessary care provided to patients eligible for assistance under the hospital's financial assistance policy to no more than the amounts generally billed to patients who have insurance covering such care. In other words, hospitals cannot charge persons eligible for financial assistance higher rates than the amounts generally billed to patients who have insurance covering such care. The Health Care Reform Act also requires that tax-exempt hospitals have a written financial assistance policy in place. Finally, the Health Care Reform Act prohibits a hospital from engaging in extraordinary collection actions (which may include, among other things, a restriction on filing suit) before it has made reasonable efforts to determine whether the subject individual is eligible for financial assistance. The 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. On September 24, 2012, the IRS issued proposed regulations interpreting various portions of these new requirements, on which taxpayers may rely until final or temporary regulations are issued. On April 5, 2013, the IRS proposed regulations regarding the community health needs assessment. As such, the interpretation of these new requirements is subject to change as the IRS releases further guidance and eventually final regulations. However, on January 13, 2014, the IRS confirmed that Section 501(c)(3) hospital organizations can rely on the proposed regulations under Section 501(r) pending the publication of final regulations or other applicable guidance.

On December 29, 2014, the IRS issued a final rule focusing on these requirements under the Health Care Reform Act. The rule finalizes proposed rules issued in June 2012 regarding financial assistance policies, as well as proposed rules issued in April 2013 regarding community needs health assessments. Though hospital organizations previously relied on the requirements of the proposed

regulations, hospital organizations are required to include on each billing statement a conspicuous written notice to inform patients about the availability of financial assistance and include contact information if patients want to learn more. Also, hospital organizations with multiple facilities may be allowed to collaborate and produce one joint Community Health Needs Assessment report and implementation strategy for all of its hospital facilities. Failure to meet these requirements could result in the application of an excise tax or, in certain egregious cases, a hospital could have its tax-exempt status revoked.

Across the nation, states and local governments have been increasingly active in scrutinizing the income and property tax exemption of healthcare organizations. It is possible that the Commonwealth of Kentucky or a local government could challenge any Health Care User's tax exemption. Depending on the circumstances, such event could have an adverse and material effect on that Health Care User.

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

State and Local Budgets

The states in which the Plant Users own and operate facilities face financial challenges, including erosion of general fund tax revenues, falling real estate values, slowing economic growth and higher unemployment, each of which may continue or worsen over the coming years. These factors have resulted in shortfalls between anticipated revenues and spending demands. The financial challenges facing states may negatively affect the Plant Users' operations and facilities in a number of ways, including but not limited to, reduction of state support for higher education, elimination or reduction of state and local health care safety net programs (resulting in 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 uninsured or underinsured patients who are unable to pay for their care or access primary care facilities, a greater number of individuals who qualify for Medicaid and reductions in Medicaid reimbursement rates. It cannot be predicted what actions will be taken in the current and future years by state legislatures and governors to address those financial problems. The states' actions will likely depend on national and state economic conditions and other factors that are uncertain at this time.

Enforceability of Remedies

The remedies available to Holders upon an Event of Default under the Indenture or the Loan Agreement are in many respects dependent upon judicial action which is subject to discretion or delay. Under existing law and judicial decisions, including specifically the Bankruptcy Code, the remedies specified in the Indenture and the Loan Agreement may not be readily available or may be limited. A court may decide not to order specific performance.

The various legal opinions delivered concurrently with the delivery of the Bonds will be qualified as to enforceability of the various legal instruments by limitations imposed by general principles of equity and by bankruptcy, reorganization, insolvency or other similar laws affecting the rights of creditors generally.

Financial Information

Certain financial information of the Corporation and the Plant Users is set forth in Appendices A through G herein. There can be no assurance that the financial results achieved by the Corporation and the Plant Users in the future will be similar to historical results. Such future results will vary from historical results and actual variations may be material.

Secondary Market

There is no guarantee that a secondary trading market will develop for the Bonds. Consequently, prospective purchasers of the Bonds should be prepared to hold their Bonds to maturity or prior redemption. Subject to applicable securities laws and prevailing market conditions, the Underwriter intends, but is not obligated, to make a market in the Bonds.

Additional Debt; Dilution

The Indenture permits the issuance of Additional Plant Bonds on a parity with the Bonds. The incurrence of Additional Plant Bonds would increase debt service requirements and could materially and adversely affect debt service coverage on the Additional Plant Bonds.

Bond Rating

There is no assurance that the rating assigned to the Bonds will not be lowered or withdrawn at any time, which could adversely affect the market price for and marketability of the Bonds. See the information herein under the caption "RATING." Since the rating on the Bonds is further based on the ratings of the underlying Plant Users, a reduction or withdrawal of a bond rating then in effect for a Plant User can be expected to adversely affect the rating of the Bonds.

Risks Relating to COVID-19 [TO BE UDPATED]

On March 6, 2020, Governor Andy Beshear issued an Executive Order declaring a State of Emergency in Kentucky to provide an immediate response to the novel coronavirus (COVID-19) emergency in the Commonwealth. On March 11, 2020, the Governor recommended social distancing for everyone, advised that all community gatherings should be cancelled or postponed and encouraged all businesses to allow employees to work from home if possible. And on March 25, 2020, the Healthy at Home initiative was issued under a Gubernatorial Executive Order to protect the health and safety of Kentuckians and mitigate the spread of COVID-19, effective during the duration of the State of Emergency or until rescinded (the "Healthy at Home Order"). The Healthy at Home Order directs that only Life-Sustaining Businesses may remain open and encourages all Kentuckians stay Healthy at Home except in extremely limited circumstances. Individuals are encouraged to only leave their residence to seek medical attention, work, care for family or household members, obtain goods and services like groceries and prescriptions, and engage in outdoor activity with strict social distancing requirements. To further protect the health and safety of the citizens, travel restrictions were implemented by an April 2, 2020 Executive Order instructing Kentucky residents not to travel into any other state and residents of any state other than the Commonwealth of Kentucky may not travel into Kentucky with limited circumstance exceptions for both.

On April 21, 2020, the Healthy at Work initiative was announced to gradually reopen business activities while continuing to keep Kentuckians safe. Healthy at Work offers a phased approach to reopening Kentucky's economy and is based on criteria set by public health experts and advice from industry experts. Phase I began on May 11 and includes the reopening of some additional non-life-sustaining businesses in the following economic sectors: manufacturing, distribution, supply-chain, construction, vehicle and vessel dealerships, office-based businesses (50% or less in office), photography,

and horse-racing (no fans). Phase II commenced May 20 with the reopening of retail and houses of worship followed by Phase III on May 25 with the reopening of barbers, salons, cosmetology businesses and similar services. Each business reopening must meet certain minimum requirements in addition to industry specific guidance.

Depending on the length and breadth of the impact of COVID-19, the effect on the Plant Users may be significant. The Plant Users anticipate that they will incur significant additional expenditures not currently budgeted to address the COVID-19 pandemic. The financial and operating data contained herein are as of the dates and for the periods indicated, which were prior to the COVID-19 outbreak. Such financial and operating data have not been updated to reflect any potential impacts of the COVID-19 outbreak on the Corporation and the Plant Users general economic and financial condition.

Additional Risk Factors Impacting the Education Industry

There are a number of additional factors generally affecting nonprofit institutions of higher education, including the University and KCTCS (the "Educational Institution Users"), that could have an adverse effect on their enrollment and their ability to generate sufficient revenues to make payments under the User Contract. These factors include, but are not limited to, the following:

(i) The continuing rising costs of providing higher education services, including without limitation increases in the costs of health care insurance, retirement plans or other benefits offered by the Educational Institution Users to their employees, increases in the costs of compliance with federal or state laws or regulations, or other increases in operating expenses;

(ii) Competition from other public and private higher education institutions;

(iii) The failure to maintain or increase funds obtained by the Educational Institution Users from other sources, including gifts and contributions from donors and income from investment of endowment funds;

(iv) A decline in the demographic pool of candidates who may choose to attend the Educational Institution Users or other changes in demand for higher education in general or for programs offered by the Educational Institution Users in particular;

(v) A decrease in student loan funds or other financial aid that enables students of limited means the opportunity to pursue higher education;

(vi) Recessions in the national, regional or local economy making higher education less affordable for prospective students and any resulting decrease in the enrollment at the Educational Institution Users;

(vii) Changes in management, personnel or the administration of the Educational Institution Users or in their strategic focus;

(viii) Employee strikes and other adverse labor actions that could result in a substantial reduction in revenues without corresponding decreases in costs; and

(ix) Natural disasters impairing the ability of the Educational Institution Users to attract prospective students or otherwise adversely affecting their ability to provide necessary facilities or services.

Additional Risk Factors Impacting the Health Care Industry

Federal and State Legislation

The Health Care Users are subject to a wide variety of federal regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare and Medicaid and other federal healthcare programs and other third party payors, and actions by, among others, the Department of Health and Human Services, the Internal Revenue Service, the Office of the Inspector

General, the National Labor Relations Board, the Joint Commission, and other accreditation and federal, state and local governmental agencies. There can be no assurance that such agencies and legislative bodies may not make regulatory or legislative policy changes that could produce adverse effects upon the ability of the Health Care Users to generate revenues or upon the utilization of its health facilities.

Health Care Reform Act of 2010. The Health Care Reform Act is designed to overhaul the United States health care system and regulate many aspects of and players in the health care arena including individuals, employers and health insurers. This legislation addresses almost all aspects of hospital and provider operations and health care delivery, and has changed and will continue to change how health care services are covered, delivered and reimbursed. These changes will result in lower reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategy and practices, among other consequences. While some providers have received reduced payments for care, millions of previously uninsured Americans have obtained insurance coverage. Requirements for state health insurance exchanges could fundamentally alter the health insurance market and negatively impact providers by taking on a rate-setting role. Federal deficit reduction efforts will likely curb federal Medicare and Medicaid spending further to the detriment of hospitals, physicians and other health care providers.

On June 28, 2012, the U.S. Supreme Court upheld most provisions of the Health Care Reform Act, including the requirement that individuals maintain health insurance coverage. The Supreme Court also ruled that the federal government could not compel states to comply with the Health Care Reform Act's requirement to expand Medicaid by eliminating all federal funds a state receives for its existing Medicaid program. On June 25, 2015, the Supreme Court upheld a key provision of the Health Care Reform Act that grants subsidies to individuals who purchase health care coverage on the federal marketplace. Attempts to proceed with legislation to repeal or amend provisions of the Health Care Reform Act continue and at this time it is not possible to predict the outcome of legislative attempts to repeal or amend the Health Care Reform Act in part or in its entirety.

A significant component of the Health Care Reform Act is the expansion of the base of health care consumers through the reformation of the sources and methods by which consumers pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents of their employees. One of the primary drivers of the Health Care Reform Act is to provide, make available or subsidize the premium costs of health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Congressional Budget Office ("CBO") estimates that insurance coverage provisions of the Health Care Reform Act will increase the number of non-elderly people who have health insurance by about 16 million in 2016 and approximately two million in each of the subsequent years through 2024. To the extent all or any of the Health Care Reform Act provisions produce the intended result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues, and a risk of physician shortages, especially in specialties necessary to provide critical intervention or chronic disease management (e.g., primary care).

The Health Care Reform Act also contains numerous provisions related to health care fraud and abuse and program integrity as well as significant amendments to existing criminal, civil and administrative anti-fraud statutes. The Health Care Reform Act requires the federal government to develop a database to capture and share healthcare provider data across federal healthcare programs to better detect and identify fraud and abuse and also provides for increased funding for anti-fraud activities, and increased penalties for violations. Increased compliance and regulatory requirements,

disclosure and transparency obligations, quality of care expectations and extraordinary enforcement provisions that could greatly increase potential legal exposure are all aspects of the Health Care Reform Act that could increase operating expenses to the members of the Health care Users.

With respect to charity care, the Health Care Reform Act contains many features from previous tax exemption reform proposals, including a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Health Care Reform Act: (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory Internal Revenue Service ("IRS") review of the hospitals' entitlement to exemption; (c) sets forth new reporting requirements including information related to community health needs assessments and audited financial statements; and (d) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels. The Health Care Reform Act does not, however, mandate specific levels of charity care for 501(c)(3) hospitals, despite the efforts of some legislators to impose such a requirement.

Some of the provisions of the Health Care Reform Act are currently effective, while others will take effect or will be phased in through 2018. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act requires the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry has been, and will continue to be, subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

No predictions can be made with any reasonable degree of certainty or reliability at this time of the interim or ultimate effects of the legislation or regulations.

As a part of the Health Care Reform Act, the payment structure from governmental payors, including Medicare and Medicaid and other government programs, as well as from private payors, has been altered. With varying effective dates, the annual Medicare market basket updates for many providers, including hospitals, will be reduced, and adjustments to payments for expected productivity gains will be implemented.

The Health Care Reform Act also contains numerous provisions related to health care fraud and abuse and program integrity as well as significant amendments to existing criminal, civil and administrative anti-fraud statutes. The Health Care Reform Act requires the federal government to develop a database to capture and share healthcare provider data across federal healthcare programs to better detect and identify fraud and abuse and also provides for increased funding for anti-fraud activities, and increased penalties for violations. Increased compliance and regulatory requirements, disclosure and transparency obligations, quality of care expectations and extraordinary enforcement provisions that could greatly increase potential legal exposure are all aspects of the Health Care Reform Act that could increase operating expenses to the Health Care Users.

Budget Control Act of 2011. The Budget Control Act of 2011 (the "Budget Control Act") limited the federal government's discretionary spending to levels necessary to reduce expenditures between federal fiscal years 2012 and 2021 by $917 billion as compared to the federal budget baseline as of 2011. The Budget Control Act also created a Joint Select Committee on Deficit Reduction (the "Super Committee") tasked with making recommendations to further reduce the federal deficit by $1.2 trillion. Due to the Super Committee's failure to act within the time specified in the Budget Control Act, sequestration (across the board cuts) in an amount necessary to achieve $1.2 trillion in savings began on

March 1, 2013. While a wide range of spending is exempted from sequestration (including Social Security, Medicaid, Veteran's benefits and pensions, federal retirement funds, civil and military pay, child nutrition and other programs), Medicare is not exempt from sequestration. As a result of these across the board spending reductions, Medicare provider payments are reduced annually by 2% of total program costs. The Bipartisan Budget Act of 2015 was signed into law on November 2, 2015, extending sequestration for Medicare and other programs into fiscal year 2025, with a 4% cut to total Medicare program costs planned for 2024.

Because Congress may make changes to the budget in the future, it is impossible to predict the impact these and any additional spending cuts may have upon the Health Care Users. Reductions in Medicare and/or Medicaid spending may have a material adverse effect upon the financial condition of the Health Care Users.

Future Legislation. Legislation is periodically introduced in the U.S. Congress and state legislatures that could result in limitations on hospital revenues, reimbursement, costs or charges or that could require an increase in the quantity of indigent care required to maintain charitable status. The effect of any such proposals, if enacted, cannot be determined at this time.

Legislative proposals that could have an adverse effect on the Health Care Users include: (a) any changes in the taxation of nonprofit corporations or in the scope of their exemption from income or property taxes; (b) limitations on the amount or availability of tax-exempt financing for corporations described in Section 501(c)(3) of the Code; and (c) regulatory limitations affecting the ability of a member of a Health Care User to undertake capital projects or develop new services.

Legislative bodies have considered legislation concerning the charity care standards that nonprofit, charitable hospitals must meet to maintain their federal income tax-exempt status under the Code and legislation mandating that nonprofit, charitable hospitals have an open-door policy toward Medicare and Medicaid patients as well as offer, in a non-discriminatory manner, qualified charity care and community benefits. Excise tax penalties on nonprofit, charitable hospitals that violate these charity care and community benefit requirements could be imposed or their tax-exempt status under the Code could be revoked. The scope and effect of legislation, if any, that may be enacted at the federal or state levels with respect to charity care of nonprofit hospitals cannot be predicted. Any such legislation or similar legislation, if enacted, could have the effect of subjecting a portion of the income of a Health Care User to federal or state income taxes or to other tax penalties and adversely affect the ability of a Health Care User to generate net revenues sufficient to meet its obligations under the User Contract.

Because of the many possible financial effects that could result from enactment of any bills or regulatory actions proposing to regulate the healthcare industry, it is not possible to predict with assurance the effect on the business of the Health Care Users of such bills or regulatory actions.

Payment for Health Care Services

A substantial portion of the patient service revenues of the Health Care Users are derived from third-party payors which reimburse or pay for the services and items provided to patients covered by such third parties for such services, including the federal Medicare program, state Medicaid programs and private health plans and insurers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care payors. Many of these programs make payments to the Health Care Users at rates other than the direct charges of the Health Care Users. Rates may be determined on a basis of other than actual costs incurred in providing services and items to such patients. Accordingly, there can be no assurance that payments made under these programs will be adequate to cover the Health Care Users' actual costs of furnishing health care services and items. In addition, the

financial performance of the Health Care Users could be adversely affected by the insolvency of, or other delay in receipt of payments from, third-party payors.

Medicare and Medicaid Programs; General.

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program and Medicaid is jointly funded by federal and state government and governed by federal and state laws. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older or disabled, or qualify for the End Stage Renal Disease Program. Medicaid is designed to pay providers for care given to the medically indigent, is funded by federal and state appropriations, and is administered by the individual states. Benefits are available under each participating state's Medicaid program, within prescribed limits, to persons meeting certain income or other eligibility requirements including children, the aged, the blind and/or disabled.

Health care providers have been and will be affected significantly by changes in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs. The Health Care Reform Act amended Medicaid funding and substantially increased the potential number of Medicaid beneficiaries. In June 2012, the Supreme Court ruled that states could decline to expand Medicaid coverage without losing their existing federal funding for the program. Certain outcomes, such as a state refusing to expand Medicaid coverage while Medicaid payment cuts are implemented, could put providers at greater risk. In fact, the newly-elected governor of Kentucky is exploring alternatives to modify or further limit Medicaid expansion and has already announced plans to dismantle the State's health insurance exchange. It is unclear how these modifications will impact future reimbursement.

Medicare.

Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS") of the federal Department of Health and Human Services ("HHS"). The Medicare and Medicaid programs have "Conditions of Participation" that a provider must satisfy on a continuing basis to qualify for reimbursement, including, but not limited to, compliance with state licensure requirements, governing body and management requirements, medical records requirements, quality assurance and utilization review requirements, physical environment standards, and nursing services standards. In order to achieve and maintain Medicare certification, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located and/or The Joint Commission, the Healthcare Facilities Accreditation Program, or DNV Healthcare Inc.

Changes in the Medicare program may have a material effect on the Health care Users. The cost of providing a unit of care may exceed the compensation realized from Medicare for providing that service. Additionally, the aggregate costs to a provider of providing care to Medicare beneficiaries may exceed aggregate Medicare payments received during the relevant fiscal year period. Reductions in Medicare reimbursement, or increases in Medicare reimbursement in amounts less than increases in the costs of providing care, may have a material adverse financial effect on the Health Care Users.

Under a prospective payment system, or PPS, the amount paid to the provider for an episode of care is established by federal regulation and is not related to the provider's charges or costs of providing that care. Presently, hospital inpatient and outpatient services, skilled nursing care, and home health care

are paid on the basis of a prospective payment system. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned diagnosis related group, or DRG. DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. All services paid under the PPS for hospital outpatient services are classified into groups called ambulatory payment classifications, or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. The capital component of care is also paid on a fully prospective basis.

The Secretary of HHS is required to review annually the DRG categories to take into account any new procedures, reclassify DRGs and recalibrate the DRG relative weights that reflect the relative resources used by hospitals with respect to discharges classified within a given DRG category. CMS may only adjust DRG weights on a budget neutral basis. There is no assurance that a Health Care User will be paid amounts that will reflect adequately changes in the cost of providing health care or in the cost of health care technology being made available to patients.

PPS-exempt hospitals and units (inpatient psychiatric, rehabilitation and long-term hospital services) are currently reimbursed under prospective payment systems separate from the PPS/DRG system used for general acute care hospitals and units. However, these exempt hospital/unit PPS payment methodologies are similar in that they utilize nationally determined payment rates (per discharge for rehabilitation and long-term care, per diem for psychiatric). These national rates are then generally subject to patient and/or facility specific adjustments for such factors as: case mix, regional wage or cost differences, medical education, disproportionate share, and outliers. The types of adjustments vary for each of the exempt PPS programs.

While PPS payments are adjusted annually using an inflation index, based on the change in a market basket of hospital costs of providing health care services, there is no assurance that future updates in the PPS payments will keep pace with the increases in the cost of providing hospital services. If a hospital incurs costs in treating Medicare inpatients that exceed the DRG level of reimbursement plus any outlier payments, the hospital will experience a loss from such services. Other third-party payors have begun implementing their own limitations on reimbursement payable to hospitals to avoid "cost-shifting," that is, the practice of offsetting losses from Medicare patients by increasing charges to other payors.

Various additional payments may be made to individual providers. Hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) currently receive additional payments in the form of disproportionate share payments. Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as "outlier payments." To determine whether a case qualifies for outlier payments, hospital-specific cost-to-charge ratios are applied to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios and combining these costs to compare them with a defined fixed-loss outlier threshold for the specific DRG. Any investigation or suit involving the outlier payments of the hospital members of the Heath Care Users could have a material adverse impact on the financial condition and the results of operations of the affected Health Care User. Eligible hospitals are also paid for a portion of their direct and indirect medical education costs. Any and all additional payments described herein are subject to reductions and modifications or other changes.

CMS continues to revise the inpatient PPS ("IPPS") and annually publishes an interim rule for notice and comment followed by a final rule. The 2016 IPPS Final Rule included a negative 0.8% documentation and coding adjustment in federal fiscal year 2016, a market place increase of 2.4% and additional adjustments resulting in an overall 0.9% increase in payment rates to general acute care hospitals that report quality data and are meaningful users of electronic health records. The 2016 IPPS

Final Rule also updated measures for the Hospital Inpatient Quality Reporting Program and measures and incentives for the Hospital Value Based Purchasing Program. Failures by hospitals to electronically report four of the clinical quality measures required by CMS will cause a decrease in IPPS reimbursement beginning in payment year 2018. In addition, the 2016 IPPS Final Rule updated the Hospital Acquired Condition Reduction Program, which began in federal fiscal year 2015. Under this program, CMS imposes financial penalties on the lowest performing hospitals with respect to hospital acquired conditions.

Several significant Medicare payment reform measures - designed to incentivize hospitals based on quality and performance measures - implemented reimbursement incentives and penalties: the Readmission Reduction Program, the Hospital Value-Based Purchasing Program, the Hospital Inpatient Quality Reporting Program, and the Hospital-Acquired Condition Reduction Program. The Readmission Reduction Program reduces Medicare payments by specified percentages to hospitals with excess or preventable hospital admissions based on historical discharge data. The Hospital Value-Based Purchasing Program, funded through an across-the-board reduction to the IPPS standardized DRG amounts, reallocates and redistributes Medicare reimbursement funds to hospitals based on how well they perform on quality and patient experience measures. The DRG percentage reduction began in federal fiscal year 2014 at 1.25% with the percentage reduction increasing by 0.25% each fiscal year until the reduction reaches a maximum of 2.0% for federal fiscal year 2017. Hospitals are able to avoid the DRG percentage reduction by meeting certain quality and patient satisfaction targets, set by CMS. Under the Hospital Inpatient Quality Reporting Program, annual payment updates to hospitals that do not successfully report designated quality measures are reduced by 2.0 percentage points and hospitals that do not participate successfully in the program will lose one-quarter of the percentage increase in their payment updates.

As of September 30, 2014, CMS adopted a policy known as the Inpatient Hospital Prepayment Review or the "Two-Midnight" rule. The Two-Midnight rule specifies that hospital stays spanning two or more midnights after the patient is admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. Stays lasting less than two midnights must be treated and billed as outpatient. The implementation of the Two-Midnight rule was delayed until January 1, 2016 and it may have an adverse financial impact on hospitals. The Health Care Users cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the Two-Midnight rule at this time and there can be no assurance that future changes in classifications of patient hospitalizations or revisions to annual documentation and coding adjustments or other payment update measures implemented in future prospective payment regulations will not result in fluctuations or declines in revenue.

The Deficit Reduction Act of 2005 (the "DRA") required the Secretary of HHS to identify complicating conditions present as a secondary diagnosis that are high cost and/or high volume and reasonably preventable through application of evidence-based guidelines (collectively referred to as "hospital-acquired conditions"). The DRA further required hospitals to begin reporting on claims for discharges, beginning October 1, 2007, whether the selected hospital-acquired conditions were present on admission. In its 2008 IPPS Final Rule, CMS included several conditions identified by the National Quality Forum as "never events" (*i.e.*, inexcusable outcomes in a health care setting). Each year, additional conditions classified as hospital-acquired or never events have been added through the inpatient prospective payment system rulemaking process. All such conditions have negative payment implications when acquired during an inpatient stay. Effective July 1, 2011, federal payments to states for Medicaid services related to hospital-acquired conditions are prohibited. Under the Hospital-Acquired Condition Reduction Program, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by one percent. The incidence of adverse events and their payment implications continue to be areas of focus for regulators.

Medicare Audits. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under the Medicare program. The Health Care Users receive payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediaries' audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting the Health Care Users to civil or criminal sanctions.

The Health Care Reform Act amended certain provisions of the Federal False Claims Act and added provisions regarding the timing of the obligation to reimburse overpayments. The effect of these changes on existing programs and systems of the Health Care Users cannot be predicted.

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

In light of the complexity of the regulations relating to the Medicare program and the ongoing threat of audits, there can be no assurance that any audit would not materially adversely affect the financial condition of the Health Care Users.

Physician Payment. Physicians may elect to "participate" or enroll in the Medicare program as a provider. Medicare Part B provides reimbursement for physician services, including employed and provider-based physicians, based upon a national fee schedule called the Resource-Based Relative Value Scale ("RBRVS"). Under the RBRVS system, payments for services are determined by the "resource costs" necessary to provide such services. Payments also are adjusted for geographical differences. The costs have three components: physician work, practice expense and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor. The conversion factor is a monetary amount that currently is determined by CMS's Sustainable Growth Rate ("SGR") system. The SGR system annually takes into account changes in the Medicare fee-for-services enrollment, input prices, spending due to law and regulation and gross domestic product, effectively changing the RBRVS on an annual basis. The RBRVS system encourages a shift towards greater reimbursement for the provision of primary care, and a reduction of technology-based diagnostic procedures and surgical procedures. This continued shift in payment emphasis may affect the relationship between a Health Care User and its medical staff and may increase pressure on a Health care User to enter into bundled or global payment models, risk-based delivery models, or increase demands by physicians for payment from hospitals. Currently, it is projected that RBRVS will have negative updates for the next few years. In that regard, there is no guarantee that reimbursement under RBRVS will cover a Health Care User's actual costs of providing physician services to Medicare beneficiaries.

Physicians who opt not to participate in the Medicare program also may provide care to Medicare beneficiaries, but will be reimbursed at a lower fee schedule. Regardless of physician enrollment status,

physicians who furnish health care services to Medicare beneficiaries must meet all applicable federal coding, documentation, and other compliance requirements.

Medical Education Payments. Medicare currently pays for a portion of the direct and indirect costs of medical education (including the salaries of residents and teachers and other overhead costs directly attributable to approved medical education programs). Payment for the direct costs of medical education ("GME") is made on a "pass-through" basis, not PPS, based on a formula that reflects the hospital's base year per-resident costs adjusted by inflation and the number of current-year reimbursable resident positions. Payment for indirect costs of medical education ("IME") is based on the ratio of a hospital's number of full-time equivalent residents to its number of beds. These payments are vulnerable to reduction or elimination. Further, there can be no assurance that payments to a Health Care User for providing medical education will be sufficient to cover the costs associated with their medical education programs.

Other Medicare Service Payments. Medicare payments for skilled nursing services, psychiatric services, inpatient rehabilitation services, general outpatient services and home health services are subject to Medicare's consolidated billing rules. Consolidated billing requires covered providers to bill Medicare for the entire package of services its patients receive, other than a few excluded services, 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. In addition, there is no assurance that a Health Care User will be fully reimbursed for all services billed through consolidated billing.

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

Provider-Based Designation. CMS regulations describe the criteria and procedures for determining whether a facility or organization is "provider-based" and thereby treated as part of another Medicare provider, rather than as a freestanding entity. The current regulations impose significantly greater requirements for obtaining provider-based status than was the case under previous regulations, and may lead to reclassification of facilities or departments of a Health Care User currently classified as "provider-based." Reclassification of any of the provider-based facilities or departments of a Health Care User could reduce reimbursement under the Medicare program. In addition, in the event that a facility or department that bills for outpatient services as a provider-based entity is found to be out of compliance with the current provider-based regulations, a Health Care User could be liable for Medicare overpayments.

Effective January 1, 2017, the Bipartisan Budget Act of 2015 will change how Medicare payments are made for most items and services furnished at off-campus departments of a hospital. Off-campus hospital departments that were not billing as provider-based entities prior to the enactment date of November 2, 2015 will be paid under the applicable non-hospital payment system. CMS has historically paid for provider-based outpatient hospital services under the Hospital Outpatient Prospective Payment System ("OPPS") which pays a facility fee for outpatient services in addition to a professional fee. If the same services were to be provided in a physician's office, only the professional fee would be paid by Medicare. As of the effective date, off-campus departments of hospitals, unless grandfathered into the OPPS payment system, will no longer be eligible to receive the facility fee payment for hospital outpatient services.

***Medicare Advantage*.** Medicare Advantage plans are alternate insurance products offered by private companies that engage in direct managed care risk contracting with the Medicare program. Under the Medicare Advantage program these private companies agree to accept a fixed, per-beneficiary payment from the Medicare program to cover all care that the beneficiary may require. The Health Care Reform Act includes significant changes to federal payments to Medicare Advantage plans resulting in a transition to benchmark payments tied to the level of fee-for-service spending in the applicable county. Decreased federal payments to the Medicare Advantage plans could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers. Future legislation or regulations may be created, to encourage increased participation in the Medicare Advantage program. The effect of such future legislation or regulations is unknown but could materially and adversely affect a Health Care User.

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

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

Payment for Medicaid patients is subject to appropriation by the respective state legislatures of sufficient funds to pay the incurred patient obligations. The federal government continues to explore options for a long-term solution to the funding difficulties with Medicaid.

The Health Care Reform Act (as modified by the June 28, 2012, Supreme Court decision) made changes to Medicaid funding, giving states the option to expand Medicaid eligibility to all individuals under age 65 with incomes at or below 133% of the federal poverty level guidelines and provided temporary federal financial support for that increased enrollment. Beginning on November 1, 2011, Kentucky obtained a waiver to implement Medicaid managed care statewide. The Health Care Reform Act also expanded the RAC Medicare program to include Medicaid, using state-based RAC contracts. No predictions can be made at this time as to the effect of these changes to the Medicaid program on the operations, results from operations or financial condition of a Health Care User.

Generally, for inpatient and outpatient providers, aggregate Medicaid payments to a group of facilities may not exceed a reasonable estimate of the amount that would be paid for those services furnished by the facilities under Medicare. Currently, Medicaid nursing facility payments are generally made using one of three payment systems (that is, cost based, per diem or case mix). There is a greater use of prospective payment systems (per diem or case mix) than cost-based systems for nursing facility services. In addition, Medicaid inpatient hospital payments are generally made under a DRG prospective payment system on a per discharge basis. For Rural Health Centers and Federally Qualified Health Centers, states do not possess the discretion to set payment rates subject to the general principles above. Instead, the Benefit Improvement and Protection Act of 2000 mandates that states implement a PPS in which payments are made based on the costs of the facility. Although the payment systems can be categorized in general terms, the specific methodology varies from state to state.

State Laws

The Health Care Reform Act imposes many new obligations on states related to health care insurance. Prior to the passage of the Health Care Reform Act, many states increased regulations related to the managed care industry. State legislatures have cited their right and obligation to regulate and oversee health care insurance and have enacted sweeping measures that aim to protect consumers and, in some cases, providers. For example, a number of states have enacted laws mandating a minimum of 48-hour hospital stays for women after delivery; laws prohibiting "gag clauses" (contract provisions that prohibit providers from discussing various issues with their patients); laws defining "emergencies," which provide that a health care plan may not deny coverage for an emergency room visit if a layperson would perceive the situation as an emergency; and laws requiring direct access to obstetrician-gynecologists without the requirement of a referral from a primary care physician. It is unclear how the increased federal oversight of state healthcare may affect the probability of future increased state oversight or impact the Health Care Users.

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

Regulatory Environment

General. The health care industry is highly dependent on a number of factors which may limit the ability of the Health Care Users to meet their obligations under the User Contract. Among other things, participants in the health care industry (such as the Health Care Users) are subject to significant regulatory requirements of federal, state and local governmental agencies; independent professional organizations and accrediting bodies; technological advances and changes in treatment modes; various competitive factors; and changes in third party reimbursement programs. Discussed below are certain of these factors which could have a significant effect on the future operations and financial condition of the Health Care Users.

***Licensing, Surveys, Investigations and Audits*.** Health facilities, including those of the Health Care Users, are subject to numerous legal, regulatory, licensing, professional certification and private accreditation requirements. These include, but are not limited to, requirements relating to Medicare Conditions of Participation, requirements for participation in Medicaid, state licensing agencies, private payors and the accreditation standards of The Joint Commission and the Healthcare Facilities Accreditation Program. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews, some of which may require affirmative action or response by a Health Care User. These activities generally are conducted in the normal course of business of health care facilities. Nevertheless, an adverse result could result in a loss or reduction in the scope of licensure, certification or accreditation of a Health Care User or could reduce the payment received or require repayment of amounts previously remitted.

From time to time, accrediting bodies may review their accreditations of a Health Care User and recommend certain actions or impose conditions on an existing accreditation. Actions in any of these areas could result in the loss of utilization or revenues, or the ability of a Health Care User to operate all or a portion of its facilities, and, consequently, could adversely affect the ability of a Health Care User to make payments under the User Contract. No assurance can be given as to the effect on future operations

of existing laws, regulations and standards for certification or accreditation or of any future changes in such laws, regulations and standards.

Kentucky Certificate of Need Law. Kentucky regulates the health care industry within its borders by administering a program requiring health care facilities to obtain a Certificate of Need ("CON") before making certain capital expenditures, adding certain new health care services, or making substantial changes in existing services. The criteria for determining whether to issue a CON include the project's consistency with the State Health Plan (which is revised annually) and any biennial state budget authorizations and limitations directly affecting the proposal; need and accessibility in the defined service area; interrelationships and linkages with the existing providers; costs, economic feasibility and resource availability; and the quality of services. After receiving a CON, the holder may be subject to biennial review to determine that the holder is in compliance with the terms as listed in its CON. No predictions can be made whether the Health Care Users will receive approval for any health care services that are regulated by the CON process which the Health Care Users may deem desirable or necessary in order to compete in its service area, or whether the CON law may be changed in a way that permits new competitors to enter the markets of the Health Care Users.

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

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

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

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

Anti-Fraud and Abuse Laws. The federal anti-kickback statute (the "Anti-Kickback Law") makes it a felony to knowingly and willfully offer, pay, solicit or receive remuneration, directly or indirectly, in order to induce business that is reimbursable under any federal health care program. The Anti-Kickback Law applies to many common health care transactions between entities and persons with which a health care entity does business including hospital-physician joint ventures, medical director agreements, physician recruitment agreements, physician office leases and other transactions. The Anti-Kickback Law has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain or pay money for the referral of services or to induce further referrals. Violation of the Anti-Kickback Law may result in imprisonment for up to five years and/or fines of up to $25,000 for each act. In addition, the Office of Inspector General ("OIG") of HHS has the authority to impose civil assessments and fines and to exclude hospitals engaged in prohibited activities from the Medicare, Medicaid, TRICARE (a health care program providing benefits to dependents of members of the uniformed services), and other federal health care programs for not less than five years.

The Health Care Reform Act amended a number of provisions of the Anti-Kickback Law. One such amendment provides that an Anti-Kickback Law violation may be established without showing that an individual knew of the statute's proscriptions or acted with specific intent to violate the Anti-Kickback Law. The new standard could significantly expand criminal and civil fraud exposure for transactions and arrangements where there is no intent to violate the Anti-Kickback Law. The Health Care Reform Act further amended the Anti-Kickback Law to explicitly provide that a violation of the statute constitutes a false or fraudulent claim under the federal False Claims Act ("FCA"), which prohibits the knowing presentation of a false, fictitious or fraudulent claim for payment to the United States government. Actions under the FCA may be brought by the United States Attorney General or as a qui tam action brought by a private individual in the name of the government.

In addition to certain statutory exceptions to the Anti-Kickback Law, the OIG has promulgated a number of regulatory "safe harbors" under the Anti-Kickback Law designed to protect certain payment and business practices. However, only a limited number of final safe harbors have been established to date, and the safe harbors are narrow and do not cover a wide range of common economic relationships involving hospitals. The regulations do not purport to comprehensively describe all lawful or unlawful economic arrangements or other relationships between health care providers and referral sources. Failure to comply with a statutory exception or regulatory safe harbor does not mean that an arrangement is unlawful but may increase the likelihood of challenge or the potential for investigation.

Pursuant to the mandates of the Health Care Fraud & Abuse Control Program under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), increased emphasis is being placed on federal investigations and prosecutions of Medicare and Medicaid "fraud and abuse" cases, and increases in personnel investigations and prosecuting such cases have been reported, which will most likely result in a higher level of scrutiny of hospitals and other health care providers, including the one or more of the Health Care Users.

Because of the breadth of the Anti-Kickback Law and associated anti-fraud and abuse laws and the narrowness of the safe harbor regulations, there can be no assurance that regulatory authorities will not take the position that one or more of the Health Care Users has violated the Anti-Kickback Law or that one or more of the Health Care Users will not be found to have violated the Anti-Kickback Law.

Stark Law. Another federal law (known as the "Stark Law") prohibits, subject to limited exceptions, a physician who has a financial relationship, or whose immediate family has a financial relationship, with entities (including hospitals) providing "designated health services" from referring Medicare patients to such entities for the furnishing of such designated health services. Stark Law

designated health services include physical therapy services, occupational therapy services, speech-language pathology, radiology or other diagnostic services (including MRIs, CT scans and ultrasound procedures), durable medical equipment, radiation therapy services, diagnostic and therapeutic nuclear medicine services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The Stark Law also prohibits the entity receiving the referral from filing a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; no finding of intent to violate the Stark Law is required. Sanctions for violation of the Stark Law include denial of payment for the services provided in violation of the prohibition, refunds of amounts collected in violation, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, exclusion from the federal health care programs, and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law's prohibition. The types of financial arrangements between a physician and an entity that trigger the self-referral prohibitions of the Stark Law are broad, and include ownership and investment interests and compensation arrangements.

The Health Care Reform Act codifies the legal concept that knowing violations of the Stark Law may also serve as the basis for liability under the FCA. Medicare providers and suppliers are expressly obligated under the Health Care Reform Act to report and return overpayments (which include payments received in violation of the Stark Law) within sixty days of the date that the overpayment is "identified." Overpayments retained after the 60-day grace period are considered an "overpayment" for false claim liability under the FCA, and are therefore subject to treble damages and penalties if there is a "knowing and improper" failure to return the overpayment.

CMS has established a voluntary self-referral disclosure protocol under which hospitals and other health care providers or suppliers may report potential Stark Law violations and seek a reduction in potential refund obligations. While over 60 settlements have been reached under the self-referral disclosure protocol, the parameters used by CMS to determine settlement amounts have not been made public. Therefore it is difficult to determine at this time the likely settlement amount for any given voluntary disclosure.

There can be no assurance that regulatory authorities will not take the position that a Health Care User has violated the Stark Law or that a one or more of the Health Care User will not be found to have violated the Stark Law.

False Claims Laws. There are principally three federal statutes addressing the issue of "false claims." First, the FCA imposes civil liability (including substantial monetary penalties and damages) on any person or corporation that (1) knowingly presents or causes to be presented a false or fraudulent claim for payment to the United States government; (2) knowingly makes, uses or causes to be made or used a false record or statement to obtain payment; or (3) engages in a conspiracy to defraud the federal government by getting a false or fraudulent claim allowed or paid. Specific intent to defraud the federal government is not required to establish the requisite knowledge. This statute authorizes private persons to file qui tam actions on behalf of the United States. Qui tam actions have been and, in the future, could be brought against a one or more of the Health Care User.

The Fraud and Enforcement and Recovery Act ("FERA"), signed into law on May 20, 2009, has expanded potential exposure under the FCA for a wide range of business transactions involving federal government funds. Pursuant to FERA amendments, the FCA may impose liability for false claims with more remote connections to the federal government. FERA has the effect of expanding liability for the retention of money owed to the government, including overpayments by Medicare.

The Health Care Reform Act further expanded the FCA by requiring a person who receives an overpayment to report and repay the overpayment within 60 days after the overpayment is identified or the date any corresponding cost report is due, whichever is later. The Health Care Reform Act defines overpayments as "any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation is not entitled." Failure to repay any overpayment within the deadline could lead to liability under the FCA.

In addition, the Health Care Reform Act eliminates "public disclosure" as a jurisdictional defense to qui tam suits. The "public disclosure bar" previously required dismissal of a qui tam suit where the allegations were publicly disclosed in (i) a criminal, civil or administrative proceeding, (ii) a congressional, administrative or U.S. Government Accountability Office report, hearing, audit or investigation, or (iii) news media. Under the Health Care Reform Act, courts are directed to dismiss the qui tam suit if the relator is not the original source of the claims or allegations that were publicly disclosed, unless the government opposes the dismissal.

In addition to the FCA, the Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to, (1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; (6) using a payment intended for a federal health care program beneficiary for another use; or (7) knowingly making or causing to be made a false statement, omission or representation of material fact in any application, bid or contract to participate in a federal health care program. The Secretary of HHS, acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal health care programs pursuant to this statute.

In addition, pursuant to HIPAA, the commission of either one of the prohibited practices listed below may lead to civil monetary penalties: (1) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or should know will result in greater payment than appropriate, *i.e.*, upcoding, and (2) engaging in a practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices could amount to civil monetary penalties of up to $10,000 for each item or service involved.

Finally, it is a criminal federal health care fraud offense to: (1) knowingly and willfully execute or attempt to execute any scheme to defraud any health care benefit program; or (2) obtain, by means of false or fraudulent pretenses, representations or promises, any money or property owned or controlled by any health care benefit program. Penalties for a violation of this federal law include fines and/or imprisonment, and a forfeiture of any property derived from proceeds traceable to the offense.

The DRA provides financial incentives to states that pass similar false claims statutes or amend existing false claims statutes that track the FCA more closely with regard to penalties and rewards to qui tam relators. A number of states, including Kentucky, have passed similar statutes expanding the prohibition against the submission of false claims to nonfederal third-party payors.

Patient Records and Patient Confidentiality. The Health Insurance Portability and Accountability Act of 1996 requires certain entities and providers to protect the privacy and security of individuals' health information. Disclosure of certain broadly defined protected health information is

prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient and a variety of safeguards must be used to protect against privacy or security breaches. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These requirements add costs and potentially create 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 up to $50,000 to $1.5 million for all identical violations in a calendar year and/or imprisonment if the information was obtained or used with the intent to sell, transfer or use the information for commercial advantage, personal gain or malicious harm.

The American Recovery and Reinvestment Act of 2009 ("ARRA") includes broad, sweeping changes to the HIPAA provisions regarding confidentiality of patient medical records. In general, the ARRA expands the enforcement of violations of patient medical record confidentiality.

Violations of HIPAA, or of comparable state privacy and security laws, may result in significant costs, liability and reputational harm. There can be no guaranty that violations by a Health Care User of HIPAA will not occur or that any such violation would not have a material adverse effect on such Health Care User.

Security Breaches and Unauthorized Releases of Personal Information. Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH"), which is part of the ARRA, requires health care providers and some of their vendors to notify individuals, and in some cases the media, when their unsecured protected health information is subject to a breach of security. In addition, many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently result in material liability and damage to a health care provider's reputation and could materially adversely affect business operations.

***HIPAA Audits*.** The Office of Civil Rights ("OCR") of the Department of Health and Human Services ("DHHS") is responsible for the enforcement of the regulations pertaining to HIPAA privacy and security. In response to a report issued by the Office of the Inspector General of DHHS (the "OIG") recommended stricter oversight of entities' compliance with HIPAA, the OCR announced that it is launching Phase 2 of its permanent audit program in 2016. Phase 2 will focus on both covered entities and business associates and will include on-site and desk audits. OCR has also indicated it is working on improving its ability to document and track corrective actions taken by covered entities and business associates in response to an OCR investigation and will require investigators to check for prior investigations at the outset of new investigations of covered entities and business associates. An audit of a Health Care User by the OCR could potentially result in civil liability under HIPAA.

***Electronic Health Records*.** HIPAA mandates the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the health care industry. The administrative simplification provisions of HIPAA have caused and will continue to cause significant and costly changes in health care. These provisions require new security measures, set standards for electronic signatures, standardize a method for identifying providers, employers, health plans and patients, require that the health care industry utilize the most efficient method to codify data and significantly change the manner in which health care entities communicate with payors.

The ARRA provides for Medicare incentive payments beginning in federal fiscal year 2011 for eligible acute care inpatient hospitals that are meaningful users of certified electronic health record ("EHR") technology. Hospitals located in one of the 50 states or the District of Columbia and who are paid under the hospital PPS are eligible to participate in the EHR incentive program. Eligible hospitals that adopt a certified EHR system and are "meaningful users" could begin receiving incentive payments in any year from federal fiscal year 2011 to 2015; however, incentive payments decrease for hospitals that started receiving payments in 2014. Hospitals that were not meaningful users of certified EHR technology by 2015 are subject to payment adjustments. The total amount a hospital may earn under the EHR incentive program is based on a complicated formula utilizing the sum of a standard "base amount" plus a discharge-related amount, the Medicare share amount, and the number of years between 2011 and 2015 that the hospital qualifies for payment. While it is impossible to accurately calculate a hospital's total incentive payment under the EHR Medicare incentive program, the payments to eligible hospitals are projected to be substantial. Conversely, any hospital that was not a meaningful user of EHR technology by 2015 is subject to reductions in PPS payments. Additionally, CMS will conduct post-payment audits and require providers to submit supporting documentation to validate their claim of meaningful use. If a provider is found to be ineligible for an EHR incentive payment, the payment will be recouped.

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

Failure to comply with EMTALA may result in a hospital's exclusion from the Medicare and/or Medicaid programs, as well as the imposition of civil monetary penalties. As such, failure of a Health Care User to meet its responsibilities under EMTALA could adversely affect the financial condition of such Health Care User.

No assurance can be given that a Health Care User will not be found to have violated EMTALA. Any sanctions imposed as a result of an EMTALA violation could have a material adverse effect on the future operations or financial condition of such Health Care User.

Environmental Laws and Regulations. Healthcare providers are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations which address, among other things, provider operations or facilities and properties owned or operated by providers. Among the types of regulatory requirements faced by healthcare providers are: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos, polychlorinated biphenyls, and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or

located at the provider; requirements for training employees in the proper handling and management of hazardous materials and wastes; and other requirements.

In their role as owners and/or operators of properties or facilities, a Health Care User may be subject to liability for investigating and remedying any hazardous substances that have come to be located on a member's property, including any such substances that may have migrated off the property. Typical healthcare provider operations include, but are not limited to, in various combinations, the handling, use, treatment, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive and flammable materials, wastes, pollutants or contaminants. As such, a member's operations are particularly susceptible to the practical, financial and legal risks associated with the obligations imposed by applicable environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance. There can be no assurance that one or more of the Health Care Users will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of such Health Care User.

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

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

No assurance can be given that a Health Care User will not be found to have violated applicable law, or that future laws, regulations or policies will not have a material adverse impact on the ability of a Health Care User to recruit and retain physicians.

Joint Ventures. The OIG has expressed its concern in various advisory bulletins that many types of joint venture arrangements involving hospitals may implicate the Anti-Kickback Statute, since the parties to joint ventures are typically in a position to refer patients of federal health care programs. In addition, under the federal tax laws governing Section 501(c)(3) organizations, a tax-exempt hospital's participation in a joint venture with for-profit entities must further the hospital's exempt purposes and the joint venture arrangement must permit the hospital to act exclusively in the furtherance of its exempt purposes, with only incidental benefit to any for-profit partners. If the joint venture does not satisfy these criteria, the hospital's tax-exemption may be revoked, the hospital's income from the joint venture may be subject to tax, or the parties may be subject to some other sanction. Many hospital joint ventures with physicians may also implicate the federal Stark Law.

Any evaluation of compliance with the Anti-Kickback Law or tax laws governing Section 501(c)(3) organizations depends on the totality of the facts and circumstances, while the Stark Law requires strict compliance with an exception if the prohibition is triggered. There can be no assurance that any joint venture arrangements to which a Health Care User is a party will not be found to have violated the Anti-Kickback Law or OIG pronouncements, the tax laws governing Section 501(c)(3) organizations or the Stark Law, or related regulations. Any determination that a Health Care User e is not in compliance with these laws and related regulations could have a material adverse effect on the future financial condition of such Health Care User.

The Health Care Users may enter into joint ventures with physicians**.** The ownership and operation of certain of these joint ventures may not meet safe harbors under the Anti-Kickback Law. Management of a Health Care User may proceed with such transactions related to the joint ventures on the assumption, after consultation with its legal counsel, that each of the transactions related to the joint ventures is in compliance with the Stark Law and the tax laws governing Section 501(c)(3) organizations, and is otherwise generally in compliance with the Anti-Kickback Law. However, there can be no assurance that regulatory authorities will not take a contrary position or that such transactions will not be found to have violated the Stark Law, the tax laws governing Section 501(c)(3) organizations and/or the Anti-Kickback Law. Any such determination could have a material adverse effect on the financial condition of such Health Care User.

Enforcement Affecting Clinical Research. In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also heightened enforcement of laws and regulations governing the conduct of clinical trials at hospitals. HHS elevated and strengthened its Office of Human Research Protections, one of the agencies with responsibilities for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. The FDA's inspection of facilities increased significantly in recent years. These agencies' enforcement powers range from substantial fines and penalties to exclusions of researchers and suspension or termination of entire research programs.

Liability under Kentucky "Fraud" and "False Claims" Laws. The Kentucky legislature has adopted a statute creating liability for the submission of false claims to Kentucky's Medical Assistance Program. Under the Kentucky statute entitled "Liability of Violators-Payment of Penalties to Medicaid Trust Fund," any provider who knowingly submits, or causes to be submitted, a claim for payment for

furnishing treatment, services or goods under a medical assistance program, which payment the provider was not entitled to receive, is in violation of such Kentucky statute. A provider found in violation of the Kentucky statute would be liable for: (1) restitution of any payment received in violation of the statute; (2) civil penalties up to three times the amount of the excess payments; (3) payment of a civil fine of $500 for each false or fraudulent claim submitted; (4) payment of legal fees and costs of investigation and enforcement of civil payments; and (5) removal as a participating provider in the medical assistance program.

Kentucky also prohibits any person with the intent to defraud from knowingly making, inducing or seeking to induce the making of a false statement or representation of a material fact to the Medicaid program regarding the conditions or operations of a facility or institution in order to qualify for initial certification or recertification as a hospital, intermediate care facility, skilled nursing facility, home health agency or other provider of services. In any matter that is within the Cabinet for Health and Family Services' jurisdiction, the legislature also prohibits any person from knowingly falsifying, concealing or covering up by any trick, scheme or device a material fact, making any false, fictitious or fraudulent statement or representation, or making or using any false writing or document knowing that it contains any false, fictitious or fraudulent statement or entry. Persons found in violation of these statutes are guilty of a felony.

Kentucky has not implemented the Deficit Reduction Act's (DRA) false claims policy. Kentucky's false claims statutes do not adequately mirror the federal False Claims Act (FCA) in accordance with the DRA's provisions providing incentives to a state for enacting a conforming statute. Attempts in recent legislative sessions to pass a state false claims act mirroring the federal FCA have not yet been successful in Kentucky. Given the federal incentives for passage of such a statute, however, it is reasonable to expect that attempts to pass such a statute will continue.

In addition, certain provisions within Kentucky's Insurance Code prohibit fraudulent insurance acts with respect to claims submitted to third-party payors. Persons or entities commit a "fraudulent insurance act" by, among other things, knowingly, and with intent to deceive or defraud, presenting or causing to be presented to an insurer, Board of Claims, special fund, or agent thereof, written or oral statements in support of a claim for payment or other benefit that contain false, incomplete or misleading information concerning facts material to the claim. Persons or entities that violate this statute are guilty of a misdemeanor unless the claims in the aggregate are valued at $500 or more, in which case the person is guilty of a felony. Such felony violations are punishable by fines and /or imprisonment of not more than five years. If it is determined that the violators established or maintained a criminal syndicate, the violations are punishable by fines and / or imprisonment of not less than ten and not more than 20 years. Any person found guilty may also be ordered to make restitution and pay for the cost of any investigation.

Kentucky has enacted laws which make it a crime for providers to knowingly solicit, receive, or offer any remuneration, including kickbacks, bribes, or rebates, in exchange for furnishing medical assistance benefits, for referring a patient to another provider for Medicare or Medicaid benefits, or in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made by the Medicare or Medicaid programs. Persons who violate these statutes are guilty of a misdemeanor unless a combination or aggregation of offenses is valued at three hundred dollars ($300) or more, in which case the violation is felony offense. Such violations are punishable by fines and/or imprisonment of not more than five (5) years. In addition, persons who violate the statutes by knowingly making, offering, or receiving a payment, a rebate of a fee, or a charge for referring a patient to another provider for furnishing of Medicare or Medicaid benefits are prohibited from billing or collecting reimbursement from the patients or third-party payors and must repay the state for services that were related to the referral. Any conduct or

activity that does not violate, or that is protected under the provisions of the federal Stark Law or the federal Anti-Kickback Statute, or federal regulations promulgated under those statutes, would not be deemed to violate the provisions of the Kentucky statute and the conduct or activity would be accorded the same protections allowed under federal law. Conversely, any conduct or activity by any provider that violates the federal Stark Law or the federal Anti-Kickback Statute, where Medicare or Medicaid payment is involved, would be deemed to violate the provisions of the Kentucky self-referral restrictions law.

There can be no assurance that one or more of the Health Care Users will not be found to have violated such laws. Sanctions under the federal Stark Law and similar laws in Kentucky and in other states in which the Health Care Users operate, including exclusion from the Medicare and Medicaid programs, could have a material adverse effect on the financial condition and results of operations of the affected Health Care User.

In the current regulatory climate, hospitals and physician groups are subject to an audit, investigation, or other enforcement action regarding the healthcare fraud laws mentioned above. 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 also 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 healthcare fraud laws described above, and therefore penalties or settlement amounts often are compounded. Generally these risks are not covered by insurance.

Controlled Substances Act. The Controlled Substances Act contains pharmacy registration, packaging and labeling requirements, as well as record-keeping requirements related to a pharmacy's inventory and its receipt and disposition of all controlled substances. Kentucky has enacted similar legislation governing pharmacies' handling of controlled substances.

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 healthcare 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 healthcare providers. Insurance frequently does not provide coverage for judgments for punitive damages. The ability of, and the cost to, a Health Care User to insure or otherwise protect themselves against malpractice claims may adversely affect their future results of operations or financial condition.

The ability of healthcare providers to obtain malpractice insurance has deteriorated and concerns that the high cost of malpractice insurance has led physicians to leave Kentucky have increased. While various tort reform proposals have been considered (and in some instances passed) by the Kentucky General Assembly over the past few years, the "open courts" provisions of the Kentucky Constitution have made it difficult for adoption of meaningful tort reform in Kentucky. In 1998, the Kentucky Supreme Court struck down as unconstitutional the portion of a new punitive damage statute that increased the legal standard for punitive damages from recklessness to a "subjective awareness that harm will result." A proposed bill to amend the Kentucky Constitution and allow caps for non-economic and punitive damages and subject all medical malpractice claims to arbitration has been introduced in the Kentucky Senate on several occasions since 2003, but has not been adopted. Kentucky does not have a

referendum or initiative process permitting its citizens to directly amend the Kentucky Constitution. Any proposed constitutional amendment must be approved by a three-fifths majority in both the Kentucky House of Representatives and the Senate, and then approved by a majority of Kentucky voters.

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, certain of these risks may not be covered by insurance. For example, some antitrust claims or business disputes are not covered by insurance and may, in whole or in part, become a direct liability of a Health Care User if determined or settled adversely.

There is no assurance that a Health Care User will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against a healthcare facility or that such coverage will be available at a reasonable cost in the future.

Private Health Plans and Insurers

Certain private insurance companies contract with hospitals on an "exclusive" or a "preferred" provider basis, and some insurers have introduced plans known as "preferred provider organizations" (the "PPOs"). Under such plans, there may be financial incentives for subscribers to use only those hospitals which contract with the plans. Under an exclusive provider plan, which includes most health maintenance organizations (the "HMOs"), private payors limit coverage to those services provided by selected hospitals. With this contracting authority, private payors may direct patients away from unselected hospitals by denying coverage for services provided by them.

Most PPOs and HMOs currently pay hospitals on a discounted fee for service basis or on a discounted fixed rate per day of care. Many healthcare providers, including the Health Care Users, do not have accurate information about their actual costs of providing specific types of care, particularly since each patient presents a different mix of services and length of stay. Consequently, the discounts offered to HMOs and PPOs may result in payment at less than actual cost and the volume of patients directed to a hospital under an HMO or PPO contract may vary significantly from projections. Therefore, the future financial consequences of such contracts are unknown and their effect on the financial condition of a Health Care User may be different in the future than that reflected in the audited consolidated financial statements set forth in APPENDIX D.

Some HMOs offer and mandate a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" to, or otherwise directed to receive care at, a particular hospital. In a capitation payment system, the hospital assumes an insurance risk for the cost and scope of care given to such HMO's enrollees. In some cases, the capitated payment covers total patient care provided, including the physician's component. If payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care, the financial condition of the hospital may erode rapidly and significantly. Often, HMO or PPO contracts are enforceable for a stated term, regardless of provider losses. Furthermore, HMO contracts may contain a requirement that the hospital care for HMO enrollees for a certain period of time regardless of whether the HMO has funds to make payment to the hospital.

Some or all of the Health Care Users may have contracts with HMOs, PPOs and other managed care providers which terms include discounted fee for service payments, discounted fixed rate per day of care payments and DRG type payment. There is no assurance that a Health Care User will maintain such contracts or obtain other similar contracts in the future. Failure to maintain such PPO and HMO

contracts could have the effect of reducing the patient base or gross revenues of such Health Care User. Conversely, participation may maintain or increase the patient base, but may result in reduced payment and lower net income to such Health Care User. Furthermore, the effect of such contracts on the financial statements of a Health Care User may be different in the future than that reflected in the audited consolidated financial statements for the current period.

Increasingly, physician practice groups, independent practice associations and other physician management companies have become a part of the process of negotiating payment rates to hospitals by private insurers and health plans. This involvement has taken many forms but typically increases the competition for limited payment resources from private insurers and health plans.

Integrated Delivery Systems

Many hospitals and health systems, including the Health Care Users, are pursuing strategies with physicians that may be capital intensive and that may create certain business and legal liabilities for the related hospital or health system. Such integration strategies take many forms, including medical service organizations ("MSOs") or physician hospital organizations ("PHOs"), which may provide a combination of financial and managed care contracting, and facilities and equipment to groups of physicians. Other integration structures include accountable care organizations ("ACOs"), hospital-based clinics or medical practice foundations, which may purchase and operate physician practices as well as provide all administrative services to physicians.

Often the startup funding for such systems, as well as operational deficits, may be capitalized by the sponsoring hospital or health system. Depending on the size and organizational characteristics of a particular system, these capital requirements may be substantial. In some cases, the sponsoring hospital or health system may be asked to provide a financial guarantee for the debt of a related entity which is carrying out an integrated delivery strategy. In certain of these structures, the sponsoring hospital or health system may have an ongoing financial commitment to support operating deficits, which may be substantial on an annual or aggregate basis.

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

All such integrated delivery developments carry with them the potential for legal or regulatory risks in varying degrees. Such developments may call into question compliance with the Medicare Anti-Kickback Law or Stark laws (collectively, the "anti-referral laws") and relevant antitrust laws (discussed below under "Antitrust"). Questions of federal or state tax exemption may arise in certain types of developments or as a result of formation, operation or future modification of such developments. MSOs which operate at a deficit over an extended period of time may raise significant risks of investigation or challenge regarding tax exemption or compliance with the Medicare anti-referral laws. In addition, depending on the type of development, a wide range of governmental billing and reimbursement issues may arise, including questions of the authorization of the entity to bill for or on behalf of the physicians involved. Other related legal and regulatory risks may arise, including employment, pension and benefits, and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding healthcare and medical practice. There can be no assurance that such issues and risks will not lead to material adverse consequences in the future.

Physician Supply. Sufficient community-based physician supply is important to hospitals and other health care entities. A shortage of physicians, especially in primary care, could become a significant issue for health providers to face in the coming years. Any physician shortage will be compounded by the expansion of coverage to the uninsured under the Health Care Reform Act. In addition, CMS annually reviews overall physician reimbursement formulas. Changes to physician compensation formulas could lead to physicians locating their practices in communities with lower Medicare and Medicaid populations. Health care providers may be required to invest additional resources for recruiting and retaining physicians or may be required to increase the percentage of employed physicians in order to continue serving the growing population base and maintain market share.

Nationwide Nursing Shortage. Health care providers depend on qualified nurses to provide quality service to patients. There is currently a nationwide shortage of qualified nurses. This shortage and the more stressful working conditions it creates for those remaining in the profession are increasingly viewed as a threat to patient safety and may trigger the adoption of state and federal laws and regulations intended to reduce that risk. For example, some states are considering legislation that would prohibit forced overtime for nurses. In response to the shortage of qualified nurses, health care providers have increased and could continue to increase wages and benefits to recruit or retain nurses and have had to utilize more expensive contract nurses.

Affiliation, Merger, Acquisition and Divestiture

As with many multi-hospital systems, the Health Care Users plan for, evaluate and pursue potential merger and affiliation candidates on a consistent basis as a part of their overall strategic planning and development process. Such planning and discussions may result in changes in the number of hospitals over time. As part of their ongoing planning and property management functions, the Health Care Users review the use, compatibility and business viability of their operations, and from time to time the Health Care Users pursue changes in the use or disposition of their facilities. Likewise, the Health Care Users occasionally receive offers from, or conduct discussions with, third parties about the potential acquisition of operations or properties which may become part of the Health Care User's system in the future, or about the potential sale of some of the operations and properties which are a part of the Health Care User. Discussions with respect to affiliation, merger, acquisition, disposition, or change of use are held on a frequent, and usually confidential, basis with other parties and may include the execution of nonbinding letters of intent. As a result, it is possible that new hospitals will be added in the future, and that the organizations and assets which make up a Health Care User may change from time to time.

Currently, some or all of the Health Care Users are affiliated with other nonprofit and for-profit organizations. In certain instances, such affiliates may conduct operations which are of strategic importance to the applicable health Care User or its operations and may subject such Health Care User to potential legal or financial liabilities. In some cases, the Health Care Users may fund the affiliates on a startup or ongoing basis, and this funding may be significant.

Additional State Laws

States, including Kentucky, are increasingly regulating the delivery of health care services in response to the federal government's failure to adopt comprehensive health care reform measures. Much of this increased regulation has centered around the managed care industry. State legislatures have cited their right and obligation to regulate and oversee health care insurance and have enacted sweeping measures that aim to protect consumers and, in some cases, providers. In recent years, a number of states have enacted laws mandating a minimum of forty-eight hour hospital stays for women after delivery; laws prohibiting "gag clauses" (contract provisions which prohibit providers from discussing various issues with their

patients); laws defining "emergencies," which provide that a health care plan may not deny coverage for an emergency room visit if a lay person would perceive the situation as an emergency; and laws requiring direct access to obstetrician-gynecologists without the requirement of a referral from a primary care physician.

Due to this increased state oversight, the Health Care Users could be subject to a variety of state health care laws and regulations, affecting both managed care organizations and health care providers. In addition, the Health Care Users could be subject to state laws and regulations prohibiting, restricting or otherwise governing preferred provider organizations, third party administrators, physician-hospital organizations, independent practice associations or other intermediaries; laws prohibiting most favored nation clauses; fee-splitting; the "corporate practice of medicine"; selective contracting ("any willing provider" laws and "freedom of choice" laws); coinsurance and deductible amounts; insurance agency and brokerage; quality assurance, utilization review and credentialing activities; provider and patient grievances; mandated benefits; rate increases; and many other areas.

In the event that the Health Care Users engage in businesses subject to such laws, the Health Care Users may be required to comply with these laws or to seek appropriate licenses or other authorizations. Such requirements may impose operational, financial and legal burdens, costs or risks on the Health Care Users.

State Budgets

Many states, including Kentucky, face significant financial challenges, including erosion of general fund tax revenues, falling real estate values, slowing economic growth and higher unemployment, each of which may continue or worsen over the coming years. These factors have resulted in a sizeable shortfall between anticipated revenues and spending demands. The duration and extent of the impact of COVID-19 on the Commonwealth's revenues, expenses and cashflow are uncertain and cannot be quantified with any degree of certainty at this time. For the current fiscal year, the Stay at Home Order will likely result in a negative revenue impact forcing budget reductions of a yet unknown magnitude. The Governor has extended the due date for certain Kentucky tax payments to July 15 from the normal April 15 date. Any income tax payment due April 15 may now be submitted on or before July 15 without penalty. Likewise, for the upcoming biennium, the duration and extent of the impact of COVID-19 make any predictions uncertain. In anticipation of a potential significant reduction in general fund revenues and cash balances, the Kentucky General Assembly adopted for the first time in history a one-year budget for the Commonwealth in lieu of the traditional two-year biennial budget.

The financial challenges facing states may negatively affect health care organizations in a number of ways. Some states, including Kentucky, may enact legislation designed to reduce their Medicaid expenditures through eligibility restrictions (causing a greater number of indigent, uninsured or underinsured patients) and additional reductions in Medicaid payment rates. The BBA may shift further funding responsibility from the Federal government to state governments, exacerbating the states' financial challenges. Moreover, the Health Care Reform Act provides for significant expansions to the Medicaid program, and Kentucky's then-Governor Beshear expanded Medicaid eligibility by executive action effective January 1, 2014. However, Kentucky's current governor, Matt Bevin, is pursuing a federal waiver for Kentucky's Medicaid program and has vowed to put an end to Kynect, the state's health insurance exchange. In the event Kentucky's Medicaid program is changed and the Kynect program terminated, these actions could have an as yet unknown effect on Health Care Users.

Antitrust

Enforcement of the antitrust laws against healthcare providers is becoming more common. 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 and certain pricing or salary setting activities, as well as other areas of activity. In some respects, the application of the federal and state antitrust laws to health care is still evolving, and enforcement activity by federal and state agencies appears to be increasing. Violation of the antitrust laws could be subject to criminal and/or civil enforcement by federal and state agencies, as well as by private litigants.

At various times, a Health Care User may be subject to an investigation by a governmental agency charged with the enforcement of the antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. The most common areas of potential liability are joint action among providers with respect to payor contracting, medical staff credentialing, division of services and use of a hospital's local market power for entry into related healthcare businesses. From time to time, a Health Care User is are or will be involved with all of these types of activities, and it cannot be predicted when or to what extent liability may arise.

With respect to payor contracting, a Health Care User may, from time to time, be involved in joint contracting activity with other hospitals or providers. The precise degree to which this or similar joint contracting activities may expose the participants to antitrust risk from governmental or private sources is dependent on a myriad of factual matters which may change from time to time. The Federal Trade Commission ("FTC") has recently taken several enforcement actions where they have found that certain activities of physician associations that negotiate and review payor contracts on behalf of their members constituted an unlawful horizontal price-fixing conspiracy. The FTC has concluded that, in the negotiation of non-risk contracts, the physician associations engaged in conduct designed to enhance the collective bargaining power of their members. In addition, a recent U.S. Supreme Court decision now allows physicians who are subject to adverse peer review proceedings to file federal antitrust actions against hospitals and seek treble damages under certain circumstances. Hospitals regularly have disputes regarding credentialing and peer review, and therefore may be subject to liability in this area. In addition, hospitals occasionally indemnify medical staff members who are involved in such credentialing or peer review activities, and may also be liable with respect to such indemnity. Recent court decisions have also established private causes of action against hospitals which use their local market power to promote ancillary healthcare businesses in which they have an interest. Such activities may result in monetary liability for the participating hospitals under certain circumstances where a competitor suffers business damage. Liability in any of these or other trade regulation areas may be substantial, depending on the facts and circumstances of each case.

The Health Care Users will work with, rely upon and sometimes invest in medical groups or medical group management companies. If any of these medical groups or management companies is determined to have violated the antitrust laws, the Health Care Users also may be subject to liability as a joint actor, or the value of any investment in such group or company may be affected.

Changes in Health Care Delivery

General. Efforts by health insurers and governmental agencies to limit the cost of health services and to reduce utilization of hospital and other health care facilities may reduce future revenues. Through various combinations of changes in governmental policy, advances in technology and treatment, increased costs of operations, increased charges, changes in payment methodology, utilization review, and greater competition, inpatient hospitalizations have generally decreased over the past five years. It is uncertain whether that decrease will continue, and to what extent the factors mentioned above will continue to create operational and economic uncertainty for hospitals in the United States. It is now generally acknowledged that hospital operations pose greater complexity and

higher risk than in years past, and this trend may continue. It is not practical to enumerate each and every operating risk which may result from operation of a health care entity, and certain risks or combinations of risks which are now unanticipated may have material adverse results in the future. Certain risks relating to operation of health care entities are enumerated below.

Labor Relations. Health care entities may be large employers with a wide diversity of employees. Increasingly, employees of health care entities are becoming unionized, and many health care entities have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trades.

Physician Contracting and Relations. The Health Care Users can reasonably be expected to enter into a wide variety of relationships with physicians. Many of these relationships may be of material importance to the operations of the facilities operated by such Health Care User, and, in an increasingly complex legal and regulatory environment, these relationships pose a variety of legal or business risks. Increasingly, the focus of these relationships is a physician practice group or independent practice association that concentrates a large number of physicians in a limited number of contracting organizations. This increases the importance of these contracts and increases the risk of the loss of one or more such contracts.

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, denied 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. All hospitals, including those operated by the Health Care Users, are subject to such risks.

Certain contracts between hospitals and physicians may be void or voidable by challenge from one of its participants in situations where a hospital exercises certain aspects of control over a physician's practice or where the physician is in a position to refer patients to the hospital and is compensated based on a percentage of revenues formula. In many cases, the determination of the validity of such agreements and the materiality of their loss is dependent on factual circumstances and on the relative position of the parties at a particular time. Consequently, the outcome cannot be determined with precision in advance of a dispute or controversy with respect to such relationships.

Certain contracts entered into with physicians or physician groups create an exclusive relationship. With increased competition among healthcare providers and the increasing frequency of the application of antitrust principles in healthcare, such exclusive relationships are subject to challenge, generally by other physicians competing with those who have the exclusive relationship. Absent facts which may arise from a specific challenge or controversy, the validity of such agreements cannot in many cases be accurately determined, nor can the materiality of the loss of the exclusive relationship to a hospital or the damages, if any, which might be assessed against the parties to it. The Health Care Users may have exclusive relationships of the type described.

Technology and Services. Scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient healthcare delivery may reduce utilization and revenues of the Health Care Users in the future. Technological advances in recent years have accelerated the trend toward the use by hospitals of sophisticated, and costly, equipment and

services for diagnosis and treatment. The acquisition and operation of certain equipment or services may continue to be a significant factor in hospital utilization, but the ability of the Health Care Users to offer such equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance such acquisitions or operations.

Competition. Increased competition from a wide variety of potential sources, including, but not limited to, other hospitals and continuing care communities, inpatient and outpatient healthcare facilities, clinics, physicians and others, could adversely affect the utilization and/or revenues of the Health Care Users. Existing and potential competitors may not be subject to various restrictions applicable to the Health Care Users, and competition may, in the future, arise from new sources not currently anticipated or prevalent.

Use of Technology; Cyber Threats

The Health Care Users use established and emerging technologies to deliver patient care, to communicate electronically regarding the same, and to maintain electronic medical records. Certain technologies used for these purposes by other healthcare providers have been targets of cyber-attacks undertaken to obtain individuals' health information and patient medical records or to render such technologies unusable such that the cyber attackers are able to demand payments of "ransom" for the release of such systems. While the Health Care Users employ information technology specialists whose role is to maintain the security of its systems and contracts with technology specialists to reduce the risk and efficacy of any such attacks on its systems, there can be no guarantee that such attacks will not be attempted or will not succeed. If any such attack against the Health Care Users were attempted, there can be no guarantee that the delivery of patient care or the security of individuals' health information or patient medical records would not be compromised. Further, if any such attach against a Health Care User were attempted, there can be no guarantee as to the speed with which or the cost at which such Health Care User could regain control of or access to its technologies. In the event that such an attack were successful in reaching individuals' health information or patient medical records, the Health Care User be financially liable for such breach. Any of the foregoing events could have an adverse and material effect on such Health Care User. See "BONDHOLDERS' RISKS – Additional Risk Factors Impacting the Health Care Industry - Patient Records and Confidentiality," "BONDHOLDERS' RISKS – Additional Risk Factors Impacting the Health Care Industry - Security Breaches and Unauthorized Releases of Personal Information" and "BONDHOLDERS' RISKS – Additional Risk Factors Impacting the Health Care Industry - Electronic Health Records."

Charity Care, Underinsured and Uninsured Patients

Recently, focus has increased on the provision of charity care by nonprofit health care institutions and their pricing policies and billing and collection practices involving the underinsured and uninsured. This increased focus has resulted in congressional hearings, governmental inquiries (including by the IRS) and private class action litigation against more than 100 nonprofit health care institutions nationwide, generally alleging the overcharging of underinsured and uninsured patients. No predictions can be made on the impact that these or related developments may have on the Health Care Users or the health care industry generally.

Other Risk Factors

The following factors, among others, may also affect the operations or financial performance of the Health Care Users:

- Competition from hospitals and/or continuing care retirement communities located within and outside of the Health Care Users' primary and secondary service areas, from other types of health care providers that may offer comparable health care services, and from alternative or substitute health care delivery systems or programs, may decrease utilization of the Health Care Users' facilities.
- Increased efforts by insurers and governmental agencies to limit the cost of hospital services (including, without limitation, the implementation of a system of prospective review of hospital rate changes and negotiating discounted rates), to reduce the number of hospital beds and to reduce utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety, and outpatient care.
- Cost increases without corresponding increases in revenue could result from, among other factors: increases in the salaries, wages, and fringe benefits of hospital employees, increases in costs associated with advances in medical technology or with inflation or future legislation which would prevent or limit the ability of the Health Care Users to increase revenues.
- Any termination or alteration of existing agreements between the Health Care Users and individual physicians and physician groups who render services to the patients of the Health Care User or any termination or alteration of referral patterns by individual physicians and physician groups who render services to the patients of the Health Care User with whom the Health Care User does not have contractual arrangements.
- Future contract negotiations between public and private insurers and participating hospitals, including the Health Care Users, and other efforts of these insurers and of employers to limit hospitalization costs and coverage could adversely affect the level of reimbursement to the Health Care Users.
- The ability of, or the cost to, the Health Care Users to continue to insure or otherwise protect itself against malpractice and general liability claims.
- Future legislation and regulations affecting hospitals, their tax-exempt status, governmental and commercial medical insurance and the health care industry in general could adversely affect the operations of the members of the Health Care Users.
- Medical and other scientific advances resulting in decreased usage of hospital facilities or services, including those of the Health Care Users.
- An inflationary economy and difficulty in increasing room charges and other fees charged while at the same time maintaining the amount or quality of health services may affect the ability of the Health Care Users to maintain sufficient operating margins.
- The cost and effect of any future unionization of employees of the Health Care Users.
- The possible inability to obtain future governmental approvals to undertake projects necessary to remain competitive both as to rates and charges as well as quality and scope of care could adversely affect the operation of the Health Care Users.
- Imposition of wage and price controls for the health care industry, such as those that were imposed and adversely affected health care facilities in the early 1970s.
- Limitations on the availability of and increased compensation necessary to secure and retain nursing, technical or other professional personnel.
- Changes in law or revenue rulings governing the nonprofit or tax-exempt status of charitable corporations, such that nonprofit corporations such as the Health Care Users, as a condition of maintaining their tax-exempt status, are required to provide increased indigent care at reduced rates or without charges or discontinue services previously provided.
- Efforts by taxing authorities to impose or increase taxes related to the property and operations of nonprofit organizations or to cause nonprofit organizations to increase the amount of services provided to indigents to avoid the imposition or increase of such taxes.
- Proposals to eliminate the tax-exempt status of interest on bonds issued to finance health facilities, or to limit the use of such tax-exempt bonds, have been made in the past, and may

be made again in the future. The adoption of such proposals would increase the cost to the Health Care Users of financing future capital needs.

- Increased unemployment or other adverse economic conditions which could increase the proportion of patients who are unable to pay fully for the cost of their care. In addition, increased unemployment caused by a general downturn in the economy of the Health Care Users' service areas or by the closing of operations of one or more major employers in such service areas may result in a significant change in the demographics of such service areas, such as a reduction in the population.

The occurrence of one or more of the foregoing, or the occurrence of other unanticipated events, could materially adversely affect the financial performance of the Health Care Users.

LITIGATION
[TO BE UDPATED]

The Corporation

There is no litigation pending or, to the Corporation's knowledge, threatened, against the Corporation that, if resolved adversely to the Corporation, would, in the opinion of the Corporation, have a material and adverse effect on the Corporation's financial position or operations or on the validity of the Corporation's obligations under the Loan Agreement.

The Issuer

There is no litigation pending or, to the Issuer's knowledge, threatened against the Issuer to restrain or enjoin the issuance, sale, execution or delivery of the Bonds, or in any way contesting or affecting the validity of the Bonds or any proceedings of the Issuer taken with respect to the issuance or sale thereof, or the pledge or application of any moneys or the security provided for the payment of the Bonds or the existence or powers of the Issuer.

TAX TREATMENT

In the opinion of Bond Counsel, under the Constitution and laws of the Commonwealth of Kentucky and official interpretations thereof, interest on the Bonds is subject to income taxation by the Commonwealth of Kentucky, but the Bonds are exempt from *ad valorem* taxation by the Commonwealth of Kentucky and its political subdivisions. Interest on the Bonds is includable in gross income for federal income tax purposes. Bond Counsel expresses no opinion regarding other federal tax consequences with respect to the Bonds. Reference is made to the form of proposed opinions of Bond Counsel contained in Appendix I hereto.

FINANCIAL STATEMENTS

The combined financial statements for the Corporation and the Plant included in **Appendix B** have been audited by _____, independent accountants, as stated in their report included in **Appendix B**. The financial statements of Norton Healthcare, Inc. included in **Appendix C** have been audited by _____, independent accountants, as stated in their report included in **Appendix C**. The financial information for the UofL Health-Louisville, Inc. included in included in **Appendix D** have been audited by _____, independent accountants, as stated in their report included in **Appendix D**. The audited financial statements of the University of Louisville included in **Appendix E** have been audited by _____, independent accountants, as stated in their report included in **Appendix E**. The audited financial statements of University Medical Center, Inc. included in **Appendix F** have been audited by _____, independent accountants, as stated in their report

included in **Appendix F**. The audited financial statements of the Kentucky Community and Technical College System included in **Appendix G** have been audited by _____, independent accountants, as stated in their report included in **Appendix G**.

LEGAL MATTERS

All legal matters incident to the validity of the Bonds are subject to the approval of Dinsmore & Shohl LLP, Louisville, Kentucky, Bond Counsel, whose opinions will be delivered with the Bonds substantially in the forms included herein at **Appendix I.** Certain legal matters will be passed upon for the Issuer by its County Attorney, Michael J. O'Connell, Esq., for the Corporation by its counsel, Dinsmore & Shohl LLP, Louisville, Kentucky; and for the Underwriter by its counsel, Frost Brown Todd LLC, Louisville, Kentucky.

RATING

Standard & Poor's Rating Service, a division of The McGraw Hill Companies, Inc. ("S&P") has assigned ratings of "__" to the Bonds. The Corporation has not applied for a rating from any other rating agency. This rating reflects only the view of S&P and any explanation of the significance of the ratings may be obtained only from S&P. Generally, a rating agency bases its rating on information and materials furnished to it and on investigations, studies and assumptions made by the rating agency. There is no assurance that the rating mentioned above will remain in effect for any given period of time or that the rating may not be lowered or withdrawn entirely by S&P if in its judgment circumstances so warrant. Any downward change in or withdrawal of a rating may have an adverse effect on the market price or marketability of the Bonds.

UNDERWRITING

The Bonds are being purchased for reoffering by Robert W. Baird & Co. Incorporated (the "Underwriter"). The Underwriter has agreed, subject to certain conditions, to purchase the Bonds from the Issuer at a purchase price of $_____for the Bonds (representing the principal amount of the Bonds, less Underwriter's discount in the amount of $_____, plus [less] net original issue premium [discount] in the amount of $_____). The initial public offering prices of the Bonds set forth on the inside cover page of this Official Statement may be changed from time to time by the Underwriter without any requirement of prior notice. The Underwriter reserves the right to join with other dealers in offering the Bonds to the public. The Bonds may be offered and sold to other dealers (including Bonds for deposit into investment trusts, certain of which may be sponsored or managed by the Underwriter) at prices other than the public offering prices stated on the inside cover page of this Official Statement.

CONTINUING DISCLOSURE
[TO BE UPDATED]

In accordance with Securities and Exchange Commission Rule 15c2-12, as amended (the "Rule"), the Corporation will agree, pursuant to a Continuing Disclosure Agreement between the Corporation and the Trustee, to be delivered on the date of issuance and delivery of the Bonds (the "Corporation Disclosure Agreement"), to cause the following information to be provided:

(i) to the Municipal Securities Rulemaking Board (the "MSRB"), certain annual financial information and operating data, including audited financial statements prepared in accordance with generally accepted accounting principles, generally consistent with the information contained for the Corporation in Appendices A and B (collectively, the "Corporation Annual Financial Information"); such

Corporation Annual Financial Information to be provided on or before 180 days following the end of the fiscal year of the Corporation, commencing with the fiscal year ending December 31, 2020;

(ii) to the MSRB through EMMA, in a timely manner, not in excess of ten business days after the occurrence of the event, notice of the occurrence of the following events with respect to the Bonds:

(a) Principal and interest payment delinquencies;
(b) Non-payment related defaults, if material;
(c) Unscheduled draws on debt service reserves reflecting financial difficulties;
(d) Unscheduled draws on credit enhancements reflecting financial difficulties;
(e) Substitution of credit or liquidity providers, or their failure to perform;
(f) Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the security, or other material events affecting the tax-exempt status of the security;
(g) Modifications to rights of security holders, if material;
(h) Bond calls, if material, and tender offers (except for mandatory scheduled redemptions not otherwise contingent upon the occurrence of an event);
(i) Defeasances;
(j) Release, substitution or sale of property securing repayment of the securities, if material;
(k) Rating changes;
(l) Bankruptcy, insolvency, receivership or similar event of the obligated person (Note: For the purposes of this event, the event is considered to occur when any of the following occur: The appointment of a receiver, fiscal agent or similar officer for an obligated person in a proceeding under the U.S. Bankruptcy Code or in any other proceeding under state or federal law in which a court or governmental authority has assumed jurisdiction over substantially all of the assets or business of the obligated person, or if such jurisdiction has been assumed by leaving the existing governing body and officials or officers in possession but subject to the supervision and orders of a court or governmental authority, or the entry of an order confirming a plan of reorganization, arrangement or liquidation by a court or governmental authority having supervision or jurisdiction over substantially all of the assets or business of the obligated person);
(m) The consummation of a merger, consolidation, or acquisition involving an obligated person or the sale of all or substantially all of the assets of the obligated person, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and
(n) Appointment of a successor or additional trustee or the change of name of a trustee, if material;
(o) Incurrence of a financial obligation of the Obligated Person, if material, or agreement to covenants, events of default, remedies, priority rights, or other similar terms of a financial obligation of the issuer or obligated person, any of which affect security holders, if material; and

(p) Default, event of acceleration, termination event, modification of terms, or other similar events under the terms of the financial obligation of the Obligated Person, any of which reflect financial difficulties.

(iii) in a timely manner, to the MSRB through EMMA, notice of a failure (of which the Corporation has knowledge) of the Corporation to provide the required Annual Financial Information on or before the date specified in the Corporation Disclosure Agreement.

The Corporation Disclosure Agreement provide a Holder, including Beneficial Owners of the Bonds, with certain enforcement rights in the event of a failure by the Corporation to comply with the terms thereof; however, defaults under the Corporation Disclosure Agreements does not constitute an event of default under the Indenture. The Corporation Disclosure Agreement may also be amended or terminated under certain circumstances in accordance with the Rule as more fully described therein. Holders of the Bonds are advised that the Corporation Disclosure Agreement, the form of which is attached hereto as Appendix J, should be read in its entirety for more complete information regarding its contents.

In accordance with the Rule, the Corporation has determined that each of the University, Norton, UofL Hospital, UofL Health and KCTCS constitutes an "Obligated Person" under the Rule (each an "Obligated Persons," and collectively, the "Obligated Persons"). Accordingly, each of the Obligated Persons will agree, pursuant to separate Continuing Disclosure Agreements between each of the Obligated Persons and the Trustee, or, in the case of Norton, pursuant to a Continuing Disclosure Undertaking, to be delivered on the date of issuance and delivery of the Bonds (collectively, the "Obligated Person Undertakings"), to cause the following information to be provided:

(a) to the Municipal Securities Rulemaking Board (the "MSRB"), certain annual financial information and operating data, including (i) in the case of the University, Norton, UofL Health and KCTCS, audited financial statements prepared in accordance with generally accepted accounting principles, generally consistent with the information contained for each of the Obligated Persons in Appendices C, E and G, and (ii) in the case of University Medical, their consolidated balance sheets and consolidated statements of operations and changes in net assets (collectively, the "Obligated Persons Annual Financial Information"); such information to be provided on or before 180 days following the end of the fiscal year of each of such Obligated Persons;

(b) to the MSRB, in a timely manner, not in excess of ten business days after the occurrence of the event, notice of the occurrence of the following events with respect to the applicable Obligated Person; and

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

(ii) The consummation of a merger, consolidation, or acquisition involving the Obligated person or the sale of all or substantially all of the assets of the Obligated Person, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

(c) to the MSRB, notice of a failure (of which the Obligated Person has knowledge) of the Obligated Person to provide the required Annual Financial Information of the Obligated Person on or before the date specified in the Obligated Person Undertaking.

Each of the Obligated Persons previously entered into continuing disclosure undertakings in connection with the issuance of the Series 2012A Bonds and the Series 2016 Bonds. In the preceding five year period, the Corporation has, to the best of the Corporation's knowledge, complied in a timely manner with its disclosure undertakings with respect to the Series 2012A Bonds and the Series 2016 Bonds as it relates to providing its audited financial statements. The Corporation was, however, late in filing the operating data (generally consistent with the operating data contained in Appendix A of the Official Statement for the Series 2012A Bonds), for the fiscal year ending December 31, 2015. During this same period Norton has, to the best of the Corporation's knowledge, complied in a timely manner with its disclosure undertakings with respect to the Series 2012A Bonds and the Series 2016 Bonds. During this same period University Medical, JHSMH and the University filed annual financial information generally consistent with the requirements set forth in the prior continuing disclosure undertakings for the Series 2012A Bonds such earlier continuing disclosure undertakings for all periods with a fiscal year that ended after December 31, 2011, except that University Medical's audited financial statements for December 31, 2012 were filed after the due date specified in its prior disclosure undertakings and no unaudited financial statements for JHSMH were available for the period ending June 30, 2012, since, as of January 1, 2012, JHSMH was consolidated with KentuckyOne Health and no twelve-month data for the period ending June 30, 2012 was available. For fiscal years that ended on or before December 31, 2011, University Medical, Jewish and the University filed annual financial information generally consistent with the requirements set forth in earlier continuing disclosure undertakings; however, such filings were undertaken in accordance with continuing disclosure undertakings for financings unrelated to those earlier bonds of the Corporation and neglected to incorporate a reference to the disclosure undertakings related to the earlier series of bonds issued by the Corporation. The audited financial statements for the Plant Users for the fiscal periods ending on June 30, 2011 or December 31, 2011, as applicable, were included in the Official Statement for the Series 2012A Bonds. KCTCS's annual financial information for the fiscal year periods ending June 30, 2011, June 30, 2012, June 30, 2013 and June 30, 2015 were not filed within the timeframe specified in the disclosure undertakings entered into by KCTCS in connection with the earlier series of bonds refunded by the Series 2012A Bonds and the disclosure undertaking for the Series 2012A Bonds, although such annual financial information was subsequently submitted and was also publicly available due to KCTCS' status as a governmental agency of the Commonwealth of Kentucky. KCTCS's annual financial information for the fiscal year period ending June 30, 2014 was, to the best of the Corporation's knowledge, filed in a timely manner in accordance with KCTCS' disclosure undertakings relating to the earlier series of bonds refunded by the Series 2012A Bonds and the disclosure undertaking for the Series 2012A Bonds. In order to insure future timely submission of the Annual Financial Information by each of the Obligated Persons, the User Contract contains provisions setting forth an obligation of each Obligated Person to enter into the Obligated Person Undertaking, and each of the Obligated Person Undertakings provides that the Corporation may be designated as the agent for the respective Obligated Persons in connection with the submission of future filings.

RELATIONSHIP AMONG PARTIES

As noted under the heading "LEGAL MATTERS" herein, Dinsmore & Shohl LLP ("Dinsmore") will deliver its approving legal opinion as bond counsel with respect to the issuance of the Bonds and will also deliver a legal opinion on certain matters as counsel to the Corporation. Both the Corporation and the Underwriter have consented to Dinsmore's acting as both bond counsel and counsel to the Corporation following Dinsmore's disclosure to the Corporation and the Underwriter, in accordance with the requirements of the Kentucky Rules of Professional Conduct, of conflicts which may arise from such dual representations. However, certain events may hereafter occur that create a conflict requiring Dinsmore to withdraw from its representation of the Corporation.

Dinsmore has represented and may hereafter represent the Corporation from time to time on matters unrelated to the Bonds.

MISCELLANEOUS

Except for the information under the captions "THE ISSUER", "THE BONDS - BOOK-ENTRY ONLY SYSTEM", "SECURITY AND SOURCES OF PAYMENT FOR THE BONDS; ADDITIONAL BONDS", "LITIGATION - The Issuer", "TAX TREATMENT," "LEGAL MATTERS", and "RATING" and in Appendices C through J herein, all information in this Official Statement and in the Appendices has been furnished by the Corporation and the Plant Users. Such information has been reviewed and approved by representatives of the Corporation for use in this Official Statement. The Issuer and the Underwriter assume no responsibility for the accuracy or completeness of such information.

The use and distribution of this Official Statement have been duly authorized by the Issuer and the Corporation.

Solely for purposes of the Rule, the Issuer and the Corporation have deemed this Official Statement final as of its date within the meaning of the Rule, except for the omission of certain pricing and other information permitted to be omitted pursuant to the Rule.

LOUISVILLE /JEFFERSON COUNTY METRO GOVERNMENT

By: /s/
Mayor

APPROVED:
LOUISVILLE MEDICAL CENTER, INC.

By: /s/
General Manager

0141958.0731499 4830-4343-2124v2

APPENDIX A

Financial and Operating Data Regarding the Plant

APPENDIX B

Audited Combined Financial Statements for the Plant and the Corporation for the Fiscal Years Ended December 31, 2019 and December 31, 2018 and Unaudited Financial Information for the Period(s) Ending _____ 30, 20__

APPENDIX C

Audited Financial Statements of Norton Healthcare, Inc. for the Fiscal Years Ended December 31, 2018 and December 31, 2019

APPENDIX D

Unaudited Financial Statements of UofL Health-Louisville, Inc. for the Fiscal Year Ended June 30, 2019

APPENDIX E

Audited Financial Statements of the University of Louisville for the Fiscal Years Ended June 30, 2018 and June 30, 2019

APPENDIX F

Unaudited Financial Statements of University Medical Center, Inc.
for the Fiscal Year Ended June 30, 2019

APPENDIX G

Audited Financial Statements of the Kentucky Community & Technical College System for the Fiscal Years Ended June 30, 2018 and June 30, 2019

APPENDIX H

Definitions of Certain Terms and Summaries of Legal Documents

APPENDIX I

Opinion of Bond Counsel

APPENDIX J

Form of Continuing Disclosure Agreement