

HOSPITAL TRUST DISTRIBUTION PROCEDURES¹

§ 1. APPLICABILITY.

Pursuant to the plan of reorganization of Mallinckrodt PLC and its Debtor affiliates (the “Plan”)², the following claims (“Hospital Channeled Claims”) shall be channeled to and liability therefor shall be assumed by the Hospital Trust as of the Effective Date: all Hospital Claims,³ which are all Claims against the Debtors held by providers of healthcare treatment services or any social services, in their capacity as such, that are not Governmental Units.⁴ Hospital Channeled Claims shall be administered, liquidated and discharged pursuant to the Hospital Trust Documents, and satisfied solely from funds held by the Hospital Trust as and to the extent provided in these distribution procedures (this “Hospital TDP”). This Hospital TDP sets forth the manner in which the Hospital Trust shall make Abatement Distributions to Holders of Hospital Channeled Claims (such Abatement Distributions, “Hospital Abatement Distributions”) that satisfy the eligibility criteria for Authorized Recipients set forth herein. Hospital Channeled Claims shall be fully discharged pursuant to this Hospital TDP.

Hospital Authorized Recipients (as defined below) are required to use all funds distributed to them from the Hospital Trust solely and exclusively for (i) the Authorized Abatement Purposes set forth in § 7 or (ii) the payment of attorneys’ fees and costs of Holders of Hospital Channeled Claims (including counsel to the Ad Hoc Group of Hospitals) (such Authorized Abatement Purposes, collectively, “Hospital Authorized Abatement Purposes”).

§ 2. CLAIMS ADMINISTRATION.

The Plan contemplates that the Hospital Trust will receive 3.57% of the Opioid MDT II Distributable Value (i) after deducting from the Opioid MDT II Distributable Value (a) reserved expenses for items (a) and (b) of the definition of Opioid MDT II Operating Expenses, and (b) the U.S. Government Opioid Claims Share, and (ii) gross of applicable Private Opioid Creditor Trust Deductions and Holdbacks.

So long as he is able to serve as of the Effective Date, the presumptive trustee of the Hospital Trust is Hon. Thomas Hogan (Ret.) (the “Trustee”). If Judge Hogan is not able to serve, then a new

¹ These procedures are qualified by the terms of the Plan. Holders of Hospital Channeled Claims are strongly advised to review the Plan as well as all of the Hospital Trust Documents and the Debtors’ Disclosure Statement for additional information on the terms of the Plan and the treatment of Hospital Channeled Claims.

² Terms used but not defined herein shall have the meaning ascribed to them in the Plan.

³ For the avoidance of doubt, “Hospital Claim,” as defined in the Plan, means “Opioid Claims (including Opioid Demands) held by a provider of healthcare treatment services or any social services, in its capacity as such, and that is not held by a Governmental Unit. For the avoidance of doubt, Hospital Opioid Claims exclude Emergency Room Physicians Opioid Claims.” (See Plan, Article I, A (Defined Terms) at ¶ 190 (definition of “Hospital Opioid Claims.”).

⁴ For the avoidance of doubt, “Governmental Unit,” as defined in the Plan, means “a governmental unit as defined in section 101(27) of the Bankruptcy Code and shall for the avoidance of doubt, include Tribes. For the avoidance of doubt, this term does not include any non-federal acute care hospitals.”

Trustee will be selected in accordance with the Plan in advance of the Effective Date by the Ad Hoc Group of Hospitals in consultation with the Debtors.⁵

The Trustee shall have the power and authority to perform all functions on behalf of the Hospital Trust, and shall undertake all administrative responsibilities as are provided in the Plan and the Hospital Trust Documents.⁶ The Trustee shall be responsible for all decisions and duties with respect to the Hospital Trust.⁷

The Trustee shall have the authority to determine the eligibility of Hospital Authorized Recipients and the amount of Hospital Abatement Distributions made by the Hospital Trust. In order to qualify as a Hospital Authorized Recipient and be eligible to receive a Hospital Abatement Distribution, Holders of Hospital Channeled Claims must comply with the terms, provisions and procedures set forth herein, including the Hospital Abatement Distribution Form Deadline and the timely submission of all forms required pursuant hereto. The Trustee may investigate any Hospital Channeled Claim, and may request information from any Holder of a Hospital Channeled Claim to ensure compliance with the terms set forth in this Hospital TDP, the other Hospital Trust Documents and the Plan.

Pursuant to section 1123(b)(3)(B) of the Bankruptcy Code and applicable state corporate law, the Trustee shall be and is appointed as the successor-in-interest to, and the representative of, the Debtors and their Estates for the retention, enforcement, settlement or adjustment of the Hospital Channeled Claims.

⁵ The Hospital Trust Agreement shall provide that, in the event of a vacancy in the Trustee position, whether by term expiration, death, retirement, resignation, or removal, the vacancy shall be filled by the unanimous vote of the Hospital Trust Advisory Committee (the “TAC”); in the event that the TAC cannot appoint a successor Trustee, for any reason, the Bankruptcy Court shall select the successor Trustee.

⁶ The Hospital Trust Agreement shall provide that the Trustee shall have the power to appoint such officers, hire such employees, engage such legal, financial, accounting, investment, auditing, forecasting, and other consultants, advisors, and agents as the business of the Hospital Trust requires, and delegate to such persons such powers and authorities as the fiduciary duties of the Trustee permit and as the Trustee, in its discretion, deem advisable or necessary in order to carry out the terms of the Hospital Trust, including without limitation the Delaware Trustee, and any third-party claims or noticing agent deemed necessary or convenient by the Trustee, and pay reasonable compensation to those employees, legal, financial, accounting, investment, auditing, forecasting, and other consultants, advisors, and agents employed by the Trustee after the Effective Date (including those engaged by the Hospital Trust in connection with its alternative dispute resolution activities).

⁷ The Hospital Trust Agreement shall provide that: (i) the Trustee shall receive a retainer from the Hospital Trust for his or her service as a Trustee in the amount of \$25,000 per annum, paid annually; (ii) hourly time shall first be billed and applied to the annual retainer; (iii) hourly time in excess of the annual retainer shall be paid by the Hospital Trust; (iv) for all time expended as a Trustee, including attending meetings, preparing for such meetings, and working on authorized special projects, the Trustee shall receive the sum of \$525 per hour; (v) for all non-working travel time in connection with Hospital Trust business, the Trustee shall receive the sum of \$275 per hour; (vi) all time shall be computed on a decimal (1/10th) hour basis; and (vii) the Trustee shall not be required to post any bond or other form of surety or security unless otherwise ordered by the Bankruptcy Court.

§ 3. QUALIFYING CERTIFICATION.

To qualify as a Hospital Authorized Recipient, a Holder of a Hospital Channeled Claim must certify in its Hospital Abatement Distribution Form (as defined below) that:

- (a) It adheres to the standard of care for the emergency department, hospital wards and outpatient clinics at the time of any prospective evaluation, diagnosis, and treatment of OUD, including with respect to the applicable standard of care for the treatment of addiction, acute withdrawal and treatment for OUD with medication assisted treatment; and
- (b) It provides discharge planning and post-discharge care coordination for patients with OUD, including information for appropriate OUD treatment services.

§ 4. ELIGIBILITY FOR HOSPITAL ABATEMENT DISTRIBUTIONS; NOTICES.

- (a) Eligibility for Hospital Abatement Distributions

To qualify as a Hospital Authorized Recipient eligible to receive Hospital Abatement Distributions from the Hospital Trust, each applicable Holder of a Hospital Channeled Claim must:

- (i) Timely submit the form attached hereto as Exhibit A (the “Hospital Abatement Distribution Form”) containing:
 - A. the certification set forth in § 3;
 - B. a certification signed by the Holder of a Hospital Channeled Claim or its attorney attesting to the accuracy and truthfulness of the Holder of a Hospital Channeled Claim’s submission. Such certification must include an attestation that no data required for claims processing and distribution valuation, and no records or information that would reasonably be relevant to the valuation of the distribution, have been misrepresented or withheld; and
 - C. the certification that the Holder of a Hospital Channeled Claim will comply with § 7 in its use of any funds distributed to it; and
- (ii) Provided all of the requisite claims data (as described in § 5, the “Requisite Claims Data”) in connection with submitting a Hospital Abatement Distribution Form.

Provided, however, that a Holder of a Hospital Channeled Claim that previously timely filed a Proof of Claim in the Chapter 11 Cases of *Purdue Pharma, L.P.* et al, No. 19-23649 in the United States Bankruptcy Court for the Southern District of New York (“Purdue”) that contained all of the Requisite Claims Data (as defined in section § 5) for such Hospital Claims have satisfied the requirements of § 4(a)(i) and § 4(a)(ii).

Any Holder of a Hospital Channeled Claim who meets all of the above criteria (i)0-(ii) (each, a “Hospital Authorized Recipient”) shall qualify for Hospital Abatement Distributions, subject to the limitations otherwise set forth herein; however, if such Holder does not meet such criteria, then it will not qualify as a Hospital Authorized Recipient and will not receive any Hospital Abatement Distributions. Any discrepancy as to whether a Holder of a Hospital Channeled Claim qualifies as a Hospital Authorized Recipient pursuant to the criteria as set forth in this § 4(a) will be resolved by the Trustee.

FOR AVOIDANCE OF DOUBT, FOR A HOLDER OF A HOSPITAL CHANNELED CLAIM TO QUALIFY AS A HOSPITAL AUTHORIZED RECIPIENT AND BE ELIGIBLE TO RECEIVE A HOSPITAL ABATEMENT DISTRIBUTION, SUCH HOLDER OF A HOSPITAL CHANNELED CLAIM MUST TIMELY SUBMIT A FULLY COMPLETED HOSPITAL ABATEMENT DISTRIBUTION FORM BY OR BEFORE THE HOSPITAL ABATEMENT DISTRIBUTION FORM DEADLINE (THAT IS, FORTY-FIVE (45) DAYS AFTER THE DATE OF THE APPLICABLE HOSPITAL ABATEMENT DISTRIBUTION DEADLINE NOTICE, AS SET FORTH HEREIN).

(b) Notices

- (i) As soon as reasonably practicable after the Effective Date of the Plan, the Trustee or the Claims Administrator, as applicable, shall cause a notice to be served on each Holder of a Hospital Channeled Claim that (i) is listed on the national registry of hospitals maintained by the American Hospital Directory®, as in effect on the Effective Date *and* (ii) is (x) a non-federal acute care hospital as defined by CMS or (y) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care. Such notice shall contain, among other things that the Trustee deems reasonable and appropriate under the circumstances, (i) this Hospital TDP, including the Hospital Abatement Distribution Form attached hereto, (ii) the URL for the Debtors’ claims and noticing website where such Hospitals can locate the Plan (<https://restructuring.primeclerk.com/mallinckrodt>), and (iii) clear instructions for submitting a Hospital Abatement Distribution Form to the Trustee, the deadline set forth in each such Hospital Abatement Distribution Form for submitting the Hospital Abatement Distribution Form being 45 days after the date of such notice.
- (ii) For any Holder of a Hospital Channeled Claim that receives a Hospital Abatement Distribution Deadline Notice pursuant to § 4(b)(i) hereof and submits a Hospital Abatement Distribution Form, and all of its parts, by the applicable deadline (with respect to each such notice, the “Hospital Abatement Distribution Form Deadline”) and whose Hospital Abatement Distribution Form is substantially complete but otherwise defective in such a manner as to render such Holder of a Hospital Channeled Claim ineligible to receive Hospital Abatement Distributions, and to the extent such defect is determined by the Trustee to be curable, the Trustee, as applicable, shall provide such Holder of a Hospital Channeled Claim with notice of the

defect and a reasonable period of time following delivery of such notice for such Holder of a Hospital Channeled Claim to cure such defective Hospital Abatement Distribution Form. The Trustee shall exercise discretion in determining defect, curability and the period of time in which a defect may be cured. Under no circumstance is the Trustee obligated to send a notice of defect for Hospital Abatement Distribution Forms that do not provide responses to the requirements set forth under §§ § 40 and § 4(a)(ii).

- (iii) Other than pursuant to the cure procedures set forth herein, any Holder of a Hospital Channeled Claim that does not submit a Hospital Abatement Distribution Form shall not qualify as a Hospital Authorized Recipient, and any Holder of a Hospital Channeled Claim that submits a Hospital Abatement Distribution Form after the Hospital Abatement Distribution Form Deadline shall not qualify as a Hospital Authorized Recipient. No Hospital Abatement Distribution Form shall be accepted after the Hospital Abatement Distribution Form Deadline.

§ 5. EVIDENCE FOR DETERMINATION OF HOSPITAL ABATEMENT DISTRIBUTIONS.

- (a) To permit the Trustee to evaluate the amount each Hospital Authorized Recipient is to receive as a Hospital Abatement Distribution, and to the extent not already submitted in connection with its Proof of Claim, a Holder of a Hospital Channeled Claim must submit all of the following, non-exhaustive, data and types of documents, unless otherwise determined in the discretion of the Trustee in consultation with the TAC and consistent with § 4(b)(iii), collectively the “Requisite Claims Data”.
 - (i) A properly and fully completed Hospital Abatement Distribution Form, with all its parts and requisite submissions, as established by the Trustee, consistent with the requirements set forth in § 4(a)(i); and
 - (ii) copies of all claims, complaints, proofs of claim, notices, settlement documents, releases, recoveries, compensation received, or similar documents that a Holder of a Hospital Channeled Claim submits or entered into in respect of claims asserted against or to be asserted against any other entity or person arising from or related to such Holder of a Hospital Channeled Claim’s OUD program or related to any of the injuries that underlie that claim presented to the Trustee.

The Trustee may request additional information as reasonably necessary in the opinion of the Trustee to determine the amount to be distributed to a Hospital Authorized Recipient. The Trustee shall establish a reasonable timeframe in which a Hospital Authorized Recipient must provide any requested information.

§ 6. DETERMINATION OF HOSPITAL ABATEMENT DISTRIBUTION AMOUNTS.

- (a) The Trustee (or its agents or representatives) shall review the timely submitted Hospital Abatement Distribution Forms.
- (b) The Trustee shall utilize (but shall have no rights in or to the intellectual property contained in) the proprietary Legier Model and Algorithm (the “Model”), prepared and operated by Legier & Company, apac, for determining the amount of each Hospital Abatement Distribution. The amount of the Hospital Abatement Distribution to be paid to each Hospital Authorized Recipient shall be determined within 120 days after the applicable Hospital Abatement Distribution Form Deadline or in a period of time determined by the Trustee to be most practicable.
- (c) The Model shall determine the amount distributable to each Hospital Authorized Recipient based on (1) the diagnostic codes associated with operational charges incurred by the Hospital Authorized Recipient in connection with the treatment of Opioid Use Disorder, (2) the portion of such charges that were not reimbursed, and (3) the following distribution determination factors and weights:⁸
 - (i) Units of morphine milligram equivalents (MME) dispensed in the Hospital Authorized Recipient’s service area (“Service Area”) during the period January 1, 2006-December 31, 2014 (the “Measurement Period”) (to be weighted at 10%);
 - (ii) Opioid use disorder rates at the State level, pro-rated for each Hospital Authorized Recipient (to be weighted at 10%);
 - (iii) Opioid overdose deaths in the Hospital Authorized Recipient’s Service Area (to be weighted at 8.75%)
 - (iv) Operational impact calculated using the Model, to include opioid diagnoses, and charge and reimbursement data (to be weighted at 35%);
 - (v) Hospital Authorized Recipient’s opioid related patients as a percentage of its total patients (to be weighted at 18.75%);
 - (vi) 17.5% for either
 - A. such Hospital Authorized Recipient having filed a timely Proof of Claim in the Purdue Pharma bankruptcy claim filing process, or

⁸ The Model calculates a Hospital Authorized Recipient’s loss resulting from its treatment of patients with OUD and other opioid diagnoses, considering the total charges and collections for each, among other things, including a causation algorithm applied to each patient encounter.

- B. such Hospital Authorized Recipient having been designated as a “Safety Net Hospital” as defined by the CARES Act as in effect on the Effective Date.⁹

§ 7. HOSPITAL AUTHORIZED ABATEMENT PURPOSES.

- (a) All net funds (after the deduction of all legal fees and litigation expenses, as described herein, and in the Hospital Trust Agreement) distributed to Hospital Authorized Recipients shall be used solely and exclusively for Opioid Use Disorder (“OUD”) abatement programs, whether currently existing or newly initiated. As a condition of receiving a Hospital Abatement Distribution, each Hospital Authorized Recipient must submit to the Trustee on its Hospital Abatement Distribution Form a written statement that all funds will be spent only in the Authorized Recipient’s Service Area for one or more of the following Hospital Authorized Abatement Purposes:
 - (i) Providing transportation to treatment facilities for patients with OUD.
 - (ii) Providing continuing professional education in addiction medicine, including addressing programs addressing stigma.
 - (iii) Counteracting diversion of prescribed medication in ED or practice, consistent with the following goal: reducing opioid misuse, OUD, overdose deaths, and related health consequences throughout the hospital Service Area (county or region).
 - (iv) Participating in community efforts to provide OUD treatment to others in the community, such as those in jails, prisons, or other detention facilities.
 - (v) Providing community education events on opioids and OUD.
 - (vi) Providing Naloxone kits and instruction to patients upon discharge.
 - (vii) Implementing needle exchange in hospital or adjacent clinic and providing on-site MAT services if possible.
 - (viii) Prospectively providing otherwise unreimbursed or under-reimbursed future medical services for patients with OUD or other opioid related diagnoses.
 - (ix) Building or leasing space to add half-way house beds.
 - (x) Participating in research regarding development of innovative OUD treatment practices.

⁹ A “Safety Net Hospital” has (a) A Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater; (b) annual uncompensated care (UCC) of at least \$25,000 per bed; and (c) profit margin of 3.0% or less.

- (xi) Directing moneys to any other public or private Authorized Recipient of funds concerning the treatment of persons with OUD or other opioid-related diagnoses; provided that such recipient's use of such funds would otherwise constitute an Authorized Abatement Purpose.
 - (xii) Medication-Assisted Treatment ("MAT") Programs: an aggregate of \$50 million may be earmarked for Holders of Hospital Channeled Claims to establish and implement a MAT program or to continue, complete and/or implement an existing MAT program already under development.¹⁰
 - (xiii) Engaging in any other abatement activity with the express permission of the Court, at the request of the Trustee.
- (b) In addition, the Hospital Trust shall, in accordance with the Plan, the Confirmation Order and the Hospital Trust Documents, make Hospital Abatement Distributions to Hospital Authorized Recipients exclusively for Hospital Authorized Abatement Purposes within each Hospital Authorized Recipients' respective Service Area identified in the claim. Decisions concerning Hospital Abatement Distributions made by the Hospital Trust will consider the need to ensure that underserved urban and rural areas, as well as minority communities, receive equitable access to the funds.
- (c) To the extent any Holder of a Hospital Channeled Claim that is otherwise a Hospital Authorized Recipient does not comply with this § 7, such Holder of a Hospital Channeled Claim shall not be a Hospital Authorized Recipient and shall be disqualified from receiving Hospital Abatement Distributions, notwithstanding any other eligibility determination pursuant to other sections or procedures set forth herein or in the other Hospital Trust Documents.

§ 8. HOSPITAL ABATEMENT DISTRIBUTIONS BY HOSPITAL TRUST.

- (a) Once the Trustee has calculated the amount of the Hospital Abatement Distribution to be paid to each Hospital Authorized Recipient, and also calculated each Hospital Authorized Recipient's *pro rata* share of the total sum of all Hospital Abatement Distributions to be paid to all Hospital Authorized Recipients, then the Trustee shall make interim Hospital Abatement Distributions, from time to time in its judgment, to those Hospital Authorized Recipients that have complied with all of the criteria and procedures described herein. Unless otherwise determined by the Trustee, such Hospital Authorized Recipients may receive one interim, and one final, distribution.
- (b) All payments made for one or more of said Hospital Authorized Abatement Purposes shall be subject to audit by the Trustee of the Hospital Trust and shall be repaid with a ten percent (10%) penalty added for any funds found by audit to have

¹⁰ The Hospital Abatement Distribution Form will provide an opportunity to indicate the proportion and amount of Hospital Abatement Distributions that the Hospital Authorized Recipient intends to apply to MAT programs.

been spent for an unauthorized purpose. Such audit may occur any time prior to the wind-down of the Trust.

- (c) Hospital Abatement Distributions will be subject to a common benefit assessment and may be subject to certain additional assessments for payment of attorneys' fees and costs of the Ad Hoc Group of Hospitals in accordance with Article IV.X.8 of the Plan.

§ 9. REPORTING BY HOSPITAL AUTHORIZED RECIPIENTS.

- (a) Within ninety (90) days after the end of a distribution period (that being the twelve (12) month period following each annual distribution date), each Hospital Authorized Recipient that received a distribution must submit to the Hospital Trust a certification regarding its satisfaction of the minimum spending requirements on Hospital Authorized Abatement Purposes or that it was unable to meet the minimum spending requirements and must carryover a portion of its distribution.
- (b) If the Hospital Authorized Recipient has not met the requirements during that period, those allocated but unused funds can carry over to the subsequent periods and will continue to carry forward each year until the Hospital Authorized Recipient meets the relevant spending requirements for Hospital Authorized Abatement Purposes. Additional annual certification(s) must be submitted until the Hospital Authorized Recipient meets the relevant spending requirements. A Hospital Authorized Recipient shall not be subject to a penalty for failing to meet the minimum spending requirements with respect to its Hospital Abatement Distribution during a given distribution period.
- (c) The Hospital Trust shall have the right to audit a claimant to determine whether the Hospital Authorized Recipient's expenditures for Hospital Authorized Abatement Purposes have met the requirements set forth in the Hospital Trust Documents.
- (d) Each Hospital Authorized Recipient, if and when requested by the Hospital Trustee (or its agents or representatives), shall provide supporting documentation, in a mutually agreed upon format, demonstrating that the Hospital Authorized Recipient's expenditures for Hospital Authorized Abatement Purposes have met the requirements of the Hospital Trust Documents. All Hospital Abatement Distribution Forms and certifications filed or submitted by Holders of Hospital Channeled Claims are subject to audit by the Hospital Trustee (or its agents or representatives). If the Hospital Trustee finds a material misstatement in a Holder of a Hospital Channeled Claim's Hospital Abatement Distribution Form or certification, the Hospital Trustee may allow that Holder of a Hospital Channeled Claim up to 30 days to resubmit its Hospital Abatement Distribution Form or certification with supporting documentation or revisions. Failure of the Holder of a Hospital Channeled Claim to timely correct its misstatement in a manner acceptable to the Hospital Trustee may result in forfeiture of all or part of the Holder of a Hospital Channeled Claim's qualification as a Hospital Authorized Recipient or right to receive Hospital Abatement Distributions.

- (e) The Trustee shall have the power to take any and all actions that in the judgment of the Trustee are necessary or proper to fulfill the purposes of Hospital Trust. The Hospital Trust retains the right to seek return by legal means of any expenditures which fail to comply with the requirements of this Hospital TDP.

§ 10. REPORTING BY THE HOSPITAL TRUST.

The Hospital Trust shall file an annual report with the Bankruptcy Court after each year that the Hospital Trust is in existence, summarizing the distributions made from the Hospital Trust and detailing the status of any Hospital Authorized Recipient audits, and any recommendations made by the Trustee relating to such audits.

EXHIBIT A
HOSPITAL ABATEMENT DISTRIBUTION FORM

See Attached

HOSPITAL ABATEMENT DISTRIBUTION FORM

HOSPITAL ABATEMENT DISTRIBUTION FORM DEADLINE: [_____]

Please read the instructions carefully before filling out this Hospital Abatement Distribution Form (this “Form”). Capitalized terms used herein and not otherwise defined, shall have the meanings ascribed to them in the *Fourth Amended Joint Plan of Reorganization (With Technical Modifications) of Mallinckrodt and Its Debtor Affiliates Under Chapter 11 of the Bankruptcy Code [D.I. 6510]* (as modified, amended or supplemented from time to time, the “Plan”) or the Hospital Trust Distribution Procedures (as modified, amended or supplemented from time to time, the “Hospital TDP”),” dated, July 20, 2021 [Docket No. 3232-2].

Each Holder of a Hospital Channeled Claim, which includes (i) Non-federal acute care hospitals, as defined by CMS, or (ii) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care, is required to complete and submit this Form in order to be eligible to receive Hospital Abatement Distributions from the Hospital Trust.

The submission of the completed Form by the Hospital Abatement Distribution Form Deadline set forth above is a prerequisite to eligibility for a Hospital Abatement Distribution, but does not guarantee that a Holder of a Hospital Channeled Claim will be deemed eligible for a Hospital Abatement Distribution. If a Holder of a Hospital Channeled Claim is deemed eligible by the Hospital Trustee pursuant to the Hospital TDP to receive Hospital Abatement Distributions, the information provided in this Form will be used to determine each such Hospital Authorized Recipient’s Hospital Abatement Distribution from the Hospital Trust (as defined in the Plan, the “Hospital Trust”). Holders of Hospital Channeled Claims may redact information on this Form or any attached documents, as they deem necessary. A Holder of a Hospital Channeled Claim shall only attach *copies* of any documents that support a claim, and shall not submit original documents; **documents submitted may be destroyed after scanning and will not be returned to the Holder of a Hospital Channeled Claim.** A person who files a fraudulent claim on behalf of a Holder of a Hospital Channeled Claim may, at a minimum, be fined up to \$500,000.00, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152,157. Holders of Hospital Channeled Claims shall provide the information requested that is, to the best of their knowledge, current and valid as of the date this Form is completed and delivered to the Hospital Trustee by such a Holder of a Hospital Channeled Claim:

Please provide the following information to the Hospital Trustee by delivering this completed Hospital Abatement Distribution Form by secure file transfer protocol (“SFTP”) as provided at www.mlnkhospitalsettlement.com prior to the Hospital Abatement Distribution Form Deadline set forth on page 1 of this Form.

Failure to submit a completed copy of this Form and requisite claims data (as described in Exhibit A #18 herein) by the Hospital Abatement Distribution Form Deadline set forth on page 1 of this Form may disqualify you from receiving a Hospital Abatement Distribution. Additionally, failure to complete any portion of the Form may result in a reduced Hospital Abatement Distribution or disqualification from receiving a Hospital Abatement Distribution.

A. Claimant Information

Please provide the information in Section A for the Holder of a Hospital Channeled Claim.

1. Name of Operating Entity:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State:	Zip:
3. Federal Employer Identification Number	_____ - _____		

B. Contact Information

Please provide the information in Section B where notices and Hospital Abatement Distribution(s) should be sent.

1. Contact Name:			
2. Contact Title:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State:	Zip:
4. Phone:	() – –		
5. Email:			
5. By filling out this Form, you are deemed to consent to receipt of notice by email. If you do not consent to receipt of notice by email, please check this box:			

Please provide the information for the Holder of a Hospital Channeled Claim.

1. Have you, as of the date of this Form, provided to the Ad Hoc Group of Hospitals or its agent substantially all of the requisite claims data relating thereto (as described in Exhibit A #18 herein) to the best of your knowledge ___ Yes ___ No

2. Are you listed on the national registry of hospitals maintained by the American Hospital Directory®, as in effect on the Effective Date and you are (a) a non-federal acute care hospital as defined by CMS or (b) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care?
___ Yes ___ No

3. Are you a named Plaintiff in any active cause of action against opioids manufacturers, distributors, or pharmacies? ___ Yes ___ No
 - a. If yes, please provide whether the active cause of action is filed (check one below):
 - i. in the MDL: _____
 - ii. in state court: _____
 - b. If yes, attach a copy of the most recently filed Complaint.

4. Unless a filed Complaint is attached to the Form, describe below, the opioid problem that has impacted each of the hospitals/facilities listed on Exhibit A, and include with particularity, data reflecting overdose and deaths from overdoses in your respective service area(s), for the period of time ranging from January 1, 2009 through October 20, 2020.

5. To qualify for distributions from the Hospital Trust, a Holder of a Hospital Channeled Claim must certify that:
- a. You and/or it adhere to the standard of care for the emergency department, hospital wards and/or outpatient clinics at the time of any prospective evaluation, diagnosis, and treatment of OUD, including with respect to the applicable standard of care for the treatment of addiction, acute withdrawal and treatment for OUD with medication assisted treatment, AND
 - b. You and/or it provide discharge planning and post-discharge care coordination for patients with OUD, including information for appropriate OUD treatment services.

Do you and/or each of the hospitals/facilities listed on Exhibit A satisfy a above?
 Yes No;

Do you and/or each of the hospitals/facilities listed on Exhibit A satisfy b above?
 Yes No.

6. Unless you have executed and submitted a Business Associates Agreement (“BAA”) to Legier & Company, *apac* previously, please execute the BAA attached as Exhibit B and return with the Form for each hospitals/facilities listed on Exhibit A.

7. Funds received from the Hospital Trust may only be used for specific abatement purposes as set forth in Section 7 of the Hospital TDP. If the Holder of a Hospital Channeled Claim on whose behalf this claim has been prepared is allocated a Hospital Abatement Distribution from the Hospital Trust, as a condition of receiving the funds, then it will use the funds for one or more specific uses as listed below.

8. Please complete Exhibit A for EACH hospital/facility owned and/or operated by the above Operating Entity for which this claim is filed.
9. Please complete the W-9 attached hereto for each entity claiming to be a Holder of a Hospital Channeled Claim and return the W-9 with this Form.

I certify that I am authorized to sign this Hospital Abatement Distribution Form and I understand that an authorized signature on this Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Signature: _____

Executed on date: (MM/DD/YYYY) _____

Print the name of the person who is completing and signing this claim.

Name (First, Middle, Last): _____

Title: _____

Hospital: _____

Address: _____

Contact phone: _____

Email: _____

HOSPITAL ABATEMENT DISTRIBUTION FORM – EXHIBIT A

HOSPITAL ABATEMENT DISTRIBUTION FORM DEADLINE: [_____]

Please provide the following information for the hospital/facility owned and/or operated by the Operating Entity reported by you in A of the Form for which a claim is filed. If there is more than one such hospital/facility, please complete a separate Exhibit A for EACH hospital/facility for which a claim is being filed.

A. Name of Hospital/Facility:			
B. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State:	Zip:
C. Duration of Ownership	Date Acquired/Opened	Date Sold/Closed	
D. Number of Staffed Beds ¹ _____			

¹ *The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."*

1. Service Area. Please list below the counties that the above-described hospital/facility serves that represents at least 75% of the total annual admissions of your hospital/facility in 2021, the population of those counties and the percentage of the total population of those counties served by the hospital/facility. Attach any supporting documents that you deem to be helpful.

2. For the hospital/facility listed above, please provide the payor mix (% of payor payments to total of all payor payments) as follows:

- a. % Medicare _____;
- b. % Medicaid _____;
- c. % TRICARE _____;
- d. % Commercial, e.g., Blue Cross Blue Shield, other non-governmental payors _____;
- e. % Self-pay _____;
- f. % All Other Payors _____;
- g. Describe the name of each payor that comprises "All Other Payors"

3. Please provide the amounts of funding, if any, received by you and/or for the hospital/facility listed above for the period of January 1, 2009 through October 20, 2020 in each of the following areas:

- a. Grants _____;
- b. Taxing authorities _____;
- c. Health-care authorities _____;
- d. State funded programs for indigent care _____;
- e. "Disproportionate Share"² _____;
- f. Foundations/charities _____;
- g. Others _____;

4. List and describe with particularity, all Hospital Authorized Abatement Purposes instituted by you at and/or in the hospital/facility listed on Exhibit A above that are intended to treat, reduce, abate and prevent opioid addiction. Include in your description the year(s) such program(s) began; whether they presently remain operational; and, the prospective end date for the program(s), if any. In addition, please provide the extent that any funding received, as described in No. 3 above, was used to pay for the abatement programs described herein.

² *Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.*

5. Prescribing practices:

- a. For the hospital/facility listed above, please provide the national ranking for prescribing the following opioids: (i) Brand Name Medications: OxyContin®, Hysingla ER®, Butrans®, Dilaudid®, Ryzolt, MS Contin®, MSIR®, Palladone®, DHC Plus®, OxyIR®, or OxyFast®; and (ii) the following Generic Medications: oxycodone extended-release tablets, buprenorphine transdermal system, hydromorphone immediate-release tablets, hydromorphone oral solution, tramadol extended release tablets, morphine extended-release tablets, oxycodone immediate-release tablets, oxycodone and acetaminophen tablets (generic to Percocet®), hydrocodone and acetaminophen tablets (generic to Vicodin® or Norco®);
-

- b. Did you provide pain management care in a pain management clinic during the period of January 1, 2009 through October 20, 2020? ___ Yes ___ No.
If yes, please provide the dates for which each of your pain management clinics were in operation.
-
-
-

6. Is the hospital/facility listed above a “safety net” hospital as defined in the CARES ACT?³
___ Yes ___ No.

- a. If yes, please provide proof of each such designation.

7. Is the hospital/facility listed above a tertiary referral center? (A hospital provides tertiary healthcare if it provides “care of a highly technical and specialized nature, in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon health problems.” See Flegel, Ken, Tertiary Hospitals Must Provide General Care (March 3, 2015), Nat’l Ctr. for Biotechnology Information, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347764>).
___ Yes ___ No.

³ A “safety net” hospital has (a) a Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater; (b) annual uncompensated care (UCC) of at least \$25,000 per bed; and (c) profit margin of 3.0% or less.

8. Does the hospital/facility listed above perform “Screening Brief Intervention Referral to Treatment” (“SBIRT”) in the emergency department? Yes No.
9. Does the hospital/facility listed above equip emergency departments to treat acute withdrawal and initiate treatment for Opioid Use Disorder (“OUD”) with medications, including buprenorphine, suboxone, and subutex, etc.? Yes No.
10. Does the hospital/facility listed above make discharge planning and post-discharge care coordination mandatory for patients with OUD? Yes No.
11. Does the hospital/facility listed above provide bridge programs to encourage access to treatment for patients with OUD? Yes No.
12. Does the hospital/facility listed above participate in community efforts to provide OUD treatment to others in the community, such as those in jails, or other detention facilities? Yes No.
13. Does the hospital/facility listed above provide transportation to OUD treatment facilities? Yes No.
14. Does the hospital/facility listed above implement needle exchange in the hospital or an adjacent clinic and/or provide on-site medication-assisted treatment (“MAT”) services? Yes No.
15. Does hospital/facility listed above use telemedicine, telehealth, and/or teleconsulting to support treatment and to support “spoke” entities? Yes No.
16. Does the hospital/facility listed above perform heart valve replacements?
 Yes No.
- a. If yes, please provide the percentage of all heart valve replacements performed that are secondary to opioid addiction. _____

17. Does the hospital/facility listed above have a Neonatal Intensive Care Unit (“NICU”) that treats babies with Neonatal Abstinence Syndrome (“NAS”)?
___ Yes ___ No.

a. If yes, does the hospital/facility have a dedicated NAS NICU? ___ Yes ___ No

b. If yes, does the hospital/facility provide obstetric and perinatal services to treat mothers with OUD? ___ Yes ___ No

18. For all inpatient and outpatient discharges during the period January 1, 2009 through October 20, 2020, from the qualifying hospital/facility listed above and operated by you, please provide the following data in CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File to be used in connection with the calculation of financial damages. **An example of the data formatting is set forth in Exhibit C. This data should be in a separate CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File for each Holder of a Hospital Channeled Claim.** Physician office visits and non-acute care visits should **NOT** be included in data provided.

For the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File, please include in the file name the name of the Holder of a Hospital Channeled Claim, City and State where located and Date Range of Data Provided, for example, PhoenixGeneral-Phoenix-AZ-Jan09-Dec12.csv. If more than one file is provided due to size limitations, each file name will be the same with only the date range of the data provided changing e.g. PhoenixGeneral-Phoenix-AZ-Jan13-Dec20.csv

It is important to note, and as further described below, that the following data for each visit/discharge will need to be repeated on each row corresponding to each different ICD diagnosis code (except for ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority). The data for the ICD diagnosis codes, ICD diagnosis code descriptions and ICD diagnosis code priority for each visit/discharge will therefore be unique to each row. For example, if a visit has 18 ICD diagnosis codes, there would be 18 rows/lines for that visit/discharge with each line containing a different ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority. For all other data fields such as Patient Medical Record Number, Date of Discharge, etc. this data will be the same, and thus repeated, on all 18 rows/lines for that visit/discharge.

To the extent the qualifying hospital/facility utilizes a coding system for any columns/data fields, please provide an index to explain the contents of any column/data field to the secure portal provided by the Hospital Trustee. For example, the Patient Type data provided includes a 1, 2, or 3 and these respective contents are 1=Inpatient, 2=Outpatient, 3=Emergency.

Please also ensure that all columns/data fields that may contain commas are updated so that such columns/data fields are placed in quotations when populating the CSV or Pipe

Delimited Text File. The columns/data fields that often contain commas include, but are not limited to, Attending Physician Name, DRG and ICD Diagnosis Code Descriptions.

Once the CSV (Comma Delimited) or Pipe Delimited Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field, ICD Diagnosis Code column/data field should not be blank or designated null for a patient visit without an explanation, etc. This will require, that in conducting your review that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **After submission of the Hospital Abatement Registration Form each claimant will be provided a secure portal by the Hospital Trustee to upload an executed Business Associate Agreement (as described in #6 of the Form), and then upload this requisite claims data to the secure portal.**

Column	Data Fields	Definitions and Clarifications
a.	Name	Name of hospital/facility for which data is provided.
b.	Address	Address of hospital/facility for which data is provided.
c.	City	City of hospital/facility for which data is provided.
d.	State	State of hospital/facility for which data is provided.
e.	Zip	Zip of hospital/facility for which data is provided.
f.	CMS Certification Number	Center for Medicare & Medicaid Services – Formerly known as the Medicare Provider Number. This should be a six-digit Medicare certification number for a hospital/facility.
g.	Patient Medical Record #	
h.	Patient Account #	
i.	Payor Financial Class Description	e.g., Blue Cross, Medicaid, Private Pay, etc.

j.	Patient Type	e.g., Inpatient or Outpatient. Hospital related clinics or physician office visits should NOT be included in data provided.
k.	Custom Patient Type	e.g., Inpatient Psych, Outpatient Single Visit, Surgery, Lab, etc. Hospital related clinics or physician office visits should NOT be included in data provided.
l.	Date of Admission	
m.	Date of Discharge	
n.	Length of Stay (days)	
o.	Admission Type Description	e.g., Emergency, Reservation, Reference Lab, etc.
p.	Discharge Disposition Description	e.g., Discharge Home, Nursing Home, Expired, etc.
q.	Patient Date of Birth	
r.	Patient Age at Discharge	
s.	Patient Gender	
t.	Patient Race	
u.	Patient City	
v.	Patient State	
w.	Patient Zip Code	
x.	Attending Physician Name	
y.	Total Charges	
z.	Total Payments	Total Payments should only contain actual payments received (e.g. insurance/self-pay). It should NOT include adjustments, bad debt, write-offs or contractual adjustments.

aa.	DRG Code	Provide Diagnosis Related Group (DRG) code for each inpatient visit/discharge.
ab.	DRG Code Description	Provide DRG description for the above DRG code.
ac.	All ICD Diagnosis Code	For each visit/discharge, provide all International Classification of Disease (ICD) diagnosis codes (ICD-9 or ICD-10, as applicable) associated with each patient visit/discharge. Note: In most instances you should have multiple ICD codes for a patient visit/discharge. Each of these ICD Diagnosis Codes related to each patient's visit should NOT be listed in multiple columns but rather each ICD Code should be listed in the same single column with each ICD Code shown on separate rows within the same single column. See Exhibit C.
ad.	ICD Diagnosis Code Descriptions	Provide ICD Diagnosis description for the above ICD Diagnosis Code.
ae.	ICD Diagnosis Code Priority	Provide whether each ICD Diagnosis Code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc.
af.	Mom's MRN - If applicable	This field pertains only to Holders of Hospital Channeled Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.
ag.	Baby's MRN - If applicable	This field pertains only to Holders of Hospital Channeled Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.

I certify that I am authorized to sign this Hospital Abatement Distribution Form Exhibit A and I understand that an authorized signature on this Hospital Abatement Distribution Form Exhibit A serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Signature: _____

Executed on date: (MM/DD/YYYY) _____

Print the name of the person who is completing and signing this claim.

Name (First, Middle, Last): _____

Title: _____

Hospital: _____

Address: _____

Contact phone: _____

Email: _____