HOSPITAL ABATEMENT DISTRIBUTION REGISTRATION FORM

HOSPITAL ABATEMENT DISTRIBUTION REGISTRATION FORM DEADLINE: September 30, 2022

Please provide the following information to the Trustee by completing this Hospital Abatement Distribution Registration Form (this "Registration Form") and email to registrationform@mlnkhospitalsettlement.com prior to completing the Hospital Abatement Distribution Claim 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"), 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] or the Hospital Abatement Distribution Claim Form (as modified, amended or supplemented from time to time, the "Claim Form").

The Holder of a Hospital Opioid Claim is described in the Plan as the Hospital Opioid Claimant (the "Claimant") and is required to complete and submit this Registration Form and the Claim Form in order to be eligible to receive Hospital Abatement Distributions from the Hospital Trust. A Hospital Opioid Claim is an Opioid Claim for an eligible Acute Care hospital defined as: (i) a non-federal acute care hospital, 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.

The claims process deadline is September 30, 2022, HOWEVER, in advance of this deadline you must first submit the Registration Form by email to allow sufficient time for your submission of all other required documents and information for your claim processing after filing your Registration Form. Failure to complete and submit your claim by September 30, 2022 renders a claimant ineligible for a distribution.

I. Claimant Information

Please provide the information for the Claimant in Section I if you are submitting a claim on behalf of an operating entity that owns one or more Acute Care hospitals/facilities ("Operating Entity").

<table>
<tr><td>A. Name of Operating Entity:</td><td colspan="3"></td></tr>
<tr><td rowspan="3">B. Address:</td><td colspan="3">Street Address Line 1</td></tr>
<tr><td colspan="3">Street Address Line 2</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="2">C. Federal Employer Identification Number:</td><td colspan="2">_____ – _____</td></tr>
</table>

II. Contact Information

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

A. Contact Name:			
B. Contact Title:			
C. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
D. Phone:	(_____) – _____ – _____		
E. Email:			
F. By filling out this Registration Form, you are deemed to consent to receipt of notice by email.			

III. Hospital/Facility Information

Please provide the following information for each Acute Care hospital/facility owned and/or operated by the above referenced Claimant in Section I above for which a claim is being filed. If there is more than one such Acute Care hospital/facility owned by the Claimant, please complete a separate Exhibit A for EACH Acute Care 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*

I certify that I am authorized to sign this Registration Form and I understand that an authorized signature on this Registration 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.

Your typed signature and submission of this Registration Form will have the same force and effect as if you signed the Registration Form on paper, which you may do alternatively.

Signature: _____

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

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

Name (First, Middle, Last): _____

Title: _____

Hospital: _____

Address: _____

_____

Contact phone: (_____) – _____ – _____

Email: _____

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."