AMENDMENT
UNIVERSITY HEALTH CARE, INC.
dba PASSPORT HEALTH PLAN
PROVIDER SERVICES AGREEMENT

This Amendment to the University Health Care, Inc., Provider Services Agreement ("the Agreement"), is made and entered into as of the effective date set forth below (the "Effective Date") by and among the provider(s) identified on the signature page ("Provider") and University Health Care, Inc. ("HMO").

WHEREAS, HMO and PROVIDER entered into the University Health Care, Inc. Provider Services Agreement.

WHEREAS, HMO and PROVIDER desire to amend the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, HMO and PROVIDER intending to be legally bound, agree as follows:

1. Capitalized Terms. All capitalized terms not otherwise defined herein shall have the meanings ascribed to such terms in the Agreement.

2. Effective Date. This Amendment shall be effective for inpatient discharges occurring on or after October 1, 2015.

3. Appendix A. The Agreement shall remain as set forth in previous agreement/amendments. However, reimbursement for Acute Care Hospital inpatient services below shall be replaced with the attached.

4. Governing Law. This Amendment shall be construed and enforced in accordance with the laws of the Commonwealth of Kentucky.

5. Reaffirmation of Other Terms and Conditions. Except as expressly modified by this Amendment, all other terms and provisions of the Agreement, as amended, shall remain in full force and effect, unmodified and unrevoked, and the same are hereby reaffirmed and ratified by HMO and Provider as if fully set forth herein.

IN WITNESS WHEREOF, HMO and PROVIDER have signed and executed this Amendment as of the date written below, but effective as of the Effective Date.

"HMO"

UNIVERSITY HEALTH CARE, INC.

By: _____

Title: Vice President of Operations

Date: 10/5/15

"PROVIDER"

BAPTIST HEALTH SYSTEMS, INC
d/b/a BAPIST HEALTH PADUCAH
d/b/a BAPIST HEALTH LEXINGTON
d/b/a BAPIST HEALTH MADISONVILLE
d/b/a BAPIST HEALTH RICHMOND
d/b/a BAPIST HEALTH CORBIN

By (Signature): _____

Print Name: Isaac J. Myers, II, M.D.

Title: Chief Health Integration Officer, Baptist Health

Date: 10/6/15

Tax ID # (s): 61-0444707, 61-0461940, 61-0654587

APPENDIX A

ACUTE-CARE HOSPITAL SERVICES AND COMPENSATION

For inpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Hospital/Provider's tax identification number ("TIN"), HMO shall pay Hospital/Provider based on the DRG methodology as defined below.

Effective October 1, 2015, the HMO shall pay Hospital Provider on a fully-prospective per discharge basis using the Medicare Severity DRG (MS-DRG) version 32 grouping software released by the Centers for Medicare and Medicaid Services (CMS). The HMO will establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect. When CMS releases subsequent versions of the DRG grouper, the HMO shall implement changes to the DRG relative weights and the geometric length-of-stay values within one hundred and twenty (120) days of the CMS release date. There will be no retroactive adjustment to claims for discharge dates occurring after the CMS effective date of such changes. All changes to the DRG grouper will be implemented on a prospective basis.

Payment Rates

Payment rates shall approximate ninety-five percent (95%) of a hospital's Medicare reimbursement excluding the following Medicare reimbursement components:

1. A Medicare low-volume hospital payment;
2. A Medicare end stage renal disease payment;
3. A Medicare new technology add-on payment;
4. A Medicare routine pass-through payment;
5. A Medicare ancillary pass-through payment;
6. A Medicare value-based purchasing payment or penalty;
7. A Medicare readmission penalty;
8. A Medicare hospital-acquired condition penalty;
9. A Medicare indirect medical education payment;
10. Any type of payment implemented by Medicare after October 1, 2015; or
11. Any type of Medicare payment not described in this Amendment.

When CMS releases periodic updates to payment rates, the HMO shall implement the changes within one hundred and twenty (120) days of the CMS release date. Within sixty (60) days after CMS publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the HMO will send a written notice to the Provider containing the hospital's data and calculation of the DRG base rate and operating and capital cost to charge ratios. The Provider will have thirty (30) days from the date of the letter to appeal these calculations.

There will be no retroactive adjustment to claims for discharge dates occurring after the CMS effective date of such changes. All changes to payment rates will be implemented on a prospective basis.

The total hospital-specific per discharge payment shall be the sum of:

1. A DRG base payment; and
2. If applicable, a cost outlier payment; and
3. If applicable, a transplant acquisition payment.

The resulting payment shall be limited to ninety-five percent (95%) of the calculated value.

The DRG base payment shall be ninety-five percent (95%) of the sum of the operating base payment and the capital base payment calculated as described below.

1. The DRG base payment shall be determined by multiplying the hospital-specific rate by the DRG relative weight.
2. The hospital-specific operating rate and capital rate referenced in this Amendment shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.
3. The Medicare IPPS standard amount established for operating labor costs shall be multiplied by the wage index associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare.

4. The operating labor costs as defined in item 3 above shall be added to the Medicare IPPS standard amount for non-labor operating costs.
5. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.

The HMO shall make a cost outlier payment per discharge as described below:

1. A discharge is eligible for outlier payment if its estimated cost exceeds the DRG's outlier threshold.
2. The estimated cost of the discharge shall be computed by multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the HMO allowed charges. The Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS.
3. The DRG's outlier threshold shall be calculated as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold. The fixed loss cost threshold shall be the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
4. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety percent (90%) of the amount by which estimated costs exceed a discharge's outlier threshold
5. For all other DRGs, a cost outlier payment shall equal eighty percent (80%) of the amount by which estimated costs exceed a discharge's outlier threshold.

The HMO shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

Transfer Payments

If a patient is transferred to or from another hospital, the HMO shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary. Transfer payments shall be calculated as described below.

1. For a service reimbursed on a prospective discharge basis, the HMO shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day up to 100 percent of the allowable per discharge reimbursement amount.
2. The average daily discharge rate shall be calculated by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
3. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect.
4. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five percent (95%) of the amount calculated for each.
5. For a hospital receiving a transferred patient, the HMO shall reimburse the standard DRG payment.

The HMO shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as described below:

1. The following shall qualify as a post-acute care facility:
    a. Skilled nursing facility;
    b. Cancer or children's hospital;
    c. Home health agency;
    d. Rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
    e. Long-term acute care hospital; or
    f. Psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.
2. The HMO shall pay each transferring hospital an average daily rate for each day of a stay.
3. A transfer related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
4. A DRG identified by CMS as being eligible for special payment shall receive fifty percent (50%) of the full DRG payment plus the average daily rate for the first day of the stay and fifty percent (50%) of the average daily rate for the remaining days of the stay up to the full DRG base payment.
5. A DRG identified by CMS as being eligible for the post-acute payment shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
6. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five percent (95%) of the amount calculated for each.

The HMO shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate for each day the patient remains in the distinct part unit.

Organ Transplants

The HMO shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification

The organ acquisition reimbursement shall include an interim reimbursement followed by a final reimbursement. Final reimbursement shall:

1. Include a cost settlement process based on the Medicare 2552 cost report form; and
2. Be designed to reimburse hospitals for ninety-five percent (95%) of organ acquisition costs.
3. An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the following rates:
    a. Kidney Acquisition - $65,000
    b. Liver Acquisition - $55,000
    c. Heart Acquisition - $70,000
    d. Lung Acquisition - $65,000; or
    e. Pancreas Acquisition - $40,000.

Upon receipt of a hospital's finalized Medicare cost report, the HMO shall calculate a final settlement at ninety-five percent (95%) of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

Hospital-Acquired Conditions and Never Events

For each diagnosis on a claim, a hospital shall specify on the claim whether the diagnosis was present upon the individual's admission to the hospital. In assigning a DRG for a claim, the HMO shall exclude from the DRG assignment consideration of any secondary diagnosis code associated with a hospital-acquired condition.

Neither the HMO nor the member shall be liable for treatment for or related to a never event.

Readmissions

An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and shall not be billed separately. Reimbursement for an unplanned readmission with the same diagnosis shall be included in the initial admission payment.

Pre-Admission Services

A pre-admission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

1. Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
2. Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Sole Community Hospitals

The operating rate for sole community hospitals shall be calculated as described below:

1. The HMO shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
2. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables.
3. The HMO shall compare the HSP rate with the operating rate described above in the Payment Rates section of the Amendment, or the standard Medicare IPPS rate. The higher of the two rates shall be utilized as the operating rate for sole community hospitals.

Medicare Dependent Hospitals

The operating rate for a Medicare dependent rate shall be calculated as described below:

1. The HMO shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
2. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables.
3. The HMO shall compare the HSP rate with the operating rate described above in the Payment Rates section, or the standard Medicare IPPS rate. If the standard Medicare IPPS rate is higher, it shall be utilized as the operating rate for Medicare dependent hospitals. If the HSP rate is higher, the HMO shall calculate the arithmetic difference between the two rates. The difference shall

be multiplied by seventy-five percent (75%). The resulting product shall be added to the standard Medicare IPPS rate to determine the hospital's operating rate.

4. If CMS terminates the Medicare dependent hospital program, a hospital that is a Medicare dependent hospital at the time of termination shall receive the standard Medicare IPPS rate as described above in the Payment Rates section of this Amendment