ANNUAL INFORMATION FORM

March 29, 2018

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GLOSSARY OF TERMS

In this Annual Information Form, the following terms have the meanings set forth below. Unless otherwise indicated, words imparting the singular include the plural and vice versa and words imparting any gender include all genders.

"2011 Promissory Note" means the 12.25% promissory note in the amount of $194.5 million issued by Medical Facilities America to the Corporation in accordance with the Transfer Agreement.

"2012 Promissory Note" means the 10.00% promissory note in the amount of $27.5 million issued by Medical Facilities America to the Corporation.

"**Arrangement**" means the court-approved plan of arrangement under the BCBCA on May 31, 2011 pursuant to which the Corporation converted from an IPS structure to a common share structure.

"ASC" means ambulatory surgery center.

"ASH" means Arkansas Surgical Hospital, L.L.C., an Arkansas limited liability company.

"**ASH Acquisition**" means the acquisition of ASH, completed on November 30, 2012.

"**ASH Exchange Agreement**" means the agreement dated November 30, 2012 among the Corporation, Medical Facilities America, Medical Facilities Holdings and ASH Holdco providing for the Exchangeable Interests in ASH.

"**ASH Holdco**" means the Arkansas limited liability company that holds a 49% interest in the related MFC Partnership.

"BCBCA" means the *Business Corporations Act* (British Columbia).

"**BHSH**" means Black Hills Surgical Hospital, LLP, a South Dakota limited liability partnership.

"**Brookside**" means Ambulatory Surgery Associates, LLC, a Michigan limited liability company doing business as Brookside Surgery Center.

"**Business Day**" means any day other than a Saturday, Sunday or statutory holiday in Toronto, Ontario.

"**Central Arkansas**" means Central Arkansas Surgical Center, LLC, a Delaware limited liability company.

"**City Place**" means Meridian Missouri Surgery Center, LLC, a Delaware limited liability company doing business as City Place Surgery Center.

"**CMS**" means the Centers for Medicare & Medicaid Services.

"**Code**" means the United States Internal Revenue Code of 1986, as amended.

"**Common Shares**" means the common shares in the capital of the Corporation.

"**Continuing Interests**" means the partnership interest (44% in ASH and 35% in each MFC Hospital (other than UMASH)) that is not exchangeable for Common Shares or transferable by the respective Subco.

"Conversion" means the conversion from an IPS structure to a common share structure pursuant to the Arrangement and the related Restructuring.

"**Corporation**" means Medical Facilities Corporation, a corporation formed under the laws of the Province of Ontario and continued under the laws of British Columbia.

"**CPI**" means the consumer price index for Canada as published by the Federal Government of Canada.

"**Credit Facility**" means the Cdn$100 million second amended and restated credit agreement among the Corporation, Medical Facilities America and Medical Facilities Holdings (as borrowers) and National Bank of Canada (as lender) dated July 7, 2015 with a maturity date on December 31, 2018.

"**CT**" means computed tomography, sometimes called CAT scan, which is the use of special x-ray equipment to obtain image data from different angles around the body, which data is then computer processed to generate a cross-section of body tissues and organs.

"**Debenture Conversion Price**" means the price at which the Debentures are convertible into Common Shares, being the price of Cdn$19.11 per Common Share or a ratio of approximately 52.3286 Common Shares per Cdn$1,000 principal amount of Debentures.

"**Debenture Indenture**" means the Trust Indenture between the Corporation and Computershare Trust Company of Canada, as trustee, dated December 21, 2012, providing for the issuance of the Debentures.

"**Debentures**" means the 5.9% convertible unsecured subordinated debentures of the Corporation issued in accordance with the Debenture Indenture.

"**DPSC**" means Dakota Plains Surgical Center, LLP, a South Dakota limited liability partnership.

"**DPSC Transaction**" means the sale by DPSC of its assets related to the operation of its specialty hospital to Avera St. Luke's on June 30, 2015.

"**DP Subco**" means the South Dakota limited liability company that holds 49% partnership interest in DPSC.

"**DSU Plan**" means the Corporation's Deferred Share Unit Plan, effective August 10, 2007, as amended, providing for the issuance of DS Units to eligible board members.

"**DS Unit**" means a right of a participant under the DSU Plan to receive an amount of money on a deferred basis subject to and in accordance with the terms of the DSU Plan.

"**Eastwind Surgical**" means Eastwind Surgical, LLC, a Delaware limited liability company.

"**Exchange Agreements**" means collectively, the Original Exchange Agreement, the OSH Exchange Agreement and the ASH Exchange Agreement.

"**Exchangeable Interests**" means the partnership interests in each MFC Hospital (other than UMASH) that are exchangeable for Common Shares by the respective Existing Partners, through their ownership interest in the related Holding Entity and Subco or ASH Holdco, as applicable, to the extent that such interests have not yet been exchanged.

"**Existing Partners**" means, in respect of each MFC Facility, the beneficial holders of the non-controlling interests in that MFC Facility.

"**Fully Diluted Basis**" assumes that the entire Retained Interest has been converted into Common Shares and that the Continuing Interests were exchanged on the same basis as the Exchangeable Interests.

"**HMOs**" means health maintenance organizations.

"**Holdco**" means collectively the SCNC Holdco and ASH Holdco.

"**Holding Entity**" in respect of an MFC Hospital (other than ASH and UMASH) means the Oklahoma or South Dakota limited liability company that holds 100% of the membership interests in its related Subco, in respect of ASH, means ASH Holdco, and in respect of SCNC, means SCNC Holdco.

"**IMD**" means Integrated Medical Delivery, L.L.C., a Delaware limited liability company.

"**IPO**" means the initial public offering of IPSs of the Corporation which occurred on March 29, 2004.

"**IPS**" means an income participating security in the capital of the Corporation, comprised of one common share and Cdn$5.90 aggregate principal amount of 12.5% subordinated notes, which converted into Common Shares of the Corporation as of May 31, 2011 pursuant to the Conversion.

"**IRS**" means the United States Internal Revenue Service.

"**Management**" refers to the management of the Corporation, Medical Facilities America, Medical Facilities Holdings and Medical Facilities IMD Holdings.

"**Management Agreement**" means the management agreement dated June 1, 2011 in respect of Medical Facilities America among the Corporation, Medical Facilities America and each Original Subco.

"Medical Facilities America" or "**MFA**" means Medical Facilities America, Inc., a Delaware corporation.

"**Medical Facilities Holdings**" or "**MFH**" means Medical Facilities (USA) Holdings, Inc., a Delaware corporation (as successor by conversion to Medical Facilities USA).

"Medical Facilities IMD Holdings" or **"MF IMD Holdings"** means Medical Facilities IMD Holdings, Inc., a Delaware corporation.

"Medical Facilities USA" means Medical Facilities Holdings (USA), LLC, a Delaware limited liability company formed by the Corporation on March 12, 2004 for the purpose of acquiring a 51% partnership interest in MFC Original Partnerships.

"**MFC**" means Medical Facilities Corporation, a corporation continued under the laws of British Columbia.

"**MFC Facility**" or "**MFC Facilities**" means, individually and collectively, the MFC Hospitals and MFC Surgical Centers.

"**MFC Hospital**" or "**MFC Hospitals**" means, individually and collectively, the specialty surgical hospitals owned by each of ASH, UMASH, OSH, BHSH and SFSH, which are licensed under applicable law as specialty hospitals.

"**MFC Facility Management**" refers to the management of the MFC Partnerships, or of a particular MFC Partnership, where indicated.

"**MFC Nueterra ASC**" or "**MFC Nueterra ASCs**" means, individually and collectively, Central Arkansas, Brookside, City Place, Miracle Hills, Eastwind Surgical, Two Rivers, and Riverview.

"**MFC Nueterra Partnership**" means MFC Nueterra Holding Company, LLC, a Delaware limited liability company, which is a partnership between Medical Facilities Holdings and Nueterra MF Holdings, LLC, in which Medical Facilities Holdings owns a 94.25% interest and Nueterra MF Holdings, LLC owns a 5.75% interest.

"**MFC Nueterra Partnership Holding Company**" or "**MFC Nueterra Partnership Holding Companies**", individually and collectively, seven holding companies wholly-owned by MFC Nueterra Partnership, each of which holds an interest in the respective MFC Nueterra ASC.

"**MFC Original Partnership**" or "**MFC Original Partnerships**" means, individually and collectively, DPSC, BHSH, and SFSH.

"**MFC Partnership**" or "**MFC Partnerships**" means, individually and collectively, ASH, UMASH, OSH, DPSC, BHSH, SFSH, SCNC and MFC Nueterra ASCs. (In certain instances where "MFC Partnership" is used, information particular to DPSC is not provided as it is no longer relevant following completion of the DPSC Transaction.)

"**MFC Surgical Centers**" means SCNC, an ASC located in California, and the MFC Nueterra ASCs.

"**Miracle Hills**" means Miracle Hills Surgery Center, LLC, a Delaware limited liability company.

"**MRI**" means magnetic resonance imaging.

"**Newport**" means SCNC doing business as Newport Center Surgical.

"**Nueterra Manager**" means NueHealth, LLC, a Delaware limited liability company, which provides management services to each MFC Nueterra ASC on behalf of the applicable MFC Nueterra Partnership Holding Company, and certain administrative services to MFC Nueterra Partnership and MFC Nueterra Partnership Holding Companies as stipulated in the Management Services Agreement dated February 1, 2018 between MFC Nueterra Partnership and NueHealth, LLC.

"**Original Exchange Agreement**" means the agreement dated March 29, 2004 among the Corporation, Medical Facilities USA and each Original Subco and any other parties agreeing to be bound by that agreement providing for the Exchangeable Interests in each MFC Original Partnership.

"**Original Holding Entity**" in respect of an MFC Original Partnership means the South Dakota limited liability company that holds 100% of the membership interests in its related Original Subco.

"**Original Subco**" or "**Original Subcos**" in respect of an MFC Original Partnership means the South Dakota limited liability company that holds a 49% partnership interest in its related MFC Original Partnership (prior to any exchange of Exchangeable Interests).

"**OSH**" means Oklahoma Spine Hospital, LLC, an Oklahoma limited liability company.

"**OSH Exchange Agreement**" means the agreement dated June 21, 2005 among the Corporation, Medical Facilities USA and OSH's related Subco and any other parties agreeing to be bound by that agreement providing for the Exchangeable Interests in OSH.

"**PAM**" means Physician's ASC Management, LLC, an Indiana limited liability company that holds an 86.0% interest in UMASH, which is owned 72.1% by Medical Facilities Holdings.

"**Partnership Agreement**" in respect of an MFC Partnership (other than UMASH) means the partnership agreement or operating agreement between the related Subco or Holdco, as applicable, and Medical Facilities Holdings or its predecessor, as applicable.

"**PPOs**" means preferred provider organizations.

"Promissory Notes" means the 2011 Promissory Note and 2012 Promissory Note issued by Medical Facilities America in favour of the Corporation.

"Restructuring" means the internal reorganization of the Corporation's U.S. holding entities which was completed following the Arrangement.

"**Retained Interest**" means the 49% partnership interest held by each Subco or Holdco, as applicable, in its related MFC Partnership prior to any exchange of Exchangeable Interests.

"**Riverview**" means Riverview Ambulatory Surgical Center, LLC, a Delaware limited liability company.

"**RRI Mishawaka**" means RRI Mishawaka Hospital, L.P., a Delaware limited partnership. Medical Facilities Holdings has a 92.0% interest in RRI Mishawaka.

"**SCNC**" means The Surgery Center of Newport Coast, LLC, a Delaware limited liability company.

"**SCNC Holdco**" means the California limited liability company that holds a 49% interest in the related MFC Partnership.

"**SFSH**" means Sioux Falls Specialty Hospital LLP, a South Dakota limited liability partnership.

"**South Dakota MFC Hospital**" or "**South Dakota MFC Hospitals**" means, individually and collectively, the surgical facilities owned by each of BHSH and SFSH, which are licensed under South Dakota Law as specialty hospitals.

"**specialty hospital**" means a hospital that is licensed as a specialty or specialized hospital.

"**Spine Hospital**" means the surgical facility owned by OSH, which is licensed under Oklahoma Law as a specialty hospital.

"**Subco and Holdco Operating Agreements**" in respect of an MFC Partnership (other than UMASH) means the operating agreement or limited partnership agreement between Medical Facilities Holdings or its predecessor, as applicable, the related Subco or Holdco and the related Holding Entity, as applicable.

"**Subco**" in respect of an MFC Hospital (other than UMASH) means the South Dakota or Oklahoma limited liability company that holds a 49% partnership interest in its related MFC Partnership (prior to any exchange of Exchangeable Interests).

"**surgical facilities**" means medical facilities where surgical procedures are performed which include ASCs, speciality hospitals and general hospitals.

"**Tax Act**" means the *Income Tax Act* (Canada) and the regulations thereunder, in each case in effect on the date hereof.

"**Two Rivers**" means Northwest Neurospine Institute, LLC, a Delaware limited liability company doing business as Two Rivers Surgery Center.

"Transfer Agreement" means the agreement dated June 1, 2011 between the Corporation and Medical Facilities America pursuant to which the Corporation transferred to Medical Facilities America the shares of Medical Facilities Holdings in exchange for 100 shares of Medical Facilities America and the 2011 Promissory Note.

"**Trustee**" means Computershare Trust Company of Canada.

"**TSX**" means the Toronto Stock Exchange.

"**UMASH**" means United Surgeons, LLC, an Indiana limited liability company.

MEDICAL FACILITIES CORPORATION

ANNUAL INFORMATION FORM

GENERAL

The information, including any financial information, disclosed in this Annual Information Form is stated as at December 31, 2017 or for the year ended December 31, 2017, as applicable, unless otherwise indicated. **Certain capitalized terms used in this Annual Information Form have the meaning set out in the "Glossary of Terms".** Unless otherwise indicated, all dollar amounts are expressed in U.S. dollars and references to "**$**" are to the lawful currency of the United States.

Certain statements in this Annual Information Form may constitute "forward-looking statements", which reflect the expectations of Management and MFC Facility Management regarding future growth, capital expenditures, results of operations, performance and business prospects and opportunities of the Corporation, Medical Facilities America, Medical Facilities Holdings, the MFC Partnerships and other subsidiaries of the Corporation referenced herein. Such forward-looking statements reflect Management's and MFC Facility Management's current beliefs and speak only as of the date of this Annual Information Form. Forward-looking statements involve significant risks and uncertainties, should not be read as guarantees of future performance or results, and will not necessarily be accurate indications of whether or not or the times at or by which such performance or results will be achieved. A number of factors could cause actual results to differ materially from the results discussed in the forward-looking statements, including, but not limited to, the factors discussed in the section entitled "Risk Factors" on page 72. Although the forward-looking statements contained in this Annual Information Form are based on what Management and MFC Facility Management believe are reasonable assumptions, the Corporation, Medical Facilities America, Medical Facilities Holdings and the MFC Partnerships cannot assure investors that actual results will be consistent with these forward-looking statements, and the differences may be material. These forward-looking statements are made as of the date of this Annual Information Form and none of the Corporation, Medical Facilities America, Medical Facilities Holdings and the MFC Partnerships or their respective management assumes any obligation to update or revise them to reflect new events or circumstances.

CORPORATE STRUCTURE

Medical Facilities Corporation

Medical Facilities Corporation was incorporated under the *Business Corporations Act* (Ontario) on January 12, 2004 and was continued under the laws of the Province of British Columbia on May 16, 2005. The registered office of the Corporation is located at 355 Burrard Street, Suite 1900, Vancouver, British Columbia and the head office of the Corporation is located at 45 St. Clair Avenue West, Suite 200, Toronto, Ontario.

The Corporation was originally established to hold 100% of the membership interests in Medical Facilities USA. On May 31, 2011, the Corporation was a party to a plan of arrangement completed under the BCBCA, wherein the Corporation converted from an IPS structure to a traditional common share structure. The Common Shares were listed and posted for trading on the TSX commencing on June 1, 2011 and trade under the symbol "DR". Concurrently with the Arrangement, the Corporation undertook a restructuring of its U.S. corporate structure.

Medical Facilities America

Medical Facilities America, Inc. was incorporated under the laws of the State of Delaware on May 19, 2011. The registered office of Medical Facilities America is located at the Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware and the head office is located at 830 Crescent Centre Drive, Suite 200, Franklin, Tennessee. Medical Facilities America is a wholly-owned subsidiary of the Corporation and was formed pursuant to the Conversion.

Medical Facilities Holdings

Medical Facilities (USA) Holdings, Inc. was converted to a Delaware corporation on June 1, 2011 pursuant to the Conversion. Prior to the Conversion, Medical Facilities Holdings was a Delaware limited liability company under the name of Medical Facilities Holdings (USA), LLC which was formed on March 12, 2004 for the purpose of acquiring a 51% partnership interest in each of the MFC Original Partnerships. The registered office of Medical Facilities Holdings is located at the Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware and the head office is located at 830 Crescent Centre Drive, Suite 200, Franklin, Tennessee. Medical Facilities Holdings is a wholly-owned subsidiary of Medical Facilities America.

Medical Facilities IMD Holdings

Medical Facilities IMD Holdings, Inc. was incorporated under the laws of the State of Delaware on December 23, 2015. The registered office of Medical Facilities IMD Holdings is located at the Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware and the head office is located at 830 Crescent Centre Drive, Suite 200, Franklin, Tennessee. Medical Facilities IMD Holdings is a wholly-owned subsidiary of the Corporation formed to acquire controlling interest in IMD.

MFC Nueterra Partnership

MFC Nueterra Holding Company, LLC was formed under the laws of the State of Delaware on December 21, 2017. The registered office of MFC Nueterra Partnership is located at the Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware and the head office is located at 830 Crescent Centre Drive, Suite 200, Franklin, Tennessee. MFC Nueterra Partnership is a partnership between Medical Facilities Holdings and Nueterra MF Holding, LLC, in which Medical Facilities Holdings owns a 94.25% membership interest and which was formed to acquire controlling interest in MFC Nueterra ASCs.

MFC Partnerships

Jurisdiction and form of incorporation, and the registered and head office of each MFC Partnership as of the date of this Annual Information Form are as follows:

MFC Partnership	Jurisdiction and Form of Incorporation	Registered and Head Office
Specialty Hospitals		
ASH	Arkansas limited liability company	5201 North Shore Drive North Little Rock, Arkansas
UMASH	Indiana limited liability company	4455 Edison Lakes Parkway Mishawaka, Indiana
OSH	Oklahoma limited liability company	Two Leadership Square, 10th Floor 211 North Robinson Oklahoma City, Oklahoma
BHSH	South Dakota limited liability partnership	216 Anamaria Drive Rapid City, South Dakota
SFSH	South Dakota limited liability partnership	910 East 20th Street Sioux Falls, South Dakota
Ambulatory Surgery Centers		
Central Arkansas	Delaware limited liability company	151 East Aspen Lane Russellville, Arkansas
Newport	Delaware limited liability company	17 Corporate Plaza, Suite 120 Newport Beach, California

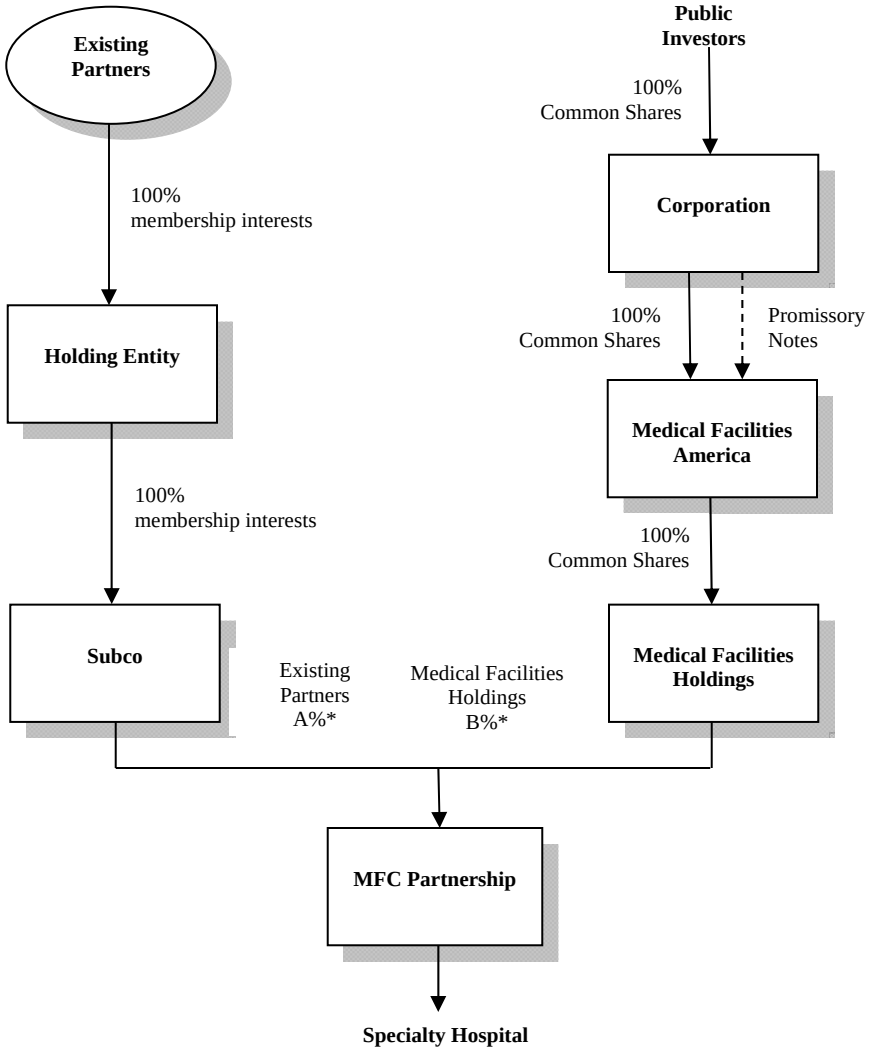
MFC Partnership	Jurisdiction and Form of Incorporation	Registered and Head Office
Brookside	Michigan limited liability company	3600 Capital Avenue SW, Suite 101 Battle Creek, Michigan
City Place	Delaware limited liability company	845 Ballas Court, Suite 100 Creve Coeur, Missouri
Miracle Hills	Delaware limited liability company	11819 Miracle Hills Drive, Suite 201 Omaha, Nebraska
Eastwind Surgical	Delaware limited liability company	955 Eastwind Drive, Suite 150 Westerville, Ohio
Two Rivers	Delaware limited liability company	74 B Centennial Loop, Suite 200 Eugene, Oregon
Riverview	Delaware limited liability company	423 Third Street, Suite D Kingston, Pennsylvania

IMD

IMD is an Oklahoma limited liability company. IMD's registered and head office address is 236NW 62nd Street, Oklahoma City, Oklahoma.

Ownership Structure

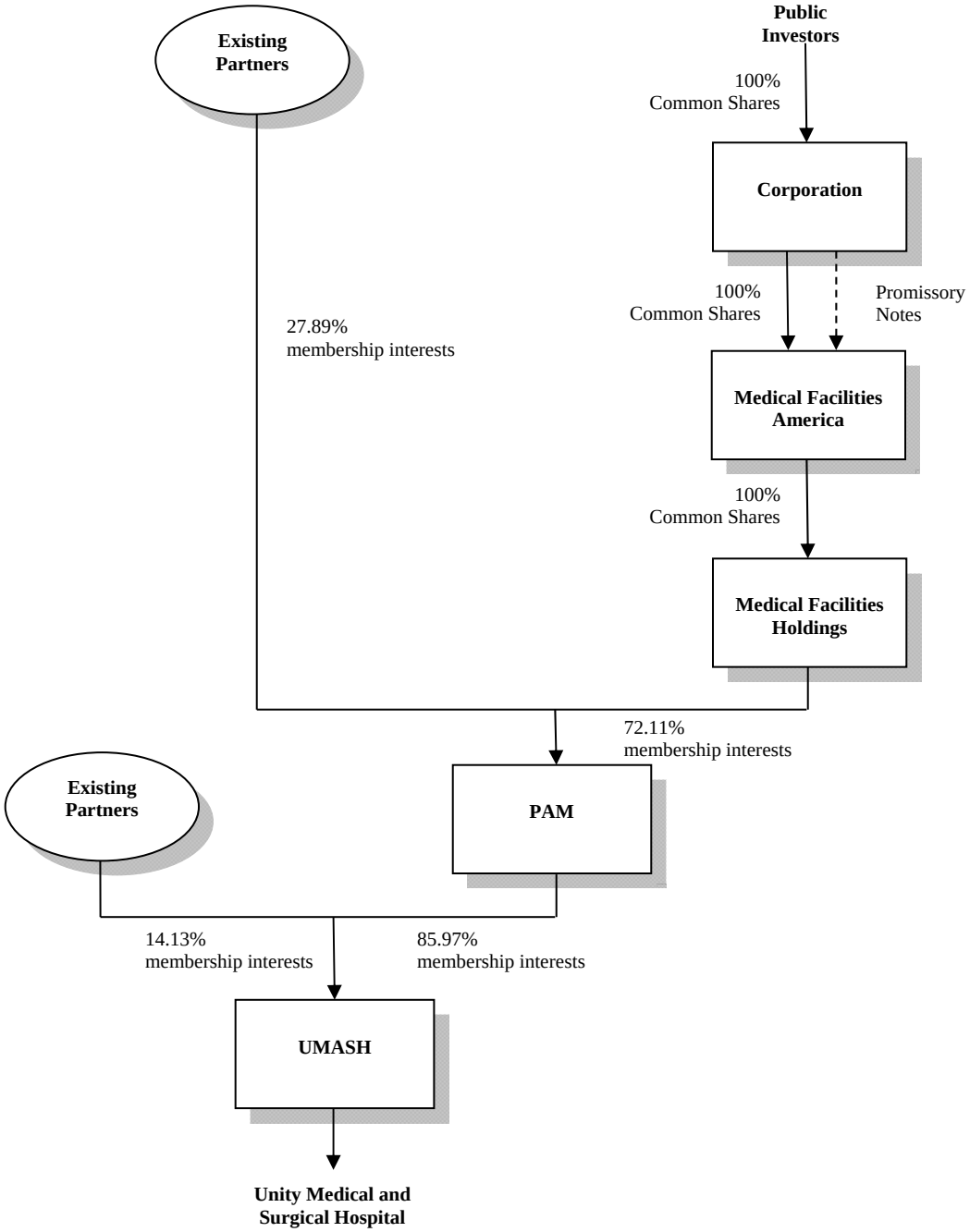
The following chart illustrates the ownership structure of each MFC Hospital (other than ASH, which has no Subco in its ownership structure but rather has the applicable Holding Entity directly holding its Retained Interest in ASH, and other than UMASH, which is illustrated in the next chart below):



(*) Breakdown of ownership in the MFC Partnerships. Percentage A represents the Retained Interest, comprised of an Exchangeable Interest and a 35% Continuing Interest (except in the case of ASH, in which the Continuing Interest is 44%), beneficially owned by the Existing Partners through their membership interests in their related Holding Entity and Subco. Percentage B represents the partnership interest in each MFC Partnership held by Medical Facilities Holdings.

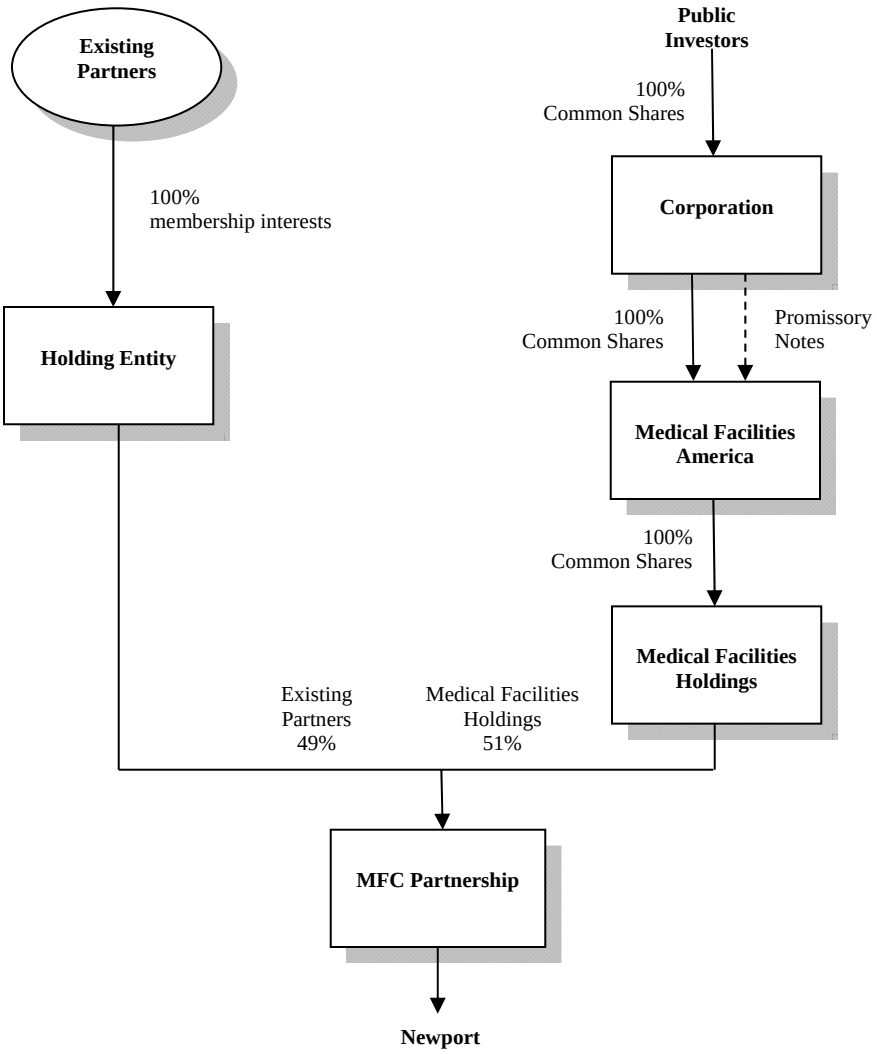
MFC Partnership	A%	B%
ASH	49.00%	51.00%
OSH	39.74%	60.26%
BHSH	45.78%	54.22%
SFSH	49.00%	51.00%

The following chart illustrates the ownership structure of UMASH:

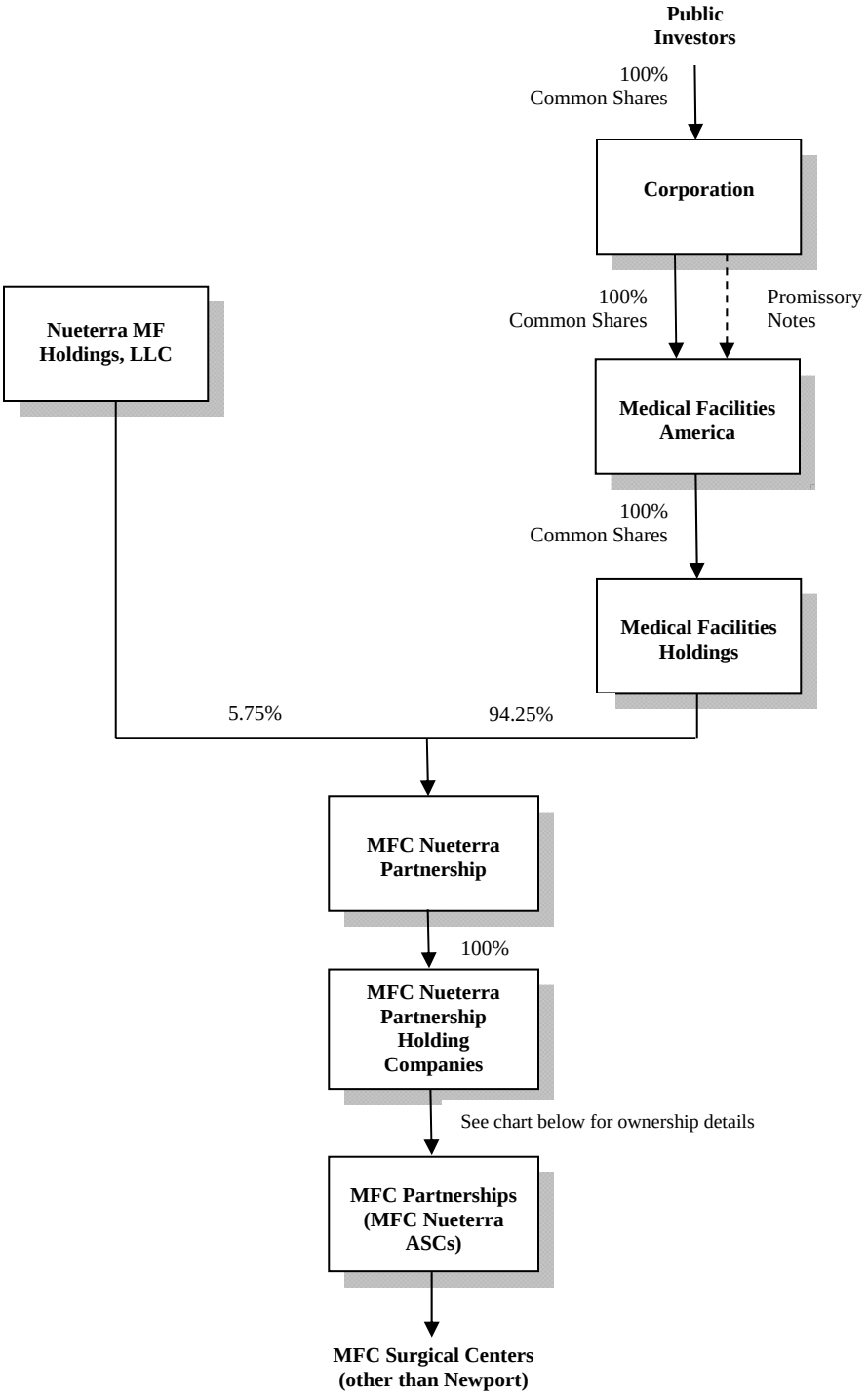


Medical Facilities Holdings has an indirect 62.0% interest in UMASH. Medical Facilities Holdings also owns a 92.0% interest in RRI Mishawaka, which owns the real property on which UMASH operates.

The following chart illustrates the ownership structure of Newport, an ASC in California in which the Corporation has indirect controlling interest:



The following chart illustrates the ownership structure of the MFC Nueterra ASCs:



MFC Nueterra Partnership's ownership (and Medical Facilities Holdings' indirect ownership) in each MFC Nueterra ASC is as follows:

MFC Nueterra Partnership Holding Company	MFC Nueterra ASC	MFC Nueterra Partnership's Ownership in MFC Nueterra ASC	Medical Facilities Holdings Indirect Ownership in MFC Nueterra ASC
Meridian Surgical Partners-Arkansas, LLC	Central Arkansas (Russellville, Arkansas)	42.59%	40.14%
Meridian Surgical Partners-Michigan, LLC	Brookside (Battle Creek, Michigan)	51.00%	48.07%
Meridian Surgical Partners-Missouri, LLC	City Place[(1)] (Creve Coeur, Missouri)	56.95%	53.68%
Meridian Surgical Partners-Nebraska, LLC	Miracle Hills (Omaha, Nebraska)	59.17%	55.77%
Meridian Surgical Partners-Ohio, LLC	Eastwind Surgical (Westerville, Ohio)	46.44%	43.77%
Meridian Surgical Partners-Oregon, LLC	Two Rivers (Eugene, Oregon)	58.64%	55.27%
Meridian Surgical Partners-Pennsylvania II, LLC	Riverview (Kingston, Pennsylvania)	59.01%	55.62%

(1) Holds 100% interest in each of CCSC, LLC, Creve Coeur Surgery Center, LLC, SLSSC, LLC, and St. Louis Spine Surgery Center, LLC.

IMD

The Corporation holds, through its wholly-owned subsidiary MF IMD Holdings (in which it holds common shares and a $1.25 million promissory note), a 51% controlling interest in IMD.

GENERAL DEVELOPMENT OF THE BUSINESS

The Corporation's operations are based in the United States. Through its wholly-owned U.S.-based subsidiaries, the Corporation owns controlling interests in seven MFC Partnerships, six of which own either a specialty hospital or an ASC. In addition, through the MFC Nueterra Partnership, the Corporation owns indirect interests in seven MFC Nueterra ASCs, which range from approximately 40% to 56%. The Corporation derives substantially all of its income from its specialty hospitals and ASCs. Through its wholly-owned U.S.-based subsidiary, the Corporation also owns a controlling interest in IMD, a shared services organization.

Three Year History

2015

On June 30, 2015, DPSC sold its assets related to the operation of its specialty hospital to Avera St. Luke's for gross proceeds of $36.9 million. DPSC distributed $33.3 million of net proceeds as follows: $21.5 million to the Corporation and $11.8 million to the Existing Partners. DPSC is expected to wind up in 2018.

On July 7, 2015, the Corporation increased the borrowing amount under the Credit Facility to Cdn$100 million or US$80 million and extended its maturity to December 31, 2018. The Corporation is in the process of increasing the borrowing amount and extending the maturity of the Credit Facility. As of March 29, 2018, US$67.8 million was outstanding under the Credit Facility.

2016

On January 14, 2016, the Corporation acquired a 51.0% controlling interest in IMD for a cash purchase price of $1.75 million. IMD is a diversified healthcare service company located in Oklahoma City that provides third-party business solutions to healthcare entities such as physician practices, facilities, and insurance companies.

On July 13, 2016, RRI Mishawaka acquired the real estate assets underlying UMASH, consisting of land and building, for $27.4 million pursuant to a purchase agreement entered into with Unity Realty, LLC, as seller, dated March 3, 2016, as amended on May 9, 2016. RRI Mishawaka is a limited partnership in which the Corporation initially held an indirect 84.0% interest, acquiring a further 8.0% interest in 2017. The remaining 8.0% interest in the partnership is held by RRI – RH Mishawaka, LLC. The acquisition of the real estate assets was funded solely by a loan from the Corporation. The Corporation funded the loan from its available cash on hand and a $20.0 million draw on its Credit Facility.

On September 23, 2016, the Corporation entered into a membership interest purchase agreement with PAM whereby it acquired an indirect 62.0% controlling interest in UMASH, a medical and surgical hospital located in Mishawaka, Indiana for a cash purchase price of $27.8 million, with funding from a draw on the Corporation's Credit Facility. UMASH's operations are approximately 86.0% owned by PAM. The Corporation purchased a 72.1% interest in PAM (representing an indirect 62.0% ownership interest in UMASH). All but 4% of the remaining ownership interest in PAM can be purchased over the three subsequent anniversaries of the initial closing, at a price to be determined by the fair market value of the hospital at the end of the prior calendar year.

The Corporation was not required to file Form 51-102F4 (Business Acquisition Report) in respect of any of the foregoing acquisitions.

On October 3, 2016, SFSH acquired the assets of Prairie States Surgical Center, an ASC located in Sioux Falls, South Dakota, which specializes in orthopedic procedures, for a purchase price of $20.3 million using cash on hand and seller and other financing. Seller financing is to be paid over a period of five years.

Key changes were made to the Corporation's leadership team in 2016. On May 1, 2016, Mr. Britt Reynolds was appointed President and Chief Executive Officer, on September 19, 2016, Mr. James Rolfe was appointed Chief Development Officer, and on November 21, 2016, Mr. Tyler Murphy was appointed Executive Vice-President, Finance. On January 1, 2017, Mr. Murphy was appointed Chief Financial Officer, replacing Mr. Michael Salter following his retirement on December 31, 2016.

2017

Changes in leadership occurred in 2017. On June 12, 2017, Mr. Reynolds resigned his employment from the Corporation following which Mr. Jeffrey Lozon was appointed as interim President and Chief Executive Officer. On October 25, 2017, Mr. Robert Horrar, who joined the Corporation on May 5, 2017 as Chief Operating Officer, was appointed as President and Chief Executive Officer.

The Corporation regularly implements normal course issuer bids to repurchase its Common Shares. Since its IPO and until December 31, 2017, the Corporation has repurchased an aggregate of 1,730,574 Common Shares/IPSs for cancellation. In May 2017, the Corporation received TSX approval for normal course issuer bid to repurchase up to 620,918 of its outstanding Common Shares for the period from May 16, 2017 to May 15, 2018.

Recent Developments

On January 12, 2018, Medical Facilities Holdings, an indirect subsidiary of the Corporation, entered into an agreement with Nueterra MF Holdings, LLC to form a partnership (MFC Nueterra Partnership) to cause MFC Nueterra Partnership to acquire an ownership interest in seven ASCs (MFC Nueterra ASCs) pursuant to a purchase agreement with Meridian Surgical Partners, LLC. Medical Facilities Holdings owns a 94.25% interest in MFC Nueterra Partnership.

On February 1, 2018, MFC Nueterra Partnership completed the acquisition of a majority interest in MFC Nueterra ASCs for a total purchase price of $46.5 million, of which the Corporation's portion was $43.9 million.

The Corporation funded its portion of the purchase price by cash on hand ($23.9 million) and by a draw on its Credit Facility ($20.0 million).

Further details about MFC Nueterra Partnership and MFC Nueterra ASCs are included throughout this Annual Information Form.

The Corporation is not required to file Form 51-102F4 (Business Acquisition Report) in respect of this acquisition.

DESCRIPTION OF THE BUSINESS

Business of the Corporation, Medical Facilities America and Medical Facilities Holdings

The Corporation was established to hold a 100% interest in Medical Facilities USA, a limited liability company. Medical Facilities Holdings, the successor entity by conversion of Medical Facilities USA, holds a 51% partnership interest or greater in each MFC Partnership, other than MFC Nueterra ASCs in which Medical Facilities Holdings holds an indirect interest of between approximately 40% to 56% in respect of each MFC Nueterra ASC. The Corporation, Medical Facilities America and Medical Facilities Holdings do not have any ongoing business operations of their own. Medical Facilities Holdings depends on the operations and assets of the MFC Facilities for cash distributions on its partnership interests in the MFC Partnerships. Medical Facilities America, in turn, depends on Medical Facilities Holdings for cash distributions to satisfy the interest obligation under the Promissory Notes and to pay dividends to the Corporation. The Corporation, in turn, depends on Medical Facilities America for cash distributions to pay dividends on the Common Shares and to pay other obligations of the Corporation, including but not limited to interest on the Debentures.

Although the business and operations of each MFC Facility are under the operational control and direction of management of each facility or, in respect of MFC Nueterra ASCs, of the Nueterra Manager, Medical Facilities Holdings exercises control and general oversight over these facilities through contractual rights which provide that certain matters are subject to the approval of the Medical Facilities Holdings board of directors, including any reduction in distributions, certain budgeting matters, material deviations from budget and specified fundamental transactions. With respect to UMASH, Medical Facilities Holdings controls the board thereof through its majority ownership of and board representation on PAM.

The board of directors of the Corporation consists of eight members, the majority of whom are unrelated to the Corporation and its subsidiaries. The boards of directors of Medical Facilities America and Medical Facilities Holdings each consists of nine members, five of whom are unrelated to Medical Facilities America, Medical Facilities Holdings and the MFC Partnerships. Five of the directors are nominees of the Corporation with the remaining being nominees of BHSH and SFSH.

The board of directors and Management of Medical Facilities Holdings are responsible for administering the affairs of Medical Facilities Holdings, working co-operatively with the Corporation to identify and implement operational best practices, assisting the MFC Facilities to realize potential synergies among them, and identifying strategic acquisition opportunities. The surgical facility industry is highly fragmented. As such, there are a number of specialty surgical hospitals and ASCs that may provide accretive growth opportunities for the Corporation. The board of directors and Management of Medical Facilities Holdings are responsible for identifying, negotiating and structuring the acquisition of additional surgical facilities. Accretive acquisitions may enhance distributable cash flow growth, increase the potential for synergies among the MFC Facilities and provide additional diversification.

The Corporation also has an indirect controlling interest in IMD and RRI Mishawaka, and an indirect majority interest in Mountain Plains Real Estate Holdings, LLC, an entity which owns the real estate assets underlying BHSH’s urgent care location in Spearfish, South Dakota.

Business of the MFC Facilities

Business Overview

The MFC Partnerships own and operate the MFC Facilities, with the exception of DPSC which sold its assets related to the operation of its specialty hospital on June 30, 2015. Each MFC Hospital is a licensed speciality surgical hospital which performs scheduled (as opposed to emergency) surgical, imaging and diagnostic procedures. The MFC Hospitals do not offer the full range of services typically found in traditional hospitals, but instead focus on a limited number of clinical specialties, including: orthopedic, ear, nose and throat, neurosurgery and other surgical procedures.

The five MFC Hospitals are located as follows: one is located in Arkansas, one is located in Indiana, one is located in Oklahoma and two of the MFC Hospitals are located in South Dakota. ASH, which performs more joint replacements than any other facility in Arkansas, is located in North Little Rock, Arkansas. UMASH, which is located in Mishawaka, a growing commercial city in Northern Indiana, specializes in the areas of spine, orthopedics, ophthalmology, ear, nose and throat, sports medicine, oral surgery, podiatry, gastroenterology, general surgery, gynecology, bariatric, and pain management. The Spine Hospital, one of the United States' first physician-owned and operated specialty surgical spine hospitals, is located in Oklahoma City, the state capital of Oklahoma. The South Dakota MFC Hospitals are two of the largest specialty hospitals in South Dakota and are situated in Rapid City and Sioux Falls, the major population centers on the east and west sides of the state, and service patients throughout South Dakota and surrounding states. Collectively, the MFC Hospitals have 47 operating rooms, 155 overnight stay rooms, 756 physicians with medical staff privileges and a clinical staff of 1,067.

The eight MFC Surgical Centers, located in Arkansas, California, Michigan, Missouri, Nebraska, Ohio, Oregon, and Pennsylvania, are licensed ASCs which perform scheduled outpatient or "same day" scheduled (as opposed to emergency) surgical and diagnostic procedures. Collectively, the MFC Surgical Centers have 19 operating rooms and 9 procedure rooms.

The MFC Facilities focus on providing high quality surgical facilities that meet the needs of their patients, physicians and payors better than competing surgical facilities in their markets. MFC Facility Management believes that their facilities:

- enhance the quality of care and the healthcare experience of patients;
- offer significant administrative, clinical and professional benefits to physicians;
- offer a competitive alternative to payors; and
- are well positioned to grow by taking advantage of the increasing demand for surgical procedures.

The business model of the MFC Facilities has been developed to encourage physicians to practice at the MFC Facilities. The scheduling, staffing, clinical procedures and protocols at each MFC Facility are designed to increase physician productivity and professional fee potential. MFC Facility Management believes that a high level of physician satisfaction and the provision of high quality healthcare in a non-institutional and convenient environment for patients, combined with favourable demographic trends and ongoing medical advancements, will continue to increase the number and complexity of procedures performed at the MFC Facilities each year.

By successfully executing a business strategy that emphasizes patient and physician satisfaction, and operating efficiency, the MFC Facilities on a combined basis have continued to experience growth in revenues attributable to higher case volumes and acuity of care.

Three of the MFC Hospitals have urgent care operations which are designed to diversify the services offered to a broader market and to enhance brand loyalty. Urgent care services are provided to the broader section of mostly local patients by specialized staff, in specially designed and constructed facilities separate from the surgical hospitals. These services are priced differently than surgical procedures.

Business and Growth Strategies

MFC Facility Management intends to continue to maintain and enhance the operating efficiency of each MFC Facility and maintain and enhance cash available for distribution by the Corporation by executing the following business and growth strategies:

- *Attract and Retain Quality Healthcare Professionals*. The MFC Partnerships intend to continue to attract and retain quality healthcare professionals. MFC Facility Management believes that the MFC Partnerships have been successful in attracting and retaining quality physicians because of the ownership and management structure and the staffing, scheduling and clinical procedures and protocols in place which are designed to increase a physician's productivity and professional fee income, promote his/her professional success, provide control over his/her practice, and enhance the quality of patient care.

- *Maintain and Enhance Operating Margins and Efficiency*. The clinical and operational procedures in place at each MFC Facility are designed to maximize operational efficiencies. By focusing on a limited number of specialized procedures, the MFC Facilities are able to develop and implement clinical and administrative best practices which increase physician productivity. Each MFC Facility intends to continue to refine its case mix in an effort to enhance its operating efficiency. Management is responsible for identifying and achieving potential synergies among the MFC Facilities, including the implementation of best practices, standardizing reporting and information systems and equipment and supplies, participating in group purchasing programs and consolidating the MFC Facilities' benefit programs.

- *Proactive Marketing*. The MFC Facilities will continue to undertake proactive marketing activities directed at physicians, other healthcare providers, patients and payors. These activities generally emphasize the benefits offered by the individual MFC Facility compared to other healthcare facilities in their respective markets, such as the ability to schedule consecutive cases without pre-emption by emergency procedures, the efficient turnaround time between cases, the simplified administrative procedures utilized at each MFC Facility and the overall patient satisfaction. The MFC Facilities also market their hospitals directly to payors, including HMOs, PPOs and other managed care organizations, employers and other payors. Payor marketing activities conducted by the MFC Facilities emphasize the high quality of care, cost advantages and convenience of the facilities.

- *y was chair of the audit committee of* . The MFC Facilities will endeavour to increase revenues and operating efficiency by the disciplined introduction of new service lines and more complex surgical and pain management procedures.

- *Acquisition of Additional Facilities*. The execution of accretive acquisitions will allow for the growth of cash available for distribution. In addition, Management believes that accretive acquisitions will enhance the potential for operational efficiencies, including the implementation of operational best practices, standardization of equipment and supplies and group purchasing programs. Finally, Management believes that acquisitions will enhance the stability of the MFC Facilities' operations on a combined basis through a broadened geographic base and diversification of their payor base and case mix and increase the Corporation's and the MFC Facilities' profile within the medical community in the United States, thereby enhancing its ability to identify and attract future acquisition opportunities.

Competitive Strengths

Management believes that the MFC Partnerships are successfully capitalizing on an attractive market opportunity in the healthcare industry. There are a number of competitive strengths that have contributed to the strong historical financial performance at each MFC Partnership which Management believes will continue to sustain the MFC Facilities' financial performance and provide a platform for future growth:

- *Physician Preference*. Physician loyalty is a key to the success of the MFC Facilities. Physicians prefer practicing at the MFC Facilities because they are able to increase the number of procedures they

perform in a given period relative to a traditional hospital setting, thereby maximizing their efficiency and increasing professional fee potential.

- *Patient Preference*. The clinical and administrative procedures in place at each MFC Facility are designed to improve the patient experience and ensure a high degree of patient satisfaction. Management believes that patients prefer the MFC Facilities over traditional hospitals and other surgical facilities because they offer the comfort of a less institutional environment, a high level of customer service and convenience, simplified administration procedures and greater scheduling flexibility while providing high quality patient care. MFC Facilities consistently rank high in industry leading surveys and studies of patient satisfaction.

- *Payor Preference*. The MFC Facilities offer payors a competitive alternative to traditional hospitals and enable them to offer their members a greater degree of choice for surgical, imaging and diagnostic procedures.

- *Established Reputation.* Each MFC Facility is well established in its service area. As of the date of this Annual Information Form, the MFC Facilities operated by ASH, UMASH, OSH, BHSH, and SFSH have been in operation for twelve, eight, eighteen, twenty one and thirty-two years, respectively. The MFC Surgical Center operated by SCNC has been in operation for fourteen years. The recently acquired MFC Nueterra ASCs have been in operation between seven and twenty years. MFC Facility Management believes that the reputation of the MFC Facilities for providing high quality clinical outcomes and excellent patient service has provided the MFC Facilities with the ability to attract quality physicians and additional patients to the MFC Facilities.

- *Strong and Experienced Management*. The MFC Facilities have strong and experienced management teams focused on providing high quality care and physician and patient satisfaction. The physician dominated management structure ensures a high level of operational efficiency and assists the MFC Facilities in attracting and retaining physicians. The executive officers of the MFC Facilities, other than MFC Nueterra ASCs, collectively have an average of over ten years of experience in healthcare administration. Management services for MFC Nueterra ASCs are provided by the Nueterra Manager, an established, nationally trusted surgical healthcare partner specializing in full-service operations management services. Management and the members of the board of directors of the Corporation have extensive financial and corporate development experience and extensive relationships throughout the healthcare industry.

Facilities, Markets Served and Competitors

Arkansas Surgical Hospital

ASH is located in North Little Rock, Arkansas. Arkansas has a population of 3,004,279 (U.S. Census Bureau 2017 estimate). Management believes that the market served by ASH is attractive for the following reasons:

- *Specialization*. Management believes that ASH's predominant focus on orthopedic surgery, spine disorders and injuries and pain management will allow it to continue to be able to compete effectively over competing facilities.

- *Established Reputation.* ASH has been in operation for almost thirteen years and has a well-established reputation in North Little Rock and vicinity. Management believes that ASH's reputation for providing high quality care and excellent patient outcomes has enabled it, and will continue to enable it, to attract physicians and patients.

ASH has been operating as a licensed surgical hospital since April 2005 and specializes predominantly in orthopedics, spine and pain management procedures. ASH operates a 126,000 square foot facility with 41 overnight rooms which accommodate 49 beds, 11 operating rooms, 2 procedure rooms and a clinical staff of 233. There are currently 230 physicians who have medical staff privileges at ASH.

ASH leases the facility building from Broadstone Net Lease, a related party. Certain minority owners of ASH are also minority owners of Broadstone Net Lease.

In January 2018, ASH opened ASH Urgent Care and Occupational Medicine in Sherwood, Arkansas. The clinic provides time-sensitive treatment of minor illnesses and injuries such as broken bones, sore throat, and flu, offers pre-employment services such as physicals, drug screenings, and vaccinations, and provides medical treatment for work-related injuries for local employers.

ASH competes with traditional hospitals, ASCs and other specialty hospitals to attract physicians, employees and patients.

Unity Medical and Surgical Hospital

UMASH is located in Mishawaka, Indiana. Indiana has a population of 6,666,818 (U.S. Census Bureau 2017 estimate). Management believes that the market served by UMASH is attractive for the following reasons:

- *Specialization.* UMASH's physicians have participated in cutting edge research and offer advanced surgical techniques available to treat spinal disorders. UMASH's orthopedic surgeons have extensive training in adult reconstructive surgery, hand and microsurgery, pediatric orthopedics and orthopedic trauma surgery. Management believes that UMASH's focus on orthopedic and spine procedures will allow it to continue to be able to compete effectively over competing facilities.

- *Established Reputation.* UMASH has been in operation for eight years and has a well-established reputation in Mishawaka and adjacent areas. UMASH is one of the top performing hospitals in the United States and routinely tops the charts in local, state and national awards for patient healthcare. Management believes that UMASH's reputation for providing high quality care and excellent patient outcomes has enabled it, and will continue to enable it, to attract physicians and patients.

UMASH opened in November 2009 as a medical and surgical hospital with related services and ancillary capacities to serve both medical and surgical patients. While UMASH specializes in orthopedic and spine procedures, it also has highly trained specialists in ophthalmology, ear, nose and throat, sports medicine, oral surgery, podiatry, gastroenterology, general surgery, gynecology, bariatric, and pain management, and provides primary care services. UMASH operates in a 49,000 square foot facility located on 4.83 acres with 29 overnight rooms and beds, 4 operating rooms, 2 procedure rooms and clinical staff of 101. There are currently 81 physicians who have medical staff privileges at UMASH.

UMASH leases the underlying land and building from RRI Mishawaka, which is majority owned by Medical Facilities Holdings.

Mishawaka, Indiana and the immediately adjacent area (South Bend, Indiana) have five acute care providers that serve as primary competition for UMASH. Both St. Joseph Regional Medical Center and Memorial Hospital of South Bend are full service acute care hospitals, each located within a five-mile radius of UMASH. Other providers in the marketplace who are not primary competitors of the services provided by UMASH include a long-term acute care facility and a neuropsychiatric facility which focuses on behavioral health services.

Oklahoma Spine Hospital

OSH is located in Oklahoma City, the state capital of Oklahoma. Oklahoma City has a population of 638,367 (U.S. Census Bureau 2016 estimate) and the State has a population of 3,930,864 (U.S. Census Bureau 2017 estimate). Management believes that the market served by OSH is attractive for the following reasons:

- *Specialization.* Although OSH competes with traditional hospitals, ASCs and other specialty hospitals to attract physicians, employees and patients, OSH is the only facility in the Oklahoma City metropolitan area that focuses on the treatment of disorders of the spine. Management believes that OSH's focus on spine disorders and injuries as well as pain management, neurosurgery and orthopedic surgery will allow it to continue to be able to compete effectively over competing facilities.

- *Established Reputation*. OSH has been in operation for eighteen years and has a well-established reputation in central and western Oklahoma. Management believes that OSH's reputation for providing high quality care and excellent patient outcomes has enabled it, and will continue to enable it, to attract physicians and patients.

OSH has been operating as a licensed hospital since December 1999 and focuses on a limited number of clinical and surgical specialties, including neurosurgery and pain management. OSH operates a 61,000 square foot facility with 7 operating rooms, 2 pain management procedure rooms, 25 private patient rooms, 14 pre-op and post-op outpatient beds, a category IV emergency services room and a clinical staff of 171. There are currently 127 physicians who have medical staff privileges at OSH.

OSH leases the facility and the underlying land from Memorial Property Holdings, LLC, a company owned by certain physicians who own the Retained Interest in OSH. The lease expires in November 2019. OSH has the renewal option to extend the lease term for another consecutive period of five years. OSH also leases approximately 7,000 square feet of administrative office space in an adjacent building owned by a physician-owner of OSH Holdings, LLC.

OSH competes with traditional hospitals, ASCs and other specialty hospitals to attract physicians, employees and patients.

South Dakota MFC Hospitals

The South Dakota MFC Hospitals are located in Rapid City and Sioux Falls, South Dakota, each servicing a largely rural market. South Dakota has a population of 869,666 (U.S. Census Bureau 2017 estimate). The South Dakota MFC Hospitals service patients throughout South Dakota and surrounding states, including parts of Minnesota, Iowa, Nebraska, North Dakota, Wyoming and Montana. Management believes that the markets served by the South Dakota MFC Hospitals are attractive for the following reasons:

- *Smaller Markets*. These communities have smaller populations with fewer hospitals and other healthcare service providers. Management believes that the smaller populations and relative significance of the one or two traditional hospitals in these markets may discourage the entry of other surgical facilities, including ASCs, as well as rehabilitation and diagnostic and imaging centers.

- *More Favourable Payment Environment.* The lower number of healthcare providers in these markets limits the ability of managed care organizations to create price competition among local healthcare providers. Consequently, the South Dakota MFC Hospitals can often negotiate reimbursement rates with managed care plans that are more favourable, in general, than those available in urban markets.

Black Hills Surgical Hospital

BHSH is located in Rapid City, South Dakota's second largest city, and has been operating as a licensed specialty hospital since January 1997. BHSH is a multi-specialty facility serving patients primarily in western South Dakota, Nebraska, North Dakota and Wyoming. The majority of revenue is generated from orthopedic and neurosurgery procedures. Additional service lines include ear, nose and throat, general surgery, gynecology, ophthalmology, cosmetic surgery and podiatry. The facility is conveniently located with access to both public and private transportation.

BHSH is approximately 75,000 square feet with 11 licensed operating rooms, 26 beds, and clinical staff of 319. There are currently 101 physicians who have medical staff privileges at BHSH. The hospital offers MRI and CT services, utilizing the latest available technology. In 2016, BHSH completed a construction project to increase operating room capacity and support functions. BHSH commenced operation of urgent care and occupational medicine clinics in 2012, adding a second clinic in 2013, and a third location in Spearfish, South Dakota in 2016. The lower level of the Spearfish facility houses the new urgent care clinic with seven exam rooms, a digital x-ray machine, and a lab. The upper level is leased to various specialists who serve patients in the Spearfish market region, including the Northwestern Black Hills area, Eastern Wyoming, and Eastern Montana.

The hospital facility and the underlying land are owned by BHSH. One of the urgent care clinics is owned, one is leased from an independent third party, and the Spearfish location is owned by Mountain Plains Real Estate Holdings, LLC, an entity which is indirectly owned by the Corporation and Medical Center Land Holdings, LLC. Medical Center Land Holdings, LLC is owned by physicians, some of whom are also owners in BHSH related Holdco.

The primary competing facility for BHSH is the not-for-profit Rapid City Regional Hospital and its affiliated specialty hospital, Same Day Surgery Center. Other facilities in the area include the Sioux San Hospital primarily servicing Native Americans, Black Hills Regional Eye Institute, Rapid City Community Health Center and numerous clinics that provide healthcare services in every speciality.

Sioux Falls Specialty Hospital

SFSH is located adjacent to the campus of Avera McKennan Hospital in Sioux Falls, South Dakota's largest city, with excellent access by public and private transportation. SFSH was established in 1985 and is a multi-specialty facility which performs orthopedic, ear, nose and throat, urology, neurosurgery, gynecology, plastic, gastrointestinal, pain management, general surgery, and ophthalmology procedures.

SFSH is approximately 76,000 square feet and is licensed for 48 beds. However, due to construction projects undertaken during 2016, SFSH is currently utilizing 38 beds which are made up of 12 operating rooms and 26 overnight rooms. SFSH has a clinical staff of 243. There are currently 217 physicians who have medical staff privileges at SFSH. SFSH is the only facility in the region offering high-field 3T MRI along with Open Upright MRI scanner technology. In 2016, SFSH acquired Prairie States Surgical Center, an ASC located in Sioux Falls, South Dakota, which specializes in orthopedic procedures and was subsequently converted to a hospital outpatient department. As a complement to its surgical operations, SFSH provides primary care and occupational health and medical services, and, in December of 2017, opened Sioux Falls Urgent Care, an urgent care clinic open 7 days a week to provide time-sensitive, affordable, and high-quality care for non-emergency illnesses and injuries.

The hospital facility is owned by SFSH and the MRI and Prairie States Surgical Center facilities are leased from related parties of SFSH.

Within the city of Sioux Falls, there are five other hospitals, including two traditional hospitals, one pediatric hospital that does not perform surgical procedures, a veterans' hospital and a specialty cardiac hospital. There are also numerous clinics that provide healthcare services in every specialty. The healthcare services industry in Sioux Falls is one of the city's primary industries, attracting patients from all over South Dakota, as well as from Minnesota, Iowa and Nebraska.

The MFC Surgical Centers

The Surgery Center of Newport Coast

SCNC is located in Newport Beach, Orange County, California and has been operating since 2004 as a Medicare Deemed Multi-Specialty Facility accredited by the Accreditation Association for Ambulatory Health Care. Management believes that the market served by SCNC is attractive for the following reasons:

- *Above-average Household Income*. Based on the U.S. Census Bureau's estimate (2012-2016), the median household income in Newport Beach is $115,845 and in Orange County is $78,145 compared to the U.S. median household income of $55,322. Management believes the relative affluence of Newport Beach and Orange County residents creates a favourable environment for SCNC, with such residents being more likely able to incur the personal costs associated with the procedures offered by this MFC Facility.

- *Diverse Payor Base.* Management believes that the densely populated nature of Orange County, together with the relative affluence of its residents, has resulted in the creation of a market having a diverse payor base of private insurance plans, including managed-care plans and self-insured employer plans.

SCNC is a 7,000 square foot facility with 2 operating rooms, 1 procedure room and 8 pre-op and post-op recovery beds. SCNC focuses primarily on orthopedic, gastroenterology, pain management, cosmetic and gynecology procedures. There are currently 22 clinical staff and 31 physicians who have medical staff privileges at SCNC. The facility is conveniently located near four major medical office towers in Newport Beach and is leased by SCNC from an unrelated third party.

In the Newport Beach area, there is one hospital, Hoag Hospital, and a few smaller non multi-specialty facilities.

MFC Nueterra ASCs

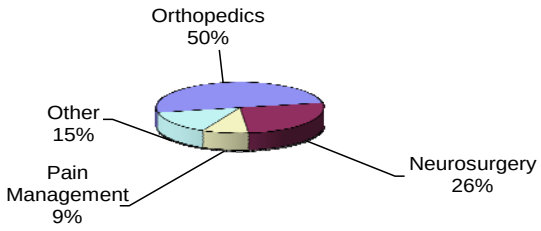
MFC Nueterra ASCs are seven well-established surgical facilities located in seven states: Arkansas, Michigan, Missouri, Nebraska, Ohio, Oregon, and Pennsylvania. MFC Nueterra ASCs collectively have 17 operating rooms and 8 procedure rooms. The physicians at MFC Nueterra ASCs specialize in orthopedics, neurosurgery, ophthalmology, pain management, otolaryngology, gastroenterology, cosmetic surgery, general surgery and podiatry. Within their respective markets, MFC Nueterra ASCs compete with traditional hospitals, specialty hospitals and other ASCs to attract both physicians and patients.

Case Mix

The MFC Hospitals focus on a limited number of high volume non-emergency surgical procedures and diagnostic and imaging services. The MFC Surgical Centers focus on orthopedics, neurosurgery, ophthalmology, pain management, otolaryngology, gastroenterology, general surgery, podiatry, gynecology, and cosmetic surgery. The case mix at each MFC Facility is a function of the clinical specialties of the physicians on the medical staff and the equipment and infrastructure at each facility. Each of the MFC Facilities intends to continue to refine its case mix as opportunities arise.

The following chart outlines the percentage of gross revenue per major specialty generated in 2017 at the MFC Facilities, other than MFC Nueterra ASCs which were acquired in February 2018.

Case Mix
(2017 Patient Gross Revenue)



Management of each MFC Facility will continue to implement the business strategies of increased marketing and operating efficiency through the adoption of best practices which are aimed at increasing the utilization of each MFC Facility.

Management believes that historical levels of growth at the MFC Facilities were achieved substantially through increasing procedure volume and by focusing on clinical specialties which enhance operating efficiency and productivity. Management believes that through further refinement of scheduling, incremental growth in the near term can be achieved without any significant infrastructure improvements or extension of current operating hours.

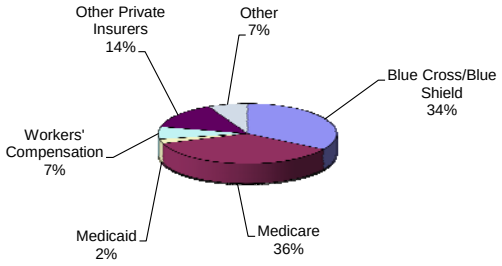
Revenue Model and Payor Mix

Fees earned by the MFC Facilities vary depending on the surgical procedure or related service performed and who is paying for the services. Revenues are generated and separately invoiced on a per-procedure basis.

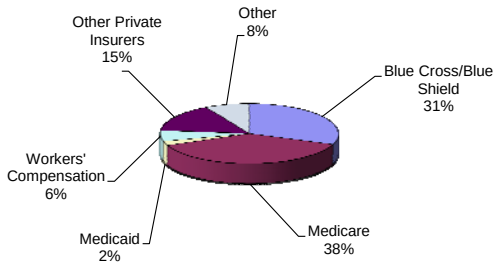
Generally, there are at least two fees for most surgical procedures and diagnostic and imaging services performed at the MFC Facilities — a facility fee and a professional fee. The facility fee is paid directly to the MFC Facility for the use of its infrastructure, surgical equipment, nursing staff, non-surgical professional services and other support services. Generally, professional fees are paid directly to the physician(s) performing the procedure and are not included in the revenue or expenses of the MFC Facilities, except for certain fees for MRI and CT scans and anesthesia services that are paid directly to the MFC Facilities. Overall revenue depends on patient occupancy levels, imaging, diagnostic and surgical procedure volumes, case mix and the payment rates of the respective payors.

The MFC Facilities receive payments for the imaging, diagnostic and surgical procedures and related services they provide from public and private health insurance plans, workers' compensation and directly from patients. The following charts outline the percentage of patient gross revenue generated in 2017 and 2016 from each primary payor group. Although these percentages have remained relatively stable over the past five years, the MFC Facilities, similar to many healthcare providers, have seen the percentage of services paid for by governmental plans such as Medicare and Medicaid increase above historical norms and, by inference, a decrease in the proportion of services covered by private insurance.

Payor Mix
(2016 Patient Gross Revenue)



Payor Mix
(2017 Patient Gross Revenue)



Note: The above charts are based on the primary payor group. Co-payment and deductible obligations paid directly by or on behalf of the patient are included as revenue attributed to the primary payor. For example, if a patient has a $500 deductible or co-payment under their insurance plan, this amount is included in the private insurance category notwithstanding the fact that the patient pays this fee directly to the MFC Facility.

The majority of patient service revenues generated by the MFC Facilities are based on payments received from private insurance plans, including managed care plans and self-insured employer plans. The majority of the U.S. population is covered by some form of managed care plan, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), generally obtained through the workplace. Managed care plans provide comprehensive health services to their members and frequently offer financial incentives for patients to use healthcare providers who are associated with the plan. Managed care plans and other private insurers typically negotiate discounted fee structures for surgical procedures with healthcare providers in an effort to control healthcare costs. The MFC Facilities are well positioned to compete for surgical procedures and related services in this environment.

Government-funded public healthcare plans include Medicare and Medicaid. Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to low-income individuals. The MFC Facilities are participating providers for both Medicare and Medicaid services. Payments derived for services rendered to Medicare and Medicaid beneficiaries are generally lower than the customary fees charged by the MFC Facilities to private insurance plans for similar services. Medicare's pricing model is a prospective payment system based on fixed payment rates. Amounts paid for procedures and related services under a prospective payment system are established by federal regulation and are not based on the costs incurred by the provider. As such, Medicare payment rates are established for each surgical procedure. Similarly,

payments for services rendered to Medicaid beneficiaries are determined in accordance with procedures and standards established by state laws and federal guidelines.

The MFC Facilities receive a relatively small proportion of their revenue directly from uninsured patients. In addition, insured patients are responsible for services not covered by their health insurance plans, and for deductibles, co-payments and co-insurance obligations under their plans. The amount of these deductibles, co-payments and co-insurance obligations has increased in recent years but does not represent a material component of the revenue generated by the MFC Facilities.

The diversity and credit strength of the MFC Hospitals' payor mix has led to a bad debt ratio averaging 1% of net revenues for ASH, 3% of net revenues for OSH, and 2% of net revenues for the South Dakota MFC Hospitals over the past five years. The higher ratio for the Spine Hospital reflects a higher percentage of surgical cases for which the reimbursement depends on the outcome of insurance claims and litigation. UMASH's bad debt ratio averaged 1% of net revenues for the fifteen months since its acquisition by the Corporation. The MFC Surgical Centers generally attempt to collect the patient portion up-front with the balance receivable primarily due from the third-party payor so there is typically low amounts of bad debt expense.

Physicians and Ownership Structure

In order to perform surgical procedures at the MFC Facilities, a physician must meet certain professional credentialing requirements established by each MFC Facility. Physicians practicing at the MFC Facilities include both physicians with an indirect ownership interest in the facilities and non-investor physicians. As at December 31, 2017, there were a total of 159 physician investors and 787 physicians credentialed at MFC Facilities, not including MFC Nueterra ASCs which were acquired in February 2018.

Management and Employees

Each MFC Partnership (other than UMASH and MFC Nueterra ASCs) has a management committee consisting primarily of physician investors or individuals representing physician investors elected for fixed terms by the Existing Partners of that MFC Partnership and one representative of the Corporation (except for DPSC, which since the DPSC Transaction has been inactive). The management committee is responsible for overseeing all operational and strategic initiatives of the surgical facility including physician recruitment and accreditation, facilities management and maintenance, administrative and human resources and all financial matters including approving payor arrangements. UMASH has a board of managers that is responsible for overseeing the overall management of the hospital consisting of six individuals, four of whom are elected by the Corporation (indirectly through its ownership of PAM) and two of whom are elected by the other physician members of UMASH. Management services to MFC Nueterra ASCs are provided by the Nueterra Manager in accordance with a management services agreement for which it receives management services fees. Each MFC Partnership has an internal management team, and OSH outsources some of its administrative functions to IMD.

The staff of each MFC Facility generally includes registered nurses, operating room technicians, radiology technicians and clerical and other support staff. None of the MFC Facilities' employees are represented by a collective bargaining agreement. Management believes that each MFC Facility has a good relationship with its employees and each offers its employees a competitive compensation package. As at December 31, 2017, there were a total of 1,544 full-time and part-time clinical and non-clinical employees at MFC Facilities, not including MFC Nueterra ASCs which were acquired in February 2018.

The MFC Facilities have experienced a high degree of physician and nurse retention as a result of the quality of services delivered and focus on both employee and patient satisfaction. MFC Facility Management believes that the MFC Facilities provide a less institutionalized work environment than traditional hospitals and improved working conditions for both nurses and staff as a result of limited number of night shifts and call duty and encourage their staff to continually upgrade their clinical and customer service skills through formal and informal training and mentoring.

Competition

The hospital and ambulatory surgery industry is highly competitive. In each market in which the MFC Facilities operate, there is competition with traditional hospitals and other ASCs and specialty hospitals to attract both physicians and patients. Patients in the MFC Facilities' primary service areas may travel to these other healthcare facilities for a variety of reasons, including the need for services not offered at the MFC Facilities, physician referrals or coverage by applicable insurance programs. MFC Facility Management believes that a facility's competitive position in the market in which it operates is affected by a number of factors, including: the scope, breadth and quality of services offered to its patients and physicians; the number, quality and specialties of the physicians who refer patients; nurses and other healthcare professionals employed or on its staff; its reputation; its managed care contracting relationships; the extent to which it is part of an integrated healthcare delivery system; its location; the location and number of competitive facilities and other healthcare alternatives; the physical condition of its buildings and improvements; the quality, age and state of the art of its medical equipment; its parking or proximity to public transportation; the length of time it has been a part of the community; and its charges for services. In addition, some of the facilities that compete with the MFC Hospitals are owned by not-for-profit organizations supported by endowments and charitable contributions. These hospitals are not subject to sales, property and income taxes. Because of the strong position the MFC Facilities enjoy in the markets where they are located, MFC Management believes that the MFC Facilities are well positioned to compete for both physicians and patients in the markets in which they operate.

There are a number of barriers to entry for new entrants into the surgical facilities market in the markets served by the MFC Facilities, including regulatory, licensing and capital requirements. In addition, the Arkansas, Indiana, Oklahoma and South Dakota markets are serviced by a number of excellent healthcare facilities, including the MFC Hospitals, thereby increasing the difficulty in attracting both physicians and patients to a new surgical facility.

Capital Expenditures

The capital expenditures of the MFC Facilities can be categorized into two types: maintenance and growth or earnings enhancing.

The table below sets out the historical and average maintenance and growth capital expenditures of the MFC Facilities for the past five years and maintenance capital expenditures as a percentage of net revenues.

	Years Ended December 31,					
	2017	**2016**	**2015**	**2014**	**2013**	**Average**
			(US$ Millions)			
Maintenance Capital Expenditures (net).....	4.8	2.6	2.8	3.0	4.3	3.5
Growth Capital Expenditures (net)	6.4	12.4	4.6	5.3	9.1	7.6
Total	**11.2**	**15.0**	**7.4**	**8.3**	**13.4**	**11.1**
Maintenance Capital Expenditures as Percentage of Net Revenues	**1.25%**	**0.75%**	**0.90%**	**0.96%**	**1.39%**	**1.05%**

Maintenance Capital Expenditures

Maintenance capital expenditures include those required to maintain and upgrade existing infrastructure, including the replacement of furnishings and routine maintenance to existing building structures and the surrounding landscape. In addition, the MFC Facilities routinely replace existing operating equipment and surgical devices. The management information systems of the MFC Facilities must also be maintained and upgraded from time to time.

Growth Capital Expenditures

Growth capital expenditures are those related to the acquisition of new equipment, expansion of existing infrastructure, subject to restrictions imposed by U.S. healthcare legislation discussed in the section entitled

"Description of the Business – Regulation" beginning on page 27, and other capital improvements. Growth capital expenditures are intended to increase productivity and cash flows, enhance margins and/or increase capacity.

In 2014, ASH remodelled its operating room space for $1.6 million and purchased new medical equipment for $0.4 million. In 2015, ASH spent $0.5 million on medical equipment and $0.1 million on information technology costs. In 2016, ASH spent $0.4 million on medical equipment and $0.1 million on information technology costs. In 2017, ASH spent $0.7 million on leasehold improvements and $0.2 million on developing urgent care clinic.

In 2016, UMASH spent $0.3 million on acquiring medical equipment and information technology costs.

In 2014, OSH spent $0.2 million on electronic health records implementation.

In 2014, BHSH purchased equipment and remodelled facility space for approximately $0.4 million to internalize laboratory services. In 2015, BHSH spent $1.4 million on construction of an urgent care clinic, $1.1 million to expand its physical plant and $0.4 million to purchase ear, nose and throat equipment. In 2016, BHSH spent $4.2 million on the expansion of its physical plant, $3.8 million on completing the construction of another urgent care clinic and $0.2 million on ear, nose and throat clinic. In 2017, BHSH spent $1.8 million to replace an MRI.

In 2014, major capital expenditures at SFSH included remodelling of the MRI facility ($0.7 million) and physician lounge ($0.7 million), electronic health records implementation ($0.1 million) and the acquisition of major equipment ($0.9 million). In 2015, SFSH spent $0.4 million acquiring major capital equipment, $0.3 million remodelling the physician lounge, $0.1 million on preparatory drawings for an operating room expansion and $0.1 million on building improvements. In 2016, SFSH's major expenditures included $2.8 million on operating room remodelling, $1.7 million on new operating room equipment, $1.0 million on leaseholds improvements and equipment for the outpatient facilities, formerly Prairie States Surgical Center, $0.5 million on locker room remodelling, and $0.5 million on CT scanner. In 2017, SFSH spent $1.1 million on operating room remodelling, $1.1 million on new operating room equipment, $0.9 million on remodelling of MRI facility, and $0.6 million on developing urgent care clinic.

In 2015, SCNC spent $0.2 million on major medical equipment.

Outlook

Maintenance capital expenditures have averaged $3.5 million (or 1.1% of the average annual net revenues) over the past five years. MFC Facility Management anticipates that in order to sustain the current capacity and utilization of the facilities, infrastructure and equipment of the MFC Facilities, maintenance capital expenditures will range between 0.8% and 1.4% of net revenues for the foreseeable future. However, there can be no assurance that actual expenditures will be within this range or that they will not be materially different from this range. In addition to cash generated from operations, the MFC Facilities have the ability to utilize vendor financing and third-party leasing arrangements to fund capital expenditures in the future. MFC Facility Management will continue to consider growth capital expenditures based on the economic merit of each project and the availability of funds.

Currency Hedging Policy

The Corporation is exposed to fluctuations in the exchange rate between the Canadian dollar and the U.S. dollar because the distributions it receives from its subsidiaries are in U.S. dollars and the dividends it pays to its shareholders, the interest on its Debentures and certain other expenses are in Canadian dollars. In order to minimize the impact of fluctuations in the exchange rate between the Canadian dollar and the U.S. dollar, the Corporation may enter into foreign exchange forward contracts which provide for the conversion of specified U.S. dollar amounts into Canadian dollar amounts at monthly intervals. As at December 31, 2017, the Corporation did not have any outstanding foreign exchange forward contracts in place to cover its future Canadian dollar requirements. The audit committee monitors compliance with the hedging policy on an on-going basis. From time to time, Management may recommend that the Corporation enter into derivative transactions covering its foreign currency exposure depending upon actual or anticipated performance and currency market conditions.

Regulation

Licensing and Accreditation

Healthcare facilities, along with their physicians and healthcare professionals, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements imposed by Medicare, Medicaid, state licensure, and private payor credentialing requirements. 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 compliance actions by the MFC Facilities that could be burdensome and costly. Each of the MFC Facilities and its affiliated physicians and allied healthcare professionals hold all licenses and accreditations necessary for its operation and the MFC Facility Management does not anticipate any issues regarding their renewal.

Physician Self-Referral Law

The U.S. federal physician self-referral law, commonly referred to as the Stark Law, prohibits a physician from making a referral for certain "designated health services" reimbursable by Medicare to an entity if the physician or a member of the physician's immediate family has a financial relationship with the entity, unless an exception applies. The Stark Law also prohibits an entity receiving a prohibited referral from billing the Medicare program for any items or services rendered to the patient, and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral. Designated health services include, among other services, inpatient and outpatient hospital services, clinical laboratory services, and radiological services. Designated health services do not include ASC services. A financial relationship is defined to include ownership or investment in, or a compensation relationship with, an entity. In addition, California has self-referral statutes similar to the Stark Law. The Corporation believes that physician-ownership of the ASC is not prohibited by the California self-referral statutes.

Among the exceptions to the Stark Law are investments by physicians (or immediate family members) in a whole hospital if the referring physician is authorized to perform services at the hospital. The MFC Facilities have relied on this exception as permitting their physician investors to refer patients to the MFC Facilities. This exception is discussed further below under the *Patient Protection and Affordable Care Act* section. There is also an exception that protects investments in large publicly-traded entities such as the Corporation.

CMS has issued regulations interpreting the Stark Law, clarifying that services that would otherwise constitute a designated health service, but that are paid by Medicare as a part of the ASC payment rate, are not a designated health service for purposes of the Stark Law. In addition, the Stark Law contains an exception covering implants, prosthetics, implanted prosthetic devices and implanted durable medical equipment provided in an ASC setting under certain circumstances. CMS has expanded the ASC exemption by excluding from the definition of "radiology and certain other imaging services" any radiology and imaging procedures that are integral to a covered ASC surgical procedure and performed immediately before, during, or immediately after the surgical procedure. Similarly, CMS has excluded from the Stark Law definition of "outpatient prescription drugs" any drugs that are "covered as ancillary services" under the revised ASC payment system. This includes drugs furnished during the immediate post-operative recovery period to a patient to reduce suffering from nausea or pain. CMS cautioned, however, that only items and services that are integral to an ASC procedure and performed on the same day qualify for the ASC exemption. The Stark Law prohibits a physician-owned ASC from furnishing outpatient prescription drugs for use in a patient's home. The MFC Facilities have relied on these regulations as permitting physician-ownership or investment interests in ASCs to which they refer patients.

In addition, there are exceptions that protect various service arrangements, such as medical director agreements, that MFC Facilities have with various physicians.

The sanctions under the Stark Law include denial and refund of payments, civil monetary penalties and exclusion from the Medicare program. Additionally, violations of the Stark Law are potentially actionable under the federal *Civil False Claims Act* discussed below.

There can be no assurance that the Stark Law or other physician self-referral laws or regulations will not be amended, enacted or promulgated in the future that would prohibit or restrict ownership in the MFC Partnerships by

physicians, referrals by the physician investors to the MFC Facilities, or which would prohibit or restrict the future growth of the MFC Partnerships. If the physician investors in the MFC Partnerships are prohibited from making referrals to the MFC Facilities, there will be a material adverse effect on the operations of the MFC Partnerships. In addition, there can be no assurance that investment in the MFC Partnerships by physicians will not be challenged by government enforcement agencies, or if challenged, that such structure and investments will be upheld by a court or administrative agency as not violating the Stark Law.

Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* ("**PPACA**") contains provisions intended to strengthen fraud and abuse enforcement and expands existing efforts to tie Medicare and Medicaid payments to performance and quality. PPACA is also designed to decrease the number of uninsured individuals by expanding coverage through public program expansion and private insurance reforms.

This law, and modifying language in a subsequently passed Reconciliation Bill, amended the Stark Law to prohibit the formation or development of any new physician-owned hospitals in the United States after a specified date. However, grandfathering provisions of the law permit existing physician-owned hospitals, including the MFC Partnerships, to continue their operations and billings to Medicare for hospital services, provided they meet certain investment and patient transparency requirements. Grandfathered hospitals like the MFC Partnerships are prohibited from expanding their baseline number of overnight beds, operating rooms, or procedure rooms unless certain narrowly-drawn growth criteria are met and the expansion is approved by the federal agency overseeing the Medicare program. As of the date of the enactment, the law also prohibits increases in the aggregate percentage value of physician ownership or investment in physician-owned hospitals, or in entities whose investments include the hospitals.

The law restricts physician investment in physician-owned hospitals, including requirements that the hospital may not: (i) condition investment on the physician making or influencing referrals or otherwise generating business for the hospital; (ii) offer investment opportunities to physicians on terms that are more favorable than those offered to non-physicians; (iii) directly or indirectly provide loans or financing for any investment in the hospital by a physician; and (iv) directly or indirectly guarantee a loan, make a payment towards a loan, or otherwise subsidize a loan, for any individual physician or group of physicians in connection with their acquisition of an ownership interest in the hospital. In addition, the hospital must distribute investment returns to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor. The law also requires disclosure of physician ownership to patients and the general public, and requires hospitals to obtain a signed patient acknowledgement as to whether the hospital has physicians present 24 hours a day, seven days a week.

The Corporation conducted an extensive review to ensure that the MFC Partnerships' operating agreements and procedures are in compliance with the provisions and limitations of the PPACA. The MFC Partnerships have updated their operating agreements and procedures as necessary to ensure compliance with the requirements of the PPACA.

Fraud and Abuse Prevention

Under the federal Anti-Kickback Statute (the "**Anti-Kickback Statute**"), it is a criminal felony offence to knowingly and wilfully offer, pay, solicit or receive remuneration in order to induce business for which reimbursement is provided under most federally-funded healthcare programs, including Medicare, Medicaid and the State Children's Health Insurance Program or SCHIP. The scope of prohibited conduct in violation of the Anti-Kickback Statute is broad and can include economic arrangements involving hospitals, physicians and other healthcare providers, including joint ventures. The limited case law interpreting the Anti-Kickback Statute generally holds that if any purpose of a payment (including indirect remuneration) is intended to induce referrals, the payments made could be in violation of the Anti-Kickback Statute, even if the payments also are intended as compensation for services actually rendered. Because of the uncertainty regarding the interpretation of the Anti-Kickback Statute and the possibility that it would make harmless (and even beneficial) conduct illegal, the United States Congress mandated the promulgation of "safe harbor" regulations.

The Office of the Inspector General ("**OIG**") of the Department of Health and Human Services ("**HHS**") has promulgated regulations that describe certain safe harbor arrangements that will not be deemed to constitute violations of the Anti-Kickback Statute. Absolute compliance with all elements of a safe harbor means that the activity will be immune from prosecution under the Anti-Kickback Statute and may serve as a basis for exclusion. An activity that fails to satisfy all elements of a safe harbor is not necessarily illegal, but the activity is not afforded immunity from prosecution or exclusion. The safe harbors described in the regulations are narrow and do not cover the wide range of economic relationships that many hospitals, physicians and other healthcare providers consider to be legitimate business arrangements not prohibited by the Anti-Kickback Statute. The OIG is responsible for identifying and eliminating fraud, abuse and waste, which it does through a nationwide program of audits, investigations and inspections. Violations for the Anti-Kickback Statute include criminal penalties, per-violation fines that under federal sentencing laws can reach $250,000 for individuals and $500,000 for entities and ten years imprisonment. Violations of the Anti-Kickback Statute also can lead to civil monetary penalties and exclusion from Medicare, Medicaid and certain other state and federal healthcare programs, as well as liability under the *False Claims Act* discussed below.

Many U.S. states, including Arkansas, Oklahoma and South Dakota, also have laws similar to the Anti-Kickback Statute that prohibit payments to physicians for patient referrals. The scope of these state laws, known as "all-payor" laws, is broad because they often apply to any payment, regardless of the source. These statutes typically provide for criminal and civil penalties, as well as loss of licensure, though little precedent exists for their interpretation or enforcement. In addition, in the *Deficit Reduction Act* of 2005, the United States Congress established a Medicaid Integrity Program to enhance federal and state efforts to detect Medicaid fraud, waste and abuse and provide financial incentives for states to enact their own false claims legislation as an additional enforcement tool against Medicaid fraud and abuse. Since then, a growing number of states have enacted healthcare fraud and abuse legislation.

Physician investments in the MFC Partnerships are not currently in complete compliance with any safe harbor and Management anticipates that they will not satisfy all of the requirements of a safe harbor in the future. However, the MFC Partnerships are in substantial compliance with several elements of safe harbors that are available for physician-owned ASCs and consistent with the requirement of several safe harbors that distributions to investing physicians be based on their relative ownership interests and not on their referrals. While Management believes that the MFC Partnerships do not violate the Anti-Kickback Statute and would have substantial arguments in the event of a challenge alleging violations of the Anti-Kickback Statute, there is no guarantee that such allegations could not be successfully brought. The potential success of such allegations would be dependent on the facts and circumstances surrounding the MFC Partnerships and their operations. If the MFC Partnerships are challenged successfully under the Anti-Kickback Statute, the physician investors could be precluded from referring patients to the MFC Facilities, resulting in termination of, or other adverse consequences to, the operations of the MFC Facilities. In addition, the MFC Facilities could be excluded from participation in federal healthcare programs. Further, MFC Partnerships and their physician investors could be subject to sanctions, including loss of professional licenses, exclusion from federal healthcare programs, and substantial fines and/or imprisonment. Additionally, violations of the Anti-Kickback Statute are potentially actionable under the federal *Civil False Claims Act* which permits government recoveries of treble damages and pre-claim penalties up to $21,563. There can also be no assurance that other anti-kickback laws or regulations will not be enacted in the future that could have a material adverse effect on the MFC Partnerships.

False Claims Act

The *False Claims Act* ("**FCA**") prohibits the submitting of or causing to be submitted false claims to the federal government or federal government programs, or the improper retention of known overpayments. The submission must have been completed with "reckless disregard" of the truth or falsity of the claim, regardless of any intent to defraud the government program or actual knowledge that the claim was false, which are factors typically required to sustain a criminal conviction. Liability includes treble damages plus penalties of $10,781 to $21,563 per claim. Violations of the Stark Law and the Anti-Kickback Statute are actionable under the FCA.

The FCA includes "whistleblower," or *qui tam*, provisions that permit private citizens to sue a claimant on behalf of the government. If the government intervenes in the action and prevails, the defendant may be required to pay treble damages, plus mandatory civil penalties for each false claim submitted to the government, and the *qui tam* plaintiff may share in a portion of any settlement or judgment. If the government does not intervene in the action,

the *qui tam* plaintiff may continue to pursue the action independently. Federal and state agencies that administer healthcare programs may implement civil monetary penalties and exclusion from government programs. As under the FCA, it often is not necessary for the agency to show that the claimant had actual knowledge that the claim was false or fraudulent in order to impose these penalties.

It is anticipated that the number of such *qui tam* actions against healthcare companies will continue to increase with the enactment of a growing number of state false claims acts and certain amendments to the FCA enacted by the United States Congress and enhanced government enforcement. The *Fraud Enforcement and Recovery Act* of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the PPACA, the knowing failure to report and return an overpayment the later of 60 days of identifying the overpayment or by the date a corresponding cost report is due, constitutes a violation of the FCA. Further, the PPACA expands the scope of the FCA to cover payments in connection with health insurance exchanges if those payments include any federal funds.

Although the Corporation intends to conduct business in compliance with all applicable federal and state fraud and abuse laws, many of the applicable laws and regulations, including those relating to financial relationships with physicians and hospitals, are broadly worded and may be interpreted or applied by prosecutorial, regulatory or judicial authorities in ways that cannot be predicted. Accordingly, there is no assurance that no arrangements or business practices will be subject to government scrutiny or be alleged or found to violate applicable fraud and abuse laws. Moreover, the standards of business conduct expected of healthcare companies under these laws and regulations have become more stringent in recent years, even in instances where there has been no change in statutory or regulatory language. If there is a determination by government authorities that the Corporation has not complied with any of these laws and regulations, it could be materially adversely affect the Corporation's business, financial condition and operations.

Fee Splitting; Corporate Practice of Medicine

Many U.S. states have laws that prohibit corporations from practicing medicine, employing physicians to practice medicine, exercising control or excessive influence over medical decisions by physicians, or engaging in certain arrangements, such as fee splitting, with physicians. In addition, many U.S. states prohibit healthcare professionals from splitting fees with other persons or entities. These laws, their interpretations and enforcement by the courts and regulatory authorities vary from state to state. Possible sanctions for these restrictions include loss of license and civil and criminal penalties, or certain agreements between the Corporation and a healthcare professional may be deemed void and unenforceable. However, these laws are often vague and have infrequently been interpreted by the courts or regulatory agencies. The Corporation believes that its operations as currently conducted are in material compliance with the applicable laws; however, there can be no assurance that the Corporation's existing structure and contractual arrangements with physicians and other healthcare professionals will not be challenged under state law prohibiting the corporate practice of medicine or fee splitting.

Certificate of Need

In some of the U.S. states where MFC Hospitals operate, the construction or expansion of existing facilities, addition of new beds or services or other capital expenditures, change of ownership or acquisition of existing facilities may be subject to review and approval by state regulatory agencies under a Certificate of Need ("**CON**") program. CON laws generally require the appropriate state agency determination of public need prior to any such actions. Failure to provide required notifications or obtain necessary state approvals can result in the inability to expand, complete an acquisition, or change ownership. Additionally, violations may result in the imposition of civil sanctions or the revocation of a facility's license.

Health Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. This media and public attention, changes in government personnel or other factors may lead to increased scrutiny of the healthcare industry. Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the healthcare area. The OIG and the Department of Justice ("**DOJ**") have, from time to time, established national enforcement initiatives, targeting all hospital providers that focus on specific

billing practices or other suspected areas of abuse. The PPACA includes additional federal funding to fight healthcare fraud, waste and abuse. In addition, governmental agencies and their agents, fiscal intermediaries and carriers, may conduct audits of healthcare operations. In addition to national enforcement initiatives, federal and state investigations have addressed a wide variety of routine healthcare operations such as: cost reporting and billing practices, including for Medicare outliers; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. Audits, inquiries and investigations from government authorities, agencies, contractors and payors occur in the ordinary course of business.

Utilization Review

Federal laws and regulations, specifically the Medicare Conditions of Participation, generally require that healthcare services to Medicare and Medicaid patients are medically necessary, meet recognized standard of care, and supported by appropriate evidence of quality and medical necessity. The *Social Security Act* established the Utilization and Quality Control Peer Review Organization ("**QIO**") program to promote the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The QIOs review Medicare treatments, admissions and discharges, ensure patients receive the appropriate care, and investigate beneficiary complaints. The QIOs may deny payment for services provided and recommend to HHS that a provider that is in substantial noncompliance with certain standards be excluded from Medicare.

Patient Records: Confidentiality and Cybersecurity

The *Health Insurance Portability and Accountability Act* of 1996, as amended, ("**HIPAA**") includes a number of "administrative simplification" provisions designed to: (i) streamline the electronic transmission of health claims; and (ii) protect the privacy and security of patient health information.

Pursuant to HIPAA, Office for Civil Rights ("**OCR**"), the agency within the HHS, has developed, implemented and enforced specific regulatory standards, including administrative, privacy and security requirements, which are discussed in greater detail below.

HIPAA requires healthcare providers (among other "covered entities") and their vendors and subcontractors ("**business associates**") to protect the confidentiality of individually identifiable health information, known as "protected health information" in any form, including electronically stored or transmitted information. In addition to requiring patient authorization for many uses and disclosures of health information, the HIPAA privacy regulations contain many administrative requirements designed to ensure that covered entities exercise prudent privacy practices. For example, HIPAA requires that covered entities: maintain detailed records of all disclosures of a patient's data, and make these records available to the patient upon his or her request; give patients the right to access, inspect, and request amendments to their health records; develop and adhere to strict privacy policies and furnish privacy notices to patients; provide privacy training for all employees; implement physical, technical, and administrative safeguards to prevent intentional or accidental misuse of health information; and designate a "privacy officer" to oversee implementation of these requirements. Covered entities are also required to have "business associate agreements" with their subcontractors, including some of the MFC Partnerships.

HIPAA security requirements are designed to ensure the confidentiality, integrity and availability of electronic protected health information. The regulations require organizations to evaluate existing security and confidentiality policies, and technical practices and procedures including access controls, audit trails, physical security and disaster recovery, protection of remote access points, protection of external electronic communications, and software and system assessment. The MFC Partnerships have incurred substantial costs to comply with these requirements. HHS is required to conduct periodic HIPAA compliance audits of covered entities and their business associates. There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns.

The *Health Information Technology for Economic and Clinical Health Act* ("**HITECH**") expanded the privacy and security requirements of HIPAA. These regulations imposed new requirements on covered entities such as the MFC Partnerships and their business associates. The modifications include mandatory federal requirements for breach notifications, enhanced patient rights to copies of their electronic records and to restrict access of health

plans to their records, required revisions to notices of privacy practices, implemented tighter restrictions on marketing and fundraising, and heightened penalties and enforcement associated with noncompliance. Significantly, penalties associated with violations of this law have increased, from up to over $55,000 per violation, and up to just over $1,650,000 for multiple violations of the same requirement. If a violation is due to willful neglect and is not corrected within 30 days, penalties are not subject to a statutory cap. In addition, state attorneys general may bring civil actions seeking injunction or damages in response to HIPAA privacy and security regulations as well as their own state laws that threaten the privacy of the personal information of state residents. As a part of the investigation, OCR is generally finding multiple violations and settlements of over $5,500,000 have been finalized. All reported breaches involving over 500 affected individuals requires a mandatory investigation.

All organizations are subject to cyber-attacks and healthcare companies are targeted based upon the robust amount of personal information they maintain. Breaches of personal information can result from deliberate acts or unintentional events, they can be from an employee, subcontractor or hacker. More recently there has been increased enforcement with large settlement agreements and corrective action plans. Further, there are significant costs associated with a breach including investigation costs, remediation and mitigation costs, notification costs, attorney fees and the potential for reputational harm and lost revenues due to a loss in confidence in the covered entity of business associate. While there are no private right of action under HIPAA, plaintiff attorneys are increasingly developing class action litigation strategies designed to obtain settlement.

As noted above, in addition to HIPAA, there are numerous other federal and state laws which also require certain additional compliance specifications.

As of December 31, 2017, the Corporation believes that operation of the MFC Partnerships and associated business associate relationships in the corporate family is conducted in material compliance with HIPAA and HITECH requirements, as well as state laws regarding the confidentiality of personally identifiable information. It is possible that compliance costs related to these and any subsequently enacted regulations would require the MFC Partnerships and other aspects of the business associate operations to make a further capital outlay. Moreover, any failure by the MFC Partnerships, and their business associates to comply with HIPAA requirements could result in substantial and possibly prolonged interruptions in the cash flows of the MFC Partnerships, as well as the costs associated with investigations, litigation and penalties.

Compliance

Consistent with the OIG Compliance Program Guidance for Hospitals, the Corporation maintains a robust compliance program that reflects its commitment to complying with all laws, rules and regulations applicable to its business, and that meets ethical obligations in conducting business. The Corporation’s compliance plan includes the seven elements noted in the OIG guidance, along with written policies and procedures addressing compliance with the Anti-Kickback Statute and the Stark Law, among others. In addition, the Corporation’s Compliance Advisor periodically reviews a substantial number of the Corporation’s arrangements with referral sources to determine the extent to which they comply with its policies and procedures and with the Anti-Kickback Statute, the Stark Law and similar state statutes.

Other Matters

Insurance

Each MFC Partnership maintains medical professional liability insurance on a claims-made basis. Coverage under these policies is contingent upon the policy being in effect when a claim is made regardless of when the events that caused the claim occurred. Each MFC Partnership also maintains general liability and umbrella coverage on a claims-made basis. The cost and availability of such coverage has varied widely in recent years. Management believes that the insurance policies are adequate in amount and coverage for the operation of the surgical facilities, but there can be no assurance that the insurance coverage is sufficient to cover all future claims or that such insurance will continue to be available at a reasonable cost.

Environmental Issues

Each MFC Partnership's operations are subject to various federal, state and local laws and regulations relating to the protection of the environment and human health and safety. The operations of the MFC Partnerships include the use, generation and disposal of certain hazardous substances. Management believes that the operations of the MFC Partnerships have been in substantial compliance with the terms of applicable environmental laws and that no liabilities exist that could reasonably be expected to have a material adverse effect on the MFC Partnership's business or financial position. No MFC Partnership has reported any existing or potential environmental issues at any of the MFC Facilities, nor has it received any inquiry or notice that has resulted, or may reasonably be expected to result in, actual or potential proceedings, claims, lawsuits or losses related to environmental liabilities.

Litigation

Each MFC Partnership may be involved, from time to time, in various litigation matters that can occur in the ordinary course of business, none of which Management believes will have any material adverse effects on the financial and operating performance of the MFC Partnerships.

Business of IMD

IMD is a diversified healthcare service company located in Oklahoma City that provides third-party business solutions to healthcare entities such as physician practices, facilities, and insurance companies.

THE CORPORATION

Share Capital of the Corporation

The authorized share capital of the Corporation consists of an unlimited number of Common Shares. As at December 31, 2017, there were 30,950,345 Common Shares issued and outstanding.

Holders of Common Shares are entitled to receive dividends as and when declared by the board of directors and are entitled to one vote per Common Share on all matters to be voted on at all meetings of shareholders. Upon the voluntary or involuntary liquidation, dissolution or winding-up of the Corporation, the holders of the Common Shares are entitled to share rateably in the remaining assets available for distribution, after payment of liabilities.

Limitations on U.S. Licensed Physician Ownership

The Stark Law exception on which the Corporation generally relies, among other things, prohibits the MFC Partnerships (as owners of MFC Hospitals) from having physician investors if a physician owned hospital accepts referrals from any physicians (or their immediate family members) who are not authorized to perform services at the hospital. A separate exception protects physician ownership in certain publicly traded companies.

Description of Debentures

As at December 31, 2017, Cdn$41,743,000 principal amount of Debentures were outstanding. The Debentures were issued under the Debenture Indenture between the Corporation and the Trustee. The Corporation may, from time to time, without the consent of the holders of the Debentures but subject to the limitations described herein and in the Debenture Indenture, issue additional debentures of the same series or of a different series under the Debenture Indenture, in addition to the Debentures issued on December 21, 2012. The Debentures are issuable only in denominations of Cdn$1,000 and integral multiples thereof.

The following is a brief summary of the terms of the Debenture Indenture and is subject to, and qualified in its entirety by, all of the provisions of the Debenture Indenture. A copy of the Debenture Indenture is available on SEDAR at www.sedar.com.

Market

The Debentures are listed for trading on the TSX under the symbol "DR.DB.A".

Interest Rate

The interest rate on the Debentures is 5.9% per annum.

Payment Dates

Interest is paid semi-annually in arrears on June 30 and December 31 in each year (or the next Business Day, if such day is not a Business Day).

Maturity Date

The Debentures will mature on December 31, 2019 ("**Debenture Maturity Date**").

Conversion

Each Debenture is convertible at the holder's option into freely-tradable, fully paid and non-assessable Common Shares at any time prior to the close of business on the earlier of the Debenture Maturity Date and the Business Day immediately preceding the date specified by the Corporation for redemption of the Debentures, at a conversion price of Cdn$19.11 per Common Share, being a ratio of approximately 52.3286 Common Shares per Cdn$1,000 principal amount of Debentures, subject to adjustment in accordance with the Debenture Indenture governing the terms of the Debentures.

Subject to the provisions thereof, the Debenture Indenture provides for the adjustment of the Debenture Conversion Price in certain events, including: (i) the subdivision or consolidation of the outstanding Common Shares; (ii) the distribution of Common Shares (or securities convertible into or exchangeable for Common Shares) to all or substantially all holders of Common Shares by way of dividend or distribution or otherwise; or (iii) the issuance of options, rights or warrants to holders of all or substantially all Common Shares entitling them for a period of not more than 45 days to acquire Common Shares or other securities convertible into or exchangeable for Common Shares at less than 95% of the current market price (as defined below) of the Common Shares.

In the case of (i) any reclassification or change (other than a change resulting only from consolidation or subdivision) of the Common Shares, (ii) any amalgamation, consolidation or merger of the Corporation, (iii) any sale, transfer or other disposition of the properties and assets of the Corporation, as, or substantially as, an entirety to any other entity, or (iv) the liquidation, dissolution or winding-up of the Corporation, the terms of the conversion privilege shall be adjusted so that the holder of the Debentures shall, after such reclassification, change, amalgamation, consolidation, merger, sale or conveyance, liquidation, dissolution or winding-up or other similar transactions, be entitled to receive the number of securities such holder would be entitled to receive if on the effective date thereof, he or she or it had been the holder of the number of securities into which the Debentures were convertible prior to the effective date of such reclassification, change, amalgamation, consolidation, merger, sale or conveyance, liquidation, dissolution or winding-up or other similar transactions.

No fractional Common Shares will be issued on any conversion, but in lieu thereof, the Corporation shall satisfy such fractional interests by a cash payment equal to the current market price (as defined below) of such fractional interest.

The term "current market price" is defined in the Debenture Indenture to mean the volume weighted average trading price of the Common Shares on the TSX for the 20 consecutive trading days ending on the fifth trading day preceding the date of the applicable event.

Redemption and Purchase

After December 31, 2017 but prior to the Debenture Maturity Date, the Debentures may be redeemed in whole or in part from time to time at the option of the Corporation on not more than 60 days' and not less than 30 days' prior notice, at a redemption price equal to the principal amount thereof plus accrued and unpaid interest up to but excluding the redemption date.

In the case of redemption of less than all of the Debentures, the Debentures will be selected by the Trustee on a pro rata basis or in such other manner as the Trustee deems equitable.

The Corporation or any of its affiliates have the right to purchase Debentures in the market, by tender or by private contract, provided however, that if an event of default under the Debenture Indenture has occurred and is continuing, the Corporation or any of its affiliates will not have the right to purchase Debentures.

Payment upon Redemption or Maturity

On redemption or on the Debenture Maturity Date, the Corporation will repay the indebtedness by paying to the Trustee in lawful money of Canada an amount equal to the principal amount of the outstanding Debentures, together with accrued and unpaid interest thereon.

Share Payment Option upon Redemption or Maturity

Subject to any required regulatory approval and provided no event of default has occurred or is continuing, the Corporation has the option to satisfy its obligation to repay the Debentures upon at least 40 days' and not more than 60 days' prior notice by delivering that number of Common Shares obtained by dividing the Cdn$1,000 principal amount of the Debentures by 95% of the volume weighted average trading price of the Common Shares on the TSX during the 20 consecutive trading days ending on the fifth trading days preceding the date fixed for redemption or the Debenture Maturity Date, as the case may be.

Change of Control

Upon the occurrence of certain change of control events involving the Corporation (as set out in the Debenture Indenture), each holder of Debentures may require the Corporation to purchase, on the date which is within 30 days following the giving of notice of the change of control event, all or any part of such holder's Debentures at a price equal to 101% of the principal amount of the Debentures plus any accrued and unpaid interest up to, but excluding, the date of repurchase.

The Debentures contain a make-whole provision on cash change of control (as defined in the Debenture Indenture). Under the provision, holders of the Debentures would be entitled to convert their debentures within a specified time period and would receive, in addition to the number of Common Shares on conversion, additional shares calculated as a function of the change of control offer price and time remaining to maturity.

Ranking

The Debentures are unsecured subordinated indebtedness of the Corporation, ranking junior to all senior indebtedness (as such term is defined in the Debenture Indenture) and trade payables. For a more detailed description, please refer to the Debenture Indenture available on SEDAR at www.sedar.com.

Dividend Policy

The Corporation pays dividends on the Common Shares, if and to the extent dividends are declared by the Corporation's board of directors and permitted by applicable law, on the 15th day of each month (or the next Business Day, if such day is not a Business Day) to holders of record at the close of business on the last Business Day of the preceding month. The board of directors declares dividends after ensuring that the Corporation (i) satisfies its debt service obligations under any credit facilities or other agreements with third parties, if any; (ii) satisfies its other expense obligations, including withholding and other applicable taxes; and (iii) retains reasonable reserves for working capital and other expenses.

The Corporation may make additional dividend payments in excess of monthly dividends during the year, as the board of directors may determine in its sole discretion.

The board of directors of the Corporation may, in its discretion, modify or repeal the Corporation's current dividend policy. No assurances can be made that the Corporation will pay dividends at the level contemplated in the future or at all.

Dividends Paid to Securityholders

Monthly dividends of Cdn$0.09375 were paid on the 15th day of each month of 2017 (or the next Business Day, if such day was not a Business Day) to holders of record at the close of business on the last Business Day of the preceding month. Total dividends for 2017 were as follows:

2017 Record Dates	Dividend Per Common Share (Cdn$)
January 31	0.09375
February 28	0.09375
March 31	0.09375
April 28	0.09375
May 31	0.09375
June 30	0.09375
July 31	0.09375
August 31	0.09375
September 29	0.09375
October 31	0.09375
November 30	0.09375
December 29	0.09375
Total 2017 Dividends	**1.125**

Monthly dividends of Cdn$0.09375 were paid on the 15th day of each month of 2016 (or the next Business Day, if such day was not a Business Day) to holders of record at the close of business on the last Business Day of the preceding month. Total dividends for 2016 were as follows:

2016 Record Dates	Dividend Per Common Share (Cdn$)
January 29	0.09375
February 29	0.09375
March 31	0.09375
April 29	0.09375
May 31	0.09375
June 30	0.09375
July 29	0.09375
August 31	0.09375
September 30	0.09375
October 31	0.09375
November 30	0.09375
December 30	0.09375
Total 2016 Dividends	**1.125**

Monthly dividends of Cdn$0.09375 were paid on the 15th day of each month of 2015 (or the next Business Day, if such day was not a Business Day) to holders of record at the close of business on the last Business Day of the preceding month. Total dividends for 2015 were as follows:

2015 Record Dates	Dividend Per Common Share (Cdn$)
January 30	0.09375
February 27	0.09375
March 31	0.09375
April 30	0.09375
May 29	0.09375
June 30	0.09375
July 31	0.09375
August 31	0.09375
September 30	0.09375
October 30	0.09375
November 30	0.09375
December 31	0.09375
Total 2015 Dividends	**1.125**

Administration

The Corporation directly administers its reporting and other public corporation obligations, with assistance from Medical Facilities America and/or Medical Facilities Holdings, as required.

Dividend Reinvestment and Share Purchase Plan

The Corporation has implemented a Dividend Reinvestment and Share Purchase Plan (the "**DRIP**"). The DRIP provides a means for eligible participants to invest all dividends on Common Shares into additional Common Shares of the Corporation. Common Shares are purchased by Computershare Trust Company of Canada on the open market through the TSX.

MEDICAL FACILITIES AMERICA

Capital of Medical Facilities America

The authorized capital of Medical Facilities America consists of 3,000 common shares of the par value of $0.0001 each. As at December 31, 2017, 200 outstanding common shares of Medical Facilities America were owned by the Corporation.

Description of 2011 Promissory Note

On June 1, 2011, Medical Facilities America issued and the Corporation subscribed for a $194,500,000 senior subordinated 12.25% promissory note of Medical Facilities America.

The following is a brief summary of the terms of the 2011 Promissory Note and is subject to, and qualified in its entirety by, all of the provisions of the 2011 Promissory Note.

Interest Rate

The interest rate on the 2011 Promissory Note is 12.25% per annum.

Payment Dates

Interest began to accrue on the date of the 2011 Promissory Note and is paid monthly, no later than 15 days immediately following the last day of the preceding month.

Maturity Date

The 2011 Promissory Note is due on June 1, 2021.

Redemption

The 2011 Promissory Note may be redeemed by Medical Facilities America, in whole or in part, from time to time, at the option of Medical Facilities America, on not more than 60 days' and not less than 30 days' notice, at the following redemption price (expressed as percentages of principal amount), plus accrued and unpaid interest on the 2011 Promissory Note, to be paid to the date of redemption (the "**2011 Note Redemption Date**") if redeemed during the twelve-month period commencing on June 1st of the years set out below:

Year	**Redemption Price**
2018	103.6250%
2019	101.5313%
2020	100.0000%

Payment upon Redemption or Maturity

On redemption or maturity of the 2011 Promissory Note, Medical Facilities America will repay the indebtedness by paying to the Corporation in lawful money of the United States of America an amount equal to the principal amount of the 2011 Promissory Note, together with accrued and unpaid interest thereon. Upon payment to the Corporation of the principal amount of the 2011 Promissory Note together with any accrued and unpaid interest thereon, the 2011 Promissory Note will be cancelled by Medical Facilities America.

Change of Control

In the case of change of control of Medical Facilities America, Medical Facilities America shall on not more than 30 days' and not less than 10 days' notice, offer to redeem the 2011 Promissory Note at a redemption price of 101%, plus accrued and unpaid interest on the 2011 Promissory Note, to be paid at the 2011 Note Redemption Date.

Security and Guaranty

The 2011 Promissory Note is secured by an unconditional guarantee of Medical Facilities Holdings, under the terms of the Guarantee Agreement made as of June 1, 2011 and is attached as Exhibit A to the 2011 Promissory Note.

Ranking

The 2011 Promissory Note is an unsecured obligation of Medical Facilities America and ranks *pari passu* with all existing and future unsecured indebtedness of Medical Facilities America, ranks junior to all existing and future senior indebtedness (including the obligation under the Credit Facility) but senior to all existing and future subordinated indebtedness. Reference is made to the 2011 Promissory Note for a complete description and the full text of its provisions.

Restrictive Covenants

The 2011 Promissory Note contains the following covenants with respect to Medical Facilities America that restrict:

- the incurrence of additional indebtedness and issuance of disqualified stock and preferred stock;
- a number of other restricted payments, including investments;
- the payment of dividends on its capital stock;
- specified sales of assets;
- specified transactions with affiliates;
- the creation of a number of liens; and
- consolidations, mergers and transfers of all or substantially all of Medical Facilities America's assets.

The limitations and prohibitions described above are subject to a number of important qualifications and exceptions. Reference is made to the 2011 Promissory Note for a complete description and the full text of its provisions.

Description of 2012 Promissory Note

On November 29, 2012, Medical Facilities America issued and the Corporation subscribed for a $27,455,108 senior subordinated 10.00% promissory note of Medical Facilities America.

The following is a brief summary of the terms of the 2012 Promissory Note and is subject to, and qualified in its entirety by, all of the provisions of the 2012 Promissory Note.

Interest Rate

The interest rate on the 2012 Promissory Note is 10.00% per annum.

Payment Dates

Interest began to accrue on the date of the 2012 Promissory Note and is paid monthly, no later than 15 days immediately following the last day of the preceding month.

Maturity Date

The 2012 Promissory Note is due on November 29, 2022.

Redemption

The 2012 Promissory Note may be redeemed by Medical Facilities America, in whole or in part, from time to time, at the option of Medical Facilities America, on not more than 60 days' and not less than 30 days' notice, at the following redemption price (expressed as percentages of principal amount), plus accrued and unpaid interest on the 2012 Promissory Note, to be paid to the date of redemption (the "**2012 Note Redemption Date**") if redeemed during the twelve-month period commencing on June 1st of the years set out below:

Year	Redemption Price
2018	103.7500%
2019	102.5000%
2020	101.2500%

Year	Redemption Price
2021	100.0000%

Payment upon Redemption or Maturity

On redemption or maturity of the 2012 Promissory Note, Medical Facilities America will repay the indebtedness by paying to the Corporation in lawful money of the United States of America an amount equal to the principal amount of the 2012 Promissory Note, together with accrued and unpaid interest thereon. Upon payment to the Corporation of the principal amount of the 2012 Promissory Note together with any accrued and unpaid interest thereon, the 2012 Promissory Note will be cancelled by Medical Facilities America.

Change of Control

In the case of change of control of Medical Facilities America, Medical Facilities America shall on not more than 30 days' and not less than 10 days' notice, offer to redeem the 2012 Promissory Note at a redemption price of 101%, plus accrued and unpaid interest on the 2012 Promissory Note, to be paid at the 2012 Note Redemption Date.

Security and Guaranty

The 2012 Promissory Note is secured by an unconditional guarantee of Medical Facilities Holdings, under the terms of the Guarantee Agreement made as of November 29, 2012 and is attached as Exhibit A to the 2012 Promissory Note.

Ranking

The 2012 Promissory Note is an unsecured obligation of Medical Facilities America and ranks *pari passu* with all existing and future unsecured indebtedness of Medical Facilities America, ranks junior to all existing and future senior indebtedness (including the obligation under each of Credit Facility and Debentures) but senior to all existing and future subordinated indebtedness. Reference is made to the 2012 Promissory Note for a complete description and the full text of its provisions.

Restrictive Covenants

The 2012 Promissory Note contains the following covenants with respect to Medical Facilities America that restrict:

- the incurrence of additional indebtedness and issuance of disqualified stock and preferred stock;
- a number of other restricted payments, including investments;
- the payment of dividends on its capital stock;
- specified sales of assets;
- specified transactions with affiliates;
- the creation of a number of liens; and
- consolidations, mergers and transfers of all or substantially all of Medical Facilities America's assets.

The limitations and prohibitions described above are subject to a number of important qualifications and exceptions. Reference is made to the 2012 Promissory Note for a complete description and the full text of its provisions.

Dividend Policy

The board of directors of Medical Facilities America has adopted a dividend policy pursuant to which Medical Facilities America pays monthly dividends on its common shares, if and to the extent dividends are declared by Medical Facilities America's board of directors and permitted by applicable law, to the shareholders of record of Medical Facilities America on the date such dividends are paid. The board of directors declares dividends after ensuring that Medical Facilities America (i) satisfies its debt service obligations under the Promissory Notes and any credit facilities or other agreements with third parties, if any; and (ii) satisfies its other expense obligations, including administration expenses, and withholding and other applicable taxes.

Management Agreement

The Management Agreement governs operations and affairs of Medical Facilities America. Pursuant to the DPSC Transaction, DP Subco waived any representation or other rights under the Management Agreement and is no longer a party to the Management Agreement. The following is a summary of certain provisions of the Management Agreement, which summary is not intended to be complete. Reference is made to the Management Agreement for a complete description and the full text of its provisions. A copy of the Management Agreement is available on SEDAR at www.sedar.com.

Board of Directors

The Management Agreement provides for a board of directors consisting of not more than eleven directors of Medical Facilities America with the Corporation having the right to appoint the majority of directors. All representatives of the MFC Original Partnerships must be U.S. residents. The board of directors of Medical Facilities America is currently comprised of nine directors. The total board of directors (giving effect to the DP Subco waiver referenced above) cannot exceed:

- seven representatives of the Corporation (five directors of the Corporation);
- two representatives of BHSH; and
- two representatives of SFSH.

The board representation rights of the MFC Original Partnerships will be adjusted as the aggregate ownership by the Subcos for BHSH and SFSH of Common Shares on a Fully Diluted Basis is reduced. Fully Diluted Basis means the proportion that the Retained Interests represent of the outstanding Common Shares from time to time on a fully exchanged basis assuming for such purpose that the Continuing Interests are exchangeable on the same basis as the Exchangeable Interests. The MFC Original Partnerships' board representation rights (giving effect to the DP Subco wavier referenced above) will be adjusted as follows (provided that the MFC Original Partnerships may agree to adjust their board representation rights as between themselves to reflect changes in their respective ownership):

Ownership on Fully Diluted Basis	Board Representation Rights
More than or equal to 20%	four representatives, two from each of BHSH and SFSH
Less than 20% but not less than 15%	three representatives
Less than 15% but not less than 10%	two representatives, one from each of BHSH and SFSH
Less than 10%	no representative

Special Approval Rights

In addition to majority approval of the board of directors of Medical Facilities America, so long as the MFC Partnerships hold not less than 20% on a Fully Diluted Basis, Medical Facilities America will not, without the approval of the four representatives of MFC Partnerships:

(i) other than in connection with an event of default under the 2011 Promissory Note and under any other senior debt documents issued in connection with senior indebtedness as defined in the 2011 Promissory Note, enter into a merger, consolidation, combination, reorganization or other business combination or transaction to which Medical Facilities America is a party if the Corporation, as a result of such transaction, does not have direct or indirect ownership of voting securities representing 50% or more of the voting power of the surviving entity following such transaction;

(ii) other than in connection with an event of default under the 2011 Promissory Note and under any other senior debt documents issued in connection with senior indebtedness as defined in the 2011 Promissory Note, directly or indirectly sell or otherwise dispose of all or substantially all of its assets;

(iii) adopt any plan or proposal for the liquidating, dissolving, reorganizing or recapitalizing of Medical Facilities America or commence any action seeking relief under any laws relating to bankruptcy, insolvency, conservatorship or relief of debtors;

(iv) enter into lines of business (not including new lines of procedures) other than those currently carried on;

(v) change its fiscal year (unless required or indicated for tax reasons) or make a material change in its accounting policies or procedures unless required under the applicable generally accepted accounting principles;

(vi) take, or permit, any action which would prevent the business from continuing on an ongoing basis;

(vii) liquidate, dissolve or wind-up its operations or permit the liquidation, dissolution or winding-up of its operations, whether voluntarily or involuntarily; or

(viii) agree to do any of the preceding.

Subject to the foregoing, such approval of the representatives of the MFC Partnerships is not required for issuances of securities of, or acquisitions by, Medical Facilities America.

Executive

The directors have the exclusive authority to manage the business and affairs of Medical Facilities America, to make all decisions regarding Medical Facilities America and to bind Medical Facilities America. The directors have appointed a chief executive officer and a chief financial officer.

Amendment

The Management Agreement provides that it can only be amended, modified or waived with the approval of the Corporation, Medical Facilities America and each Original Subco.

Termination

The Management Agreement will automatically terminate in the event of the liquidation or dissolution of Medical Facilities America and will automatically terminate in respect of each MFC Original Partnership once each MFC Original Partnership no longer has any rights to appoint any representatives.

MEDICAL FACILITIES HOLDINGS

Capital of Medical Facilities Holdings

The authorized capital of Medical Facilities Holdings consists of 3,000 common shares of the par value of $0.0001 each. As at December 31, 2017, 100 outstanding common shares of Medical Facilities Holdings were owned by Medical Facilities America.

Dividend Policy

The board of directors of Medical Facilities Holdings has adopted a dividend policy pursuant to which Medical Facilities Holdings will distribute its available cash to the maximum extent possible, subject to applicable law, by way of monthly dividends, if and to the extent dividends are declared by Medical Facilities Holdings' board of directors and permitted by applicable law, to its sole stockholder on its securities after (i) satisfying its debt service obligations under any credit facilities or other agreements with third parties, if any; and (ii) satisfying its other expense obligations, including administration expenses, and withholding and other applicable taxes.

Business Development and Acquisition Committee

The board of directors of Medical Facilities Holdings, which is comprised of the same members as the board of directors of Medical Facilities America, has a business development and acquisition committee comprised of the following individuals as at March 29, 2018: David Bellaire (Chair), Marilynne Day-Linton, Stephen Dineley and Jeffrey Lozon. This committee is responsible for the oversight and guidance of Medical Facilities Holdings' business development and acquisition processes as well as the review of potential acquisition targets and recommendations to the board of directors of Medical Facilities Holdings regarding same.

THE MFC PARTNERSHIPS

For purposes of this section, UMASH and MFC Nueterra ASCs are excluded from the definition of "MFC Partnerships". Please refer to the sections below entitled "UMASH and PAM" and "MFC Nueterra Partnership" for a description of those entities.

Capital of the MFC Partnerships

Medical Facilities Holdings owns the partnership interest in each MFC Partnership and the Existing Partners of each MFC Partnership own the partnership interest in their respective MFC Partnerships as set out in the table below.

MFC Partnership	Subco / Holdco Interest	Medical Facilities Holdings Interest
ASH	49.00%	51.00%
OSH	39.74%	60.26%
BHSH	45.78%	54.22%
SFSH	49.00%	51.00%
SCNC	49.00%	51.00%

The partnership interests carry such number of votes equal to the partnership interest on all matters to be voted on at all meetings of partners. Holders of partnership interests are entitled to their pro rata distribution equivalent to their partnership interest as and when declared by the management committee of each MFC Partnership. Upon the voluntary or involuntary liquidation, dissolution or winding-up of an MFC Partnership, the holders of partnership interests will be entitled to share rateably in the remaining assets available for distribution, after payment of all liabilities.

Distribution Policy

The management committee of each MFC Partnership has adopted a policy that each MFC Partnership will distribute its available cash to the maximum extent possible, subject to applicable law and compliance with their existing credit facilities, by way of monthly distributions on its partnership interests or other distributions on its securities, after:

- satisfying its debt service obligations under its credit facilities or any other agreements with third parties;
- satisfying its other expense obligations, including withholding and other applicable taxes; and
- retaining reasonable working capital or other reserves, including amounts on account of capital expenditures and such other amounts as may be considered appropriate by its management committee, subject to Medical Facilities Holdings' prior approval in certain circumstances.

Capital expenditures of each MFC Partnership and other expenditures may be financed:

- by borrowings under its credit facilities;
- by additional issuances of securities to Medical Facilities Holdings and/or its related Subco or Holdco;
- from the working capital and cash flow of the business; and/or
- by seller and vendor financing or other third-party borrowings.

Subject to certain limitations and exceptions, each MFC Partnership, and the MFC Partnerships as a group, will be limited as to the amount of liabilities which may be incurred.

Partnership Agreements

The following is a summary of certain provisions of the Partnership Agreements, each entered into by Medical Facilities Holdings or its predecessor, an MFC Partnership and its respective Subco or Holdco, as the case may be, which summary is not intended to be complete. Each Partnership Agreement has substantially similar terms. Reference is made to each Partnership Agreement for a complete description and the full text of its provisions.

Managers

The management committee of each MFC Partnership is comprised of persons elected by the governing board of the affiliated Subco or Holdco, as the case may be, and one representative of Medical Facilities Holdings designated by the Corporation. Executive management is determined for each MFC Partnership by its management committee.

Budget

Each MFC Partnership is responsible for preparing a budget for the following fiscal year by October 31 of each year (or, in the case of ASH, by a deadline agreed upon by ASH Holdco and Medical Facilities Holdings), addressing projected revenue, expenditure and distributions. Any such budget which (i) reflects a material change (increase of 15% or more) in capital expenditures, reserves, debt or debt service obligations or significant expense items (specifically labour, overhead or any other expense item representing more than 15% of revenue), (ii) contemplates a reduction in distributions over the previous year (or, in the case of ASH, a reduction in distributions of more than 8% over the previous year), or (iii) contemplates the incurrence of any extraordinary or non-recurring items will be subject to approval of the Medical Facilities Holdings board of directors. Except in respect of ASH, in the event that the MFC Partnership and Medical Facilities Holdings do not agree on a proposed budget, Medical Facilities Holdings will be entitled to establish the budget for the MFC Partnership.

Fundamental Decisions

For each MFC Partnership, (i) any expenditure deviations from the budget for the then current year in an aggregate amount exceeding the lesser of (A) CPI plus 5% of budgeted cash flow (calculated in a prescribed manner) for the then current fiscal year; and (B) $1.5 million; (ii) any reduction in distributions from budgeted amounts, and for each MFC Original Partnership, or (iii) any incurrence of indebtedness which would cause the MFC Partnerships alone, or the MFC Partnerships in the aggregate, to exceed certain limitations, will be subject to approval of the Medical Facilities Holdings board of directors. In addition, the following fundamental transactions on the part of the MFC Partnerships will be subject to the approval of the Medical Facilities Holdings board of directors:

(i) entering into a merger, consolidation, combination or other material transaction of that nature;

(ii) directly or indirectly selling or otherwise disposing of all or substantially all of MFC Partnership's assets;

(iii) adopting any plan or proposal for liquidating, dissolving, reorganizing or recapitalizing the MFC Partnership or commencing any action seeking relief under any laws relating to bankruptcy, insolvency, conservatorship or relief of debtors;

(iv) consummating an acquisition or acquisitions or entering into contracts (other than payor contracts or those relating to capital expenditures contemplated in the budget which would result in expenditures in excess of certain prescribed limits);

(v) entering into lines of business other than those currently carried on (not including new lines of surgery);

(vi) changing its fiscal year or making a material change in its accounting policies or procedures unless required under the applicable generally accepted accounting principles;

(vii) taking, or permitting, any action which would prevent the business from continuing on an ongoing basis;

(viii) issuing, redeeming, purchasing, transferring or agreeing to the transfer of any partnership interests (subject to rights of exchange of the Exchangeable Interests);

(ix) substantively changing the MFC Partnership's distribution policy;

(x) entering into material transactions outside of the normal course of business; or

(xi) agreeing to do any of the preceding.

The incurrence of indebtedness or liens in excess of $500,000 in a twelve-month period (other than indebtedness to fund distributions) on the part of the MFC Original Partnerships, any amendment to the lease arrangements with Memorial Property Holdings, LLC on the part of the Spine Hospital and non-arm's length transactions with ASH Holdco or its members and transactions with officers and/or managers of ASH or its affiliates also require the approval of the Medical Facilities Holdings board of directors. Certain of the numerical thresholds adjust annually based on the CPI.

Limitation on Liabilities

The MFC Partnerships are prohibited from exceeding, without the consent of Medical Facilities Holdings, aggregate liabilities incurred in the ordinary course, other than excluded liabilities, of $2 million in respect of ASH, $5 million in respect of each of OSH, BHSH and SFSH, and $200,000 in respect of SCNC. The definition "excluded liabilities" includes: (i) any secured indebtedness of the MFC Partnerships, existing as at November 30, 2012 for ASH and as at March 29, 2004 for the MFC Original Partnerships; (ii) in respect of SCNC, any amount owing under the SCNC existing credit facility; (iii) any indebtedness incurred in the ordinary course secured by the MFC

Partnerships' accounts receivable and/or inventory; (iv) capital equipment financing secured by the equipment; (v) any fixed asset mortgages incurred in the ordinary course; and (vi) in respect of ASH, a loan made by ASH Holdco and/or Medical Facilities Holdings to ASH.

Ownership Restrictions

Each Subco or Holdco, as the case may be, is prohibited from selling or transferring its Retained Interest (other than exchanges of the Exchangeable Interest) in the applicable MFC Partnership without the approval of the board of directors of Medical Facilities Holdings.

Senior Management of MFC Partnerships

The board of directors of Medical Facilities Holdings has the right to terminate any member of senior management of any of the MFC Partnerships if such officer is not terminated by the respective MFC Partnership in circumstances where (i) the officer has engaged in conduct which is fraudulent or grossly negligent, (ii) the officer has participated in or acquiesced to a material breach of the MFC Partnership's non-financial (including reporting) obligations to Medical Facilities Holdings, or (iii) (except in the case of ASH) the MFC Partnership for a given year materially underperforms its budget (other than a budget imposed by Medical Facilities Holdings unless such budget has been determined by an independent qualified arbiter to have been reasonably attainable) and such underperformance is, in the reasonable opinion of the Medical Facilities Holdings board of directors, attributable in material part to the officer's performance.

Reporting

Each MFC Partnership provides monthly financial reporting to Medical Facilities Holdings in such manner as Medical Facilities Holdings may reasonably request to support for: (i) Medical Facilities Holdings' discharge of its responsibility for the Corporation's financial disclosure requirements; and (ii) Medical Facilities Holdings' monitoring of budget compliance.

Management Services

Arrangements pursuant to which management services are provided to any MFC Partnership operate on the terms negotiated by the affected MFC Partnership. In particular, a company owned by certain indirect non-controlling owners of SFSH provides coding and billing services to SFSH.

Amendment

Each Partnership Agreement for each MFC Partnership provides that it can only be amended, modified or waived with the unanimous approval of the parties thereto.

SUBCOS/HOLDCOS

The Subco for each of BHSH and SFSH is a South Dakota limited liability company. OSH's related Subco is an Oklahoma limited liability company. ASH's related Holdco is an Arkansas limited liability company. SCNC's related Holdco is a California limited liability partnership.

Operating Agreements

The following is a summary of certain provisions of the Subco and Holdco Operating Agreements, entered into by the Corporation, Medical Facilities Holdings or its predecessor, as applicable, each Subco or Holdco and/or each Holding Entity, as applicable, with respect to certain matters relating to each Subco or Holdco, which summary is not intended to be complete. Reference is made to the Subco and Holdco Operating Agreements for a complete description and the full text of their provisions.

Ownership Restrictions

The Subco or Holdco is not permitted to sell, transfer or pledge its partnership interests in the applicable MFC Partnership to a third party without the prior approval of the board of directors of Medical Facilities Holdings. In respect of the MFC Hospitals Subcos, the respective Subco does not require the approval of Medical Facilities Holdings to exchange its Exchangeable Interest. Further, the Subco or Holdco will not transfer its partnership interests in the applicable MFC Partnership or, in respect of the MFC Hospital Subcos, transfer Common Shares it receives upon exchange of the Exchangeable Interests, and no membership interests in the Subco or Holdco may be transferred, if such transfer might lead to a violation of the Stark Law.

Amendment

The Corporation and Medical Facilities Holdings have the right to approve any amendment to the operating agreements that would adversely affect their interests, including with respect to Subco's or Holdco's continued ownership of the Retained Interest.

Retained Interests

The Existing Partners in respect of each MFC Partnership indirectly hold 49% or less of the outstanding partnership interests in the respective MFC Partnership through their ownership interests, in the case of the MFC Hospitals (other than ASH), in the related Holding Entity and the Holding Entity's ownership interest in the related Subco, and in the case of Newport and ASH, in the related Holdco (please refer to the section entitled "Corporate Structure – Ownership Structure" beginning on page 9 above).

Pursuant to the terms of the Exchange Agreements applicable in respect of the MFC Hospitals, each Subco and ASH Holdco are entitled to exchange up to 14% and 5%, respectively, of the outstanding partnership interests (the "**Exchangeable Interests**") for Common Shares (to the extent that such interest has not yet been exchanged). The balance of each Subco and ASH Holdco partnership interests in their related MFC Partnership, representing 35% and 44% partnership interest, respectively, in such MFC Partnership, will not be exchangeable into Common Shares or transferable by the respective Subco and ASH Holdco (the "**Continuing Interests**" and together with the Exchangeable Interests, the "**Retained Interests**").

Distributions on Retained Interests

The Retained Interest in each MFC Partnership entitles the related Subco and ASH Holdco to distributions on a pro rata basis equivalent to the distributions by such MFC Partnership to Medical Facilities Holdings. Consequently, in respect of the MFC Hospitals, prior to any exchange of Exchangeable Interests (whereupon the entitlements would be adjusted proportionately), each Subco and ASH Holdco, will receive 49% of the distributions made by its related MFC Partnership, and Medical Facilities Holdings will receive 51% of such distributions. To date, the MFC Hospitals have exercised the right to exchange the following Exchangeable Interests and, as a result, are entitled to receive the following amount of the distributions made by their related MFC Partnership.

MFC Partnership	Exchangeable Interests Exchanged (%)	Remaining Exchangeable Interests (%)	Distribution Entitlement (%)
ASH	0.00	5.00	49.00
OSH	9.26	4.74	39.74
BHSH	3.22	10.78	45.78
SFSH	0.00	14.00	49.00

Exchange Agreements

The following is a summary of certain provisions of the Exchange Agreements, which summary is not intended to be complete. Reference is made to each Exchange Agreement for a complete description and the full text of its provisions.

Subject to the limitations described below, the Exchange Agreements grant each Subco and ASH Holdco the right to periodically exchange all or any portion of its Exchangeable Interests in their related MFC Partnership for Common Shares, based on the exchange ratio. The exchange ratio calculates the number of Common Shares to be issued to a Subco or ASH Holdco in exchange for their Exchangeable Interests pursuant to a formula that measures the cash distributions by the MFC Partnership for the prior twelve-month period relative to the distributions by all MFC Partnership during that period.

Exchanges will occur quarterly (on the fifth Business Day after the public release of financial information for the immediately preceding quarter). The number of Exchangeable Interests exchanged for Common Shares in any fiscal quarter will be subject to the following thresholds applicable to the MFC Partnerships, collectively, (i) a maximum exchange equal to 3% of the number of Common Shares outstanding on the effective date of the exchange ("**Maximum Exchange Amount**"), and (ii) a minimum exchange equal to 1.5% of the number of Common Shares outstanding on the effective date of the exchange ("**Minimum Exchange Amount**"). The Minimum Exchange Amount will not apply if the related Subco or ASH Holdco elects to bear the administrative and other costs associated with such an exchange. The Exchange Agreements require that Common Shares acquired on exchange be immediately sold, unless their retention would not affect the regulatory status of the MFC Partnerships.

Subject to the right of the related Subco to exchange its Exchangeable Interest, a member of a Holding Entity has the right to redeem a portion of his, her or its membership interests in the Holding Entity (corresponding to the proportion of the membership interests in the MFC Partnership that are exchangeable and unexchanged). The Holding Entity has the option of paying for such redeemed membership interests in cash or Common Shares. For purposes of any such redemption into Common Shares, a member's membership interests in the Holding Entity will be redeemed based on an exchange ratio which calculates the number of Common Shares to be issued to a Subco in exchange for its Exchangeable Interests pursuant to a formula which considers factors such as (i) the aggregate amount of cash distributed by the MFC Partnership to its related Subco in respect of the twelve-month period (ending on the last day of the most recently completed fiscal quarter), (ii) the weighted average of the number of Retained Interests comprising partnership interests in the MFC Partnership owned by its related Subco during such period, (iii) the aggregate amount of cash distributed to Medical Facilities Holdings by all MFC Partnerships (and any other medical or surgical facilities in which Medical Facilities Holdings has an interest) in respect of the preceding twelve-month period (ending on the last day of the most recently completed fiscal quarter) and (iv) the weighted average number of Common Shares outstanding during such period.

The Exchange Agreements also provide that, in the event that a purchaser offers to purchase more than 20% of the interests in Medical Facilities Holdings held indirectly by the Corporation pursuant to an agreement with the Corporation, or 20% of the outstanding Common Shares pursuant to a non-exempt take-over bid in respect of which the Corporation proposes to enter into a support agreement with such purchaser, then it will be a condition of any such agreement or support agreement that the purchaser will offer to purchase a pro rata portion of the Exchangeable Interests of the MFC Partnerships held by each Subco or ASH Holdco, on the same terms and subject to the same conditions as are applicable to the purchase of the interests of Medical Facilities Holdings held indirectly by the Corporation or the Common Shares of the Corporation in accordance with the formula and restrictions set out in the Exchange Agreements. If an unsolicited non-exempt take-over bid from a person acting at arm's length to holders of the Exchangeable Interests is made for the Common Shares and a contemporaneous offer on the same terms and conditions is not made for the Exchangeable Interests, then provided not less than 20% of Common Shares, other than Common Shares held at the date of the take-over bid by or on behalf of the offeror or associates or affiliates of the offeror, are taken-up and paid for pursuant to the bid, then from and after the date of first take-up under the bid the Exchangeable Interests will be exchangeable at an exchange ratio which results in the Exchangeable Interests being exchangeable for 110% of the number of Common Shares into which they were exchangeable under the exchange ratio previously in effect. With respect to proposed sales by a Subco or ASH Holdco of its Retained Interests, each Subco or ASH Holdco will be prohibited from transferring its Retained Interest (other than exchanges of Exchangeable Interests) without the approval of the board of directors of the Corporation.

HOLDING ENTITIES

The Holding Entity related to each of BHSH and SFSH is a South Dakota limited liability company. OSH's related Holding Entity is an Oklahoma limited liability company.

Operating Agreement

The following is a summary of certain provisions of the Original Holding Entities' and OSH's related Holding Entity's operating agreements entered into between the Corporation, the predecessor to Medical Facilities Holdings, and each Holding Entity with respect to certain matters relating to each Original Holding Entity and OSH's related Holding Entity, as applicable, which summary is not intended to be complete. In respect of SCNC, the agreement entered into by the predecessor to Medical Facilities Holdings, the general partner of the SCNC Holding Entity and certain principals of the SCNC Holdco governs those certain matters relating to SCNC Holdco, similar to the other Holding Entities' Operating Agreements, as discussed below. In respect of ASH, the agreement entered into by Medical Facilities Holdings and ASH Holdco governs those certain matters relating to ASH Holdco, similar to the other Holding Entities' Operating Agreements, as discussed below. The SCNC and ASH related Holding Entities hold interests in their respective MFC Partnerships directly rather than through a Subco and, therefore, include provisions generally consistent with the operating agreements for the other Holding Entities as well as provisions consistent with the operating agreements for other MFC Partnerships' related Subcos. Reference is made to the Holding Entities' operating agreements for a complete description and the full text of their provisions.

Ownership Restrictions

The Holding Entity is not permitted to sell, transfer or pledge its membership interests in the respective Subco without the prior approval of the board of directors of Medical Facilities Holdings. Further, the Holding Entity will not transfer its membership interests in the applicable Subco if such transfer might lead to a violation of the Stark Law.

Amendment

The governing document provides that the ownership provisions listed below can only be amended, modified or waived with the approval of the board of directors of Medical Facilities Holdings. The other provisions of the operating agreement of the Holding Entity will not require the approval of the Corporation or Medical Facilities Holdings.

Ownership Provisions

The operating agreement governing the business and affairs of each Holding Entity (other than ASH) provides as follows (note that Put Rights are only available to members of the Original Holding Entities).

Mandatory Purchase and Sale

In the event that a member of a Holding Entity retires, dies, or becomes permanently disabled (each a "**Mandatory Repurchase Event**"), the member will have the obligation to sell and, subject to the limitations described below, the Holding Entity will have the obligation to repurchase, the membership interests held by such member (each a "**Mandatory Repurchase**").

Limited Put Rights of Members

During the months of June and December of each year, a member may give the Original Holding Entity written notice (which must be received by the Holding Entity in such month) of the member's desire to compel the Original Holding Entity to repurchase a designated number of membership interests (a "**Put**") and, subject to the limitations described below, the Original Holding Entity will repurchase the designated number of membership interests (a "**Put Repurchase**").

Closings

Closings of Mandatory Repurchases, which are the result of Mandatory Repurchase Events during the months of January through June, and Put Repurchases, which are the result of Puts in the month of June, will occur as soon as reasonably practicable after June 30 ("**First Semester Repurchases**"). Closings of Mandatory Repurchases, which are the result of Mandatory Repurchase Events during the months of June through December,

and Put Repurchases, which are the result of Puts in the month of December, will occur as soon as reasonably practicable after December 31 ("**Second Semester Repurchases**").

Limitations on Mandatory Repurchases and Put Repurchases

The maximum number of membership interests that the Holding Entity will be required to repurchase in any year pursuant to Mandatory Repurchases and Put Repurchases will be 4% of the difference between the number of membership interests outstanding as of the end of the prior calendar year less the number of membership interests repurchased during the current year by reason of Mandatory Repurchase Events and Puts which occurred during the prior year but for which the closing occurred during the current year (the "**Maximum Repurchase Obligation**"). First Semester Repurchases in any given year will correspondingly reduce the available Maximum Repurchase Obligation for Second Semester Repurchases in such year (possibly to zero). Membership interests which are to be redeemed pursuant to the right of a member to redeem a portion of his or her membership interests, as described in the section entitled "Subcos/Holdcos – Exchange Agreements" beginning on page 47 above, will not be subject to the limitations imposed by the Maximum Repurchase Obligation. In addition, the Holding Entity may, in its sole discretion, determine to repurchase membership interests in excess of the Maximum Repurchase Obligation provided that under no circumstances will the Holding Entity make repurchases which might adversely affect the MFC Partnership's exemption under the Stark Law.

If for any semester the sum of (i) the membership interests subject to Mandatory Repurchases, and (ii) membership interests that have been Put, or in the case of the Holding Entity related to OSH, the membership interest subject to Mandatory Repurchases alone, exceeds the Maximum Repurchase Obligation as of the end of that semester, then the membership interests to be repurchased by reason of the death of a member will have priority in the order of the deaths of the members over other repurchases, and all other membership interests to be repurchased will be repurchased on a pro rata basis rounded to the nearest whole number.

Any membership interests that are subject to a Mandatory Repurchase or which have been Put, but which are not repurchased at the end of a semester because of the limitations imposed by the Maximum Repurchase Obligation, will be carried forward to subsequent semesters without the requirement of further notice. In such cases, such deferred repurchases will have equal priority with other Mandatory Repurchases and Put Repurchases which are the result of Mandatory Repurchase Events and Puts during such semester; provided, however, that membership interests to be repurchased by reason of the death of a member will have priority in the order of the deaths of the members over other repurchases. The purchase price to be paid for such deferred repurchases will be the purchase price in effect at the time of such deferred repurchase, not the purchase price in effect at the time of the initial Put or Mandatory Redemption Event.

Option to Purchase — Physicians

A Holding Entity has the right (but not the obligation) to purchase, without the approval of Medical Facilities Holdings, and a member has the obligation to sell, membership interests held by a physician member who no longer has privileges at the specialty hospital operated by the MFC Partnership, or relocates their primary residence outside of the service area.

Option to Purchase — Non-Physicians

A Holding Entity has the right (but not the obligation) to purchase without the approval of Medical Facilities Holdings, and the member has the obligation to sell, membership interests held by a member who is not a physician if they are no longer employees, members of the governing body, or entities providing comprehensive management services to the MFC Partnership.

Sales to New Members

Membership interests may be sold by a Holding Entity without the approval of Medical Facilities Holdings to (i) existing members of the Holding Entity; (ii) physicians on the medical staff of the specialty hospital operated by the applicable MFC Partnership; (iii) employees or members of the governing body of the MFC Partnership; and (iv) entities providing comprehensive management services to the MFC Partnership, provided in each case that the issuances will not lead to a violation of the Stark Law.

Transfers of Membership Interests

Membership interests may be transferred, sold or assigned by a member of a Holding Entity without the approval of Medical Facilities Holdings to (i) existing members of the Holding Entity; (ii) physicians on the medical staff of the MFC Hospital operated by the applicable MFC Partnership; (iii) employees or members of the governing body of the MFC Partnership; and (iv) entities providing comprehensive management services to the MFC Partnership, provided in each case that the issuances will not lead to a violation of the Stark Law. Any such transfer will be subject to the approval of the applicable Holding Entity.

Offers to Sell

Except as otherwise provided above, no membership interests may be sold or otherwise transferred without the prior approval of Medical Facilities Holdings and the Holding Entity. A member of a Holding Entity who desires to transfer his, her or its membership interests other than as provided above will offer them to the Holding Entity. In the event the Holding Entity elects to purchase less than all of such offered membership interests, the member may, in his, her or its discretion, elect to retain all of his, her or its offered membership interests.

Purchase Price

The purchase price for any issuance, transfer, sale, redemption, or offering of membership interests of an Original Holding Entity will be at fair market value as determined not less than annually by the governing board of the Original Holding Entity. The purchase price for any issuance transfer, sale, redemption or offering of membership interests of OSH's related Holding Entity will be at the lesser of: (i) book value multiplied by the percentage interest of the departing members, and (ii) fair market value.

Instalment Payments

For any purchase or redemption of membership interests by the Holding Entity, the purchase price may, at the election of the governing board, be paid over a period of five years in five annual instalments, with the first payment due at closing and the second, third, fourth and fifth instalments due on the first, second, third and fourth anniversaries of the closing (in exercising its discretion, the governing board will consider the terms of the non-solicitation and non-competition agreements for the redeemed holder and the desirability of an instalment payment to ensure compliance with such agreements). Unless the Holding Entity otherwise determines, interest on the principal balance will be paid at the applicable federal interest rate in effect on the date of first payment.

ASH Holdco

A member of ASH Holdco may not transfer his, her or its interests without the prior written approval of the ASH Holdco board and Medical Facilities Holdings or, if one or both of such approvals are not provided, by the approval of holders of a majority of interests in ASH Holdco. In addition, transfers of interests are not permitted if the proposed transferee does not meet prescribed membership requirements and if the transfer might result in a violation of applicable law. ASH Holdco has a right of first refusal in respect of proposed transfers. ASH Holdco may redeem a member's interest in certain circumstances, including breach of the ASH Holdco operating agreement, the imposition of a regulatory sanction or suspension of professional privileges and with the approval of a majority of the disinterested members. Additionally, ASH Holdco may, or if requested by Medical Facilities Holdings shall, redeem a member's units upon the occurrence of certain events, including the member's death, disability, bankruptcy, retirement from practice within the local service area, relocation of practice, and other events. The purchase price for the member's units in such event is based on a formula prescribed by the ASH Holdco operating agreement, payable in instalments plus interest in certain circumstances.

Non-Solicitation and Non-Competition Agreements

Subject to the exceptions noted below, each Subco and Holdco, each Holding Entity and each member of a Holding Entity (and the equity owners of any member that is not a natural person) has entered into a non-solicitation and non-competition agreement pursuant to which such member is prohibited for so long as the executing party is a member of the Holdco or Holding Entity and for a period of two years thereafter, without the consent of Medical Facilities Holdings, directly or indirectly, on his or her own behalf or in the service or on behalf of others, as a

director, governor, trustee, owner (except as an owner of less than 5% of the outstanding stock of a publicly-owned corporation), employee, consultant, advisor, independent contractor or in any other capacity, engage in a business that is in competition with the MFC Original Partnerships and located within a 100-mile radius of the site of the related MFC Hospital.

For purposes of the non-solicitation and non-competition agreement, a business is deemed to be in competition with an MFC Hospital if it owns or operates a specialty hospital, general hospital, ASC, or cardiac or catheterization services. The obligation to enter into non-solicitation and non-competition agreements does not apply to any member of the Holding Entity which is a non-profit organization and which owns and operates a general hospital, and certain existing arrangements and capacities will be grandfathered. The non-solicitation and non-competition agreements do not affect a physician's right to refer patients to any other facility or in any way impede the exercise of the physician's medical judgment or preclude a physician member of an Original Holding Entity or Holdco from performing procedures typically performed in the office setting if no additional license is required for the procedure and it does not typically involve the utilization of a professional anesthesia provider. In addition, a physician's employment by a general hospital providing competing services shall not constitute a breach of the non-solicitation and non-competition agreement.

Notwithstanding the foregoing, any person who is a member of the Original Holding Entity is exempted from the provisions of the non-solicitation and non-competition agreement, but only (i) for those competing services provided in the office setting and billed by the member or by the professional practice which employs the member as of October 15, 2003 (including any employment in any hospital or clinic that provides competing services); (ii) to the extent the member had the capacity to provide such competing services as of October 15, 2003 with respect to equipment, space and staff (i.e., a member will be permitted to expand a competing service to the capacity of an underutilized piece of equipment); and (iii) at no more than the number of sites such services were offered by the member as of October 15, 2003.

OSH's related Subco and Holding Entity and each member of the related Holding Entity (and the equity owners or representatives of any member that is not a natural person) entered into a non-solicitation and non-competition agreement pursuant to which such member is prohibited for so long as the executing party is a member of the Spine Hospital's related Holding Entity and for a period of five years thereafter, without the consent of Medical Facilities Holdings, directly or indirectly, on his or her own behalf or in the service or on behalf of others, as a director, governor, manager, trustee, owner (except as an owner of less than 5% of the outstanding stock of a publicly-owned corporation), employee, consultant, advisor, independent contractor or in any other capacity to (i) engage in a business that is in competition with the Spine Hospital; (ii) maintain any financial relationship (including any ownership or investment interest) with any business that is in competition with the Spine Hospital; (iii) develop, own, operate, lease, manage, invest in or finance any business that is in competition with the Spine Hospital; or (iv) provide financial, consulting or managerial assistance relating to the formation and/or operation of a business that is in competition with the Spine Hospital to any other person, company, business or enterprise that owns, operates or manages a business that is in competition with the Spine Hospital, each within Oklahoma County (or any counties contiguous to Oklahoma County). For purposes of the non-solicitation and non-competition agreement, a business is deemed to be in competition with the Spine Hospital if it owns or operates a specialty hospital, general hospital, ASC, pain management facility, surgery center or other facility that provides surgical care or pain management services. The non-solicitation and non-competition agreements do not affect a physician's right to refer patients to any other facility or in any way impede the exercise of the physician's medical judgment.

ASH, ASH Holdco, the Corporation, Medical Facilities America and Medical Facilities Holdings entered into a non-solicitation and non-competition agreement pursuant to which each of the Corporation, Medical Facilities America and Medical Facilities Holdings (hereinafter "**MF Parties**") agrees that, during the period beginning on the closing date of the ASH Acquisition and extending until the earlier of (a) five years following the date on which no MF Party will own any interest in ASH or (b) the cessation of the business of the ASH in Pulaski County, Arkansas and its contiguous counties (the "**Market Area**"), (the "**Restricted Period**") it will not, directly or indirectly, (except as the owner of 5% or less of the stock of a publicly-owned corporation) (i) engage in a business that owns or operates a surgical or specialty hospital, general hospital, ASC, pain management facility, surgery center or other facility that provides surgical care, pain management or ancillary hospital services (a "**Competing Business**"), (ii) maintain any financial relationship with a Competing Business, (iii) develop, own, operate, lease, manage, invest in or finance any Competing Business, or (iv) provide financial consulting or managerial assistance relating to the

formation and/or operation of any Competing Business to any other person or business that owns, operates or manages a Competing Business, each within the Market Area.

The agreement provides for certain exclusions from the non-competition and non-solicitation restrictions. In particular, the agreement provides that the MF Parties are not prevented from acquiring an interest in any person which is at the time of ASH Acquisition (i) had securities publicly listed and trading on a stock exchange, and/or (ii) had a direct or indirect ownership interest (10% or greater) in not less than four businesses that qualify as a Competing Business. During the Restricted Period, each MF Party agrees that it will not, directly or indirectly, on its own behalf or in the service or on behalf of others, solicit or induce or attempt to solicit or induce any person employed by ASH to leave such employment for employment with a Competing Business, or wilfully dissuade or discourage any person or entity from using, employing or conducting business with ASH, or intentionally disrupt or interfere with, or seek to disrupt or interfere with, ASH or contractual relationship between ASH and any supplier who during the term of the agreement supplies or supplied materials or services to ASH, or during the six-month period preceding the transactions contemplated by the purchase agreement supplied materials or services to ASH.

ASH, ASH Holdco, Medical Facilities Holdings and individual members of ASH Holdco entered into a non-solicitation, non-disclosure and non-competition agreement in favour of Medical Facilities Holdings pursuant to which each such member agreed that, during the period beginning on the closing date of the ASH Acquisition and extending until the earlier of (a) five years following the date on which such member terminates his, her or its interest in ASH or (b) the cessation of the business of ASH in Market Area, he, she or it will not, directly or indirectly, on his, her or its behalf or in the service of or on the behalf of others, as a director, governor, manager, officer, trustee, owner (except as the owner of 5% or less of the stock of a publicly-owned corporation), employee, consultant, advisor, independent contractor, or in any other similar capacity (i) engage in a Competing Business, (ii) maintain any financial relationship with a Competing Business, (iii) develop, own, operate, lease, manage, invest in or finance any Competing Business, or (iv) provide financial, consulting or managerial assistance relating to the formation and/or operation of any Competing Business to any other person or business that owns, operates or manages a Competing Business, each within the Market Area.

SCNC's related non-solicitation and non-competition agreement restricts the Holdco member from engaging in a business that is in competition with and located within a 15-mile radius of SCNC. In connection with the acquisition of SCNC, only certain principal members of the SCNC Holdco, which principal members at the time of acquisition, owned, directly and indirectly, in the aggregate a 61.23% interest in the SCNC Holdco, entered into the non-solicitation and non-competition agreement.

Each non-solicitation and non-competition agreement includes provisions providing for the assignment (by power of attorney) of the holder's membership interest in such Holding Entity (and any entitlement to undistributed distributions) in the event of a breach of the agreement.

UMASH AND PAM

Medical Facilities Holdings owns a 72.1% membership interest in PAM, which in turn owns an 86.0% membership interest in UMASH, resulting in Medical Facilities Holdings owning, indirectly, a 62.0% membership interest in UMASH. The remainder of the membership interests in PAM and UMASH are held by certain UMASH physicians and personnel.

The membership interests carry such number of votes equal to the membership interest on all matters to be voted on at all meetings of members. Holders of membership interests are entitled to their pro rata distribution equivalent to their membership interest as and when declared by the board of managers of UMASH and PAM. Upon the voluntary or involuntary liquidation, dissolution or winding-up of UMASH or PAM, the holders of membership interests will be entitled to share rateably in the remaining assets available for distribution, after payment of all liabilities.

Operating Agreements

Distribution Policy

The operating agreements of UMASH and PAM provide that all available cash, as determined by the board of managers (other than cash funds obtained from capital contributions of members and loans to the company), after payment or provision for (i) operating expenses, (ii) all outstanding unpaid current obligations, and (iii) a reasonable working capital reserve in an amount determined by the board of managers, shall be distributed to the members on a pro rata basis in accordance with their respective percentage interests. In the case of UMASH, distributions are made on a quarterly basis and in the case of PAM, distributions are made on an annual basis.

Management

The board of managers of each of UMASH and PAM is comprised of six persons, four of whom are appointed by PAM (in the case of UMASH) and Medical Facilities Holdings (in the case of PAM) and two of whom are appointed by the other members. Through its majority ownership of PAM, the PAM appointees to the UMASH board are ultimately determined by Medical Facilities Holdings, thus giving Medical Facilities Holdings indirect authority over decisions at the UMASH level. The board of managers of UMASH and PAM have the authority to manage UMASH and PAM, subject to certain decisions that require unanimous approval of the board of managers and thus are limitations on Medical Facilities Holdings' authority, as outlined below. Executive management is determined by the board of managers of UMASH and PAM.

Fundamental Decisions

Pursuant to the UMASH operating agreement, the following decisions require unanimous approval of the board of managers of UMASH and PAM and thus are limitations on the authority of Medical Facilities Holdings:

(i) incurrence of debt;

(ii) entering into or amending non-arms' length contracts;

(iii) making a capital call or requiring a capital contribution;

(iv) amending the operating agreement;

(v) merging or any other change of control transaction or substantial sale;

(vi) requiring any guarantees of debt by the members;

(vii) conducting activities unrelated to the current activities of the hospital;

(viii) relocating the hospital; and

(ix) liquidating or dissolving the company.

Ownership Restrictions

Members of UMASH or PAM that are individual physicians or entities owned by physician shall meet all criteria for UMASH or PAM, as applicable, to comply with the "grandfather provisions" of the Stark Law. At no time may the direct or indirect ownership of UMASH by physicians exceed the applicable restrictions in the Stark Law.

PAM is permitted to transfer any of its interest in UMASH without restriction. Other members of UMASH may only transfer their interest with the prior consent of the board of managers of UMASH and in compliance with applicable law and subject to a right of first refusal of UMASH (in the first instance), the other non-PAM members (in the second instance) and PAM (in the third instance).

MFH is permitted to transfer any of its interest in PAM without restriction. Other members of PAM may only transfer their interest with the prior consent of the board of managers of PAM and in compliance with applicable law and subject to a right of first refusal of PAM (in the first instance), MFH (in the second instance) and the other non-MFH members (in the third instance).

Non-Competition

So long as a member of UMASH or PAM remains a member of UMASH or PAM, as applicable, and for two years thereafter, it shall not, directly, or indirectly, without board approval, (i) invest in or acquire any healthcare facility providing services similar to those provided by UMASH and which operates within a 50-mile radius of UMASH; (ii) own, lease or otherwise contract to use real property or equipment of an entity or a facility within a 50-mile radius of UMASH to provide medical or management services related to surgical services; and (iii) in any capacity own, operate, manage, be employed by, work for, make an investment in or contract with any entity or facility that provides medical or management services related to surgical services within a 50-mile radius of UMASH. Notwithstanding the foregoing, PAM and Medical Facilities Holdings have the right to acquire and hold interests in, and enter into agreements with, any healthcare facility other than a surgical hospital which is located with a 50-mile radius of UMASH.

Reporting

The board of managers of each of UMASH and PAM must require that UMASH and PAM adopt, maintain, fulfill and enforce such regular financial reporting, and adopt disclosure, reporting and other related policies to permit the Corporation to comply with applicable securities law, stock exchange rules and regulatory policies and best practices, including systems and processes necessary or appropriate to support the Corporation's internal controls over financial reporting and disclosure controls and procedures and policies governing matters such as confidentiality, trading, insider reporting, whistleblowing and code of conduct.

Additional Subscriptions and Redemptions

The PAM operating agreement provides that Medical Facilities Holdings has the right to subscribe for an additional approximate 23.9% membership interest in PAM (6.7% in 2017, 6.7% in 2018 and 10.6% in 2019); provided that all parties must agree on the right of Medical Facilities Holdings to exercise its subscription right in respect of 2017. Upon such subscription, the equivalent membership interest held by certain existing members will be redeemed on a pro rata basis. If the entire membership interest available for subscription in a given year is not subscribed for in that year, Medical Facilities Holding has the right to subscribe for that amount along with the subscriptions available in the succeeding years.

The same existing members of PAM who hold, collectively, an approximate 23.9% membership interest in PAM, have the right to require PAM to redeem their interests (6.7% in 2017, 6.7% in 2018 and 10.6% in 2019), and if such right is exercised, Medical Facilities Holdings would be required to subscribe for the corresponding interest in PAM.

All such additional subscriptions and redemptions will be at fair market value at the time of the relevant subscription and redemption; provided that a member who was a physician at UMASH at the time that the operating agreement was entered into no longer provides services to UMASH on a full-time basis at the time of the relevant subscription, such member shall not have the right to redeem his or her interest, and if Medical Facilities Holdings subscribes for additional interests, the purchase price in respect of the interest being redeemed from such physician will be reduced by 75%.

In 2017, Medical Facilities Holdings did not subscribe for additional membership interest in PAM and PAM did not redeem any membership interests.

Amendments

The operating agreements of UMASH and PAM provide that amendments to the operating agreement must be approved unanimously by the board of managers after being provided to all members and managers. Upon such

approval, all members are bound; provided, however that certain administrative amendments do not require prior notice to the members.

MFC NUETERRA PARTNERSHIP

Medical Facilities Holdings owns a 94.25% membership interest in MFC Nueterra Partnership.

MFC Nueterra Partnership Operating Agreement

MFC Nueterra Partnership is governed by an Amended and Restated Limited Liability Company Agreement dated January 12, 2018 (the "**MFC Nueterra Partnership Operating Agreement**").

Distribution Policy

MFC Nueterra Partnership distributes available cash flow (as described in the MFC Nueterra Partnership Operating Agreement) monthly in accordance with the respective interests held by each of Medical Facilities Holdings and Nueterra MF Holdings, LLC ("**Nueterra**"), as members. MFC Nueterra Partnership also distributes an amount equal to the tax liability of each partner for the preceding year, if available after provision for payment of all outstanding and unpaid expenses and the minimum amounts currently due with respect to any loans and advances made.

Management

The board of managers of MFC Nueterra Partnership is authorized to manage the business of MFC Nueterra Partnership, subject to matters requiring approval of both Medical Facilities Holdings and Nueterra listed below. The board of managers consists of two appointees of Medical Facilities Holdings and one appointee of Nueterra. Nueterra may appoint a non-voting observer to attend board meetings.

MFC Nueterra Partnership has also entered into a management services agreement (the "**MFC Nueterra Partnership MSA**") with the Nueterra Manager as described below.

Fundamental Decisions and Amendments

Consent of both Medical Facilities Holdings and Nueterra is required for the following activities:

- amendments to a constating document of MFC Nueterra Partnership, other than certain administrative amendments;
- the issuance of additional units of MFC Nueterra Partnership or dilution of Nueterra's interest;
- a call for an additional capital contribution; and
- the selection of a third party appraisal firm in certain circumstances.

Transfer Restrictions

Except as summarized below, interests in MFC Nueterra Partnership may not be transferred without board approval, other than to a financial institution as collateral or to an affiliate.

If Medical Facilities Holdings or an affiliate proposes to sell its interest to a third party, it may require the other members of MFC Nueterra Partnership to sell their interests as well (". If Medical Facilities Holdings chooses not to exercise its drag-along rights, Nueterra may sell its interest at the same price and on the same terms and conditions to a proposed purchaser pursuant to tag-along rights.

Should the MFC Nueterra Partnership MSA be terminated due to a certain terminating event (as described therein), Medical Facilities Holdings may purchase all (but not less than all) of Nueterra's interest in MFC Nueterra Partnership.

Reporting

Within 13 business days of each month end, the Nueterra Manager will provide unaudited financial statements and operating reports. The reports and statements will include the prior month, year to date, and twelve month period and comparative data for the previous year for each entity in the partnership structure and each MFC Nueterra ASC. Any audited balance sheets prepared will also be provided.

Restrictive Covenants

The MFC Nueterra Partnership Operating Agreement contains mutual non-competition obligations which endure for one year after membership in MFC Nueterra Partnership has ended. Non-competition obligations restrict the management, ownership, either directly or indirectly, of an ASC or surgical hospital within a five-mile radius of each MFC Nueterra ASC, subject to certain exceptions. Mutual non-solicitation covenants prohibit members from soliciting current employees or independent contractors of any MFC Nueterra ASC, MFC Nueterra Partnership or any MFC Nueterra Partnership Holding Company during the term of membership and for one year thereafter.

If a member breaches either the non-competition or non-solicitation covenants, the non-breaching member may purchase all of the breaching member's units in MFC Nueterra Partnership or cause MFC Nueterra Partnership to purchase the breaching member's units at a specified price.

Broad confidentiality obligations also bind Medical Facilities Holdings and Nueterra, which survive for three years after membership in MFC Nueterra Partnership has ended.

MFC Nueterra ASC Operating Agreements

There are individual limited liability company operating agreements (each a "**MFC Nueterra ASC Operating Agreement**") in respect of each of the MFC Nueterra ASCs, as well as a management services agreement between five MFC Nueterra Partnership Holding Companies and corresponding MFC Nueterra ASC subsidiaries. The parties to each MFC Nueterra ASC Operating Agreement are the applicable MFC Nueterra Partnership Holding Company and one or more third party entities comprised of physician and non-physician members, some of which are non-profit entities (each a "**Partner**").

Each MFC Nueterra ASC is governed by a board of directors, the majority of which in each case is appointed by the MFC Nueterra Partnership Holding Company, which is wholly owned by MFC Nueterra Partnership. A majority of directors is generally required to implement a decision of the board.

The consent of the applicable MFC Nueterra Partnership Holding Company and a majority of interests held by the Partners is required for certain fundamental activities or changes.

Interests in an MFC Nueterra ASC may be transferred by an MFC Nueterra Partnership Holding Company member to: (a) an affiliate; (b) a purchaser in connection with a change of control of an MFC Nueterra Partnership; (c) another member of the MFC Nueterra ASC with consent of the board, or in some cases, upon the occurrence of certain triggering events (bankruptcy or exclusion or suspension from any federal health care program in which case such interest may be purchased by the non-breaching member); (d) a new member upon the consent of the other members; or (e) a physician practicing in the area of the MFC Nueterra ASC in accordance with certain procedural obligations.

If a Partner wishes to sell its interest to a third party purchaser, the MFC Nueterra ASC has the first opportunity to buy all of the Partner's interest. If the MFC Nueterra ASC does not exercise its right of first opportunity, the applicable MFC Nueterra Partnership Holding Company or its individual members may purchase the offered interests.

Management Services Agreements

Pursuant to the MFC Nueterra Partnership MSA, the Nueterra Manager provides managerial services to the MFC Nueterra ASCs on behalf of each MFC Nueterra Partnership Holding Company as each MFC Nueterra Partnership Holding Company is required to do pursuant to site-specific managements agreements or the applicable

MFC Nueterra ASC Operating Agreement, and provides certain administrative services to MFC Nueterra Partnership and the MFC Nueterra Partnership Holding Companies.

Obligations of the Nueterra Manager include coordinating all MFC Nueterra ASC business and administrative activities, accounting and bookkeeping, policies and procedures, oversight of personnel, day-to-day operations and maintaining licenses and permits.

In consideration for the provision of management services, the Nueterra Manager is paid all management fees due under the site-specific management agreements and permitted expenses and costs. The fees range between 5-6% of all collections from fees or other charges arising out of the operations of the MFC Nueterra ASC.

Notwithstanding its authority to manage the MFC Nueterra ASCs, the Nueterra Manager may not undertake certain fundamental changes or actions without the consent of MFC Nueterra Partnership.

The MFC Nueterra Partnership MSA expires on February 1, 2025. MFC Nueterra Partnership may terminate the agreement at any time after February 1, 2019 on 60 days' notice if the Nueterra Manager or one of its affiliates does not make its required capital contribution required under the MFC Nueterra Partnership Operating Agreement by December 31, 2018. On the fifth anniversary of the MFC Nueterra Partnership MSA, February 1, 2023, MFC Nueterra Partnership may terminate the MFC Nueterra Partnership MSA with 90 days' notice for any reason on payment of a fee in the amount of the management fees for the trailing 90-day period immediately preceding the fifth anniversary date. The MFC Nueterra Partnership MSA may also be terminated for cause upon the occurrence of any one of certain terminating events described therein.

Some of the site specific management agreements persist beyond February 1, 2025 or continue indefinitely pursuant to the MFC Nueterra ASC Operating Agreements.

INTEGRATED MEDICAL DELIVERY

Medical Facilities IMD Holdings

Medical Facilities IMD Holdings is a Delaware corporation that is wholly-owned by the Corporation. On January 14, 2016, Medical Facilities IMD Holdings issued a $1.25 million demand promissory note to the Corporation, bearing interest at a rate of 10% per year.

IMD

The business and affairs of IMD are governed by an amended and restated operating agreement dated as of January 1, 2016 among IMD, Medical Facilities IMD Holdings and IMD Holdings, LLC, the minority interestholder. The capital of IMD is divided into two classes. Class A Units are non-voting units, and are held as to 51% by Medical Facilities IMD Holdings (indirectly, by the Corporation). Class B Units are voting, but with no economic rights; Medical Facilities IMD Holdings is the sole holder of Class B Units. The holder(s) of the Class B Units are entitled to appoint three of the five members of IMD's board of managers, and the holder(s) of the Class A Units are entitled to appoint the other two. If Medical Facilities IMD Holdings, as the holder of the Class B Units, determines to sell all of its interests in IMD, it has the right to compel all other holders to sell on the same terms.

DIRECTORS, OFFICERS AND MANAGEMENT

The Corporation

Directors of the Corporation

The Corporation's articles of incorporation provide for a minimum of three directors, a majority of whom must be resident Canadians, provided that the Corporation is a public company. The directors of the Corporation are Marilynne Day-Linton (Chair), David Bellaire, Stephen Dineley, Irving Gerstein, Robert Horrar, Dale Lawr, Jeffrey Lozon, and Reza Shahim, a majority of whom are unrelated to and independent of (for regulatory purposes) the Corporation and its subsidiaries. Each director of the Corporation, with the exception of Stephen Dineley, Robert Horrar and Reza Shahim, has also been appointed to the boards of directors of Medical Facilities America and

Medical Facilities Holdings. David Bellaire and Jeffrey Lozon also serve as directors of Medical Facilities IMD Holdings and managers of IMD. Robert Horrar also serves on the board of managers of UMASH and on the board of managers of PAM. Further information on each director is provided in the section entitled "Directors, Officers and Management – Directors and Officers of the Corporation and its Subsidiaries" on page 62 below.

The term of office for each of the directors of the Corporation will expire at the time of the next annual general meeting of shareholders of the Corporation. Directors are elected at each annual meeting of shareholders of the Corporation. A director may be removed by a resolution passed by a majority of the shareholders or may resign. The vacancy created by the removal of a director must be filled at the shareholder meeting at which he or she was removed. A vacancy not so filled at a shareholder meeting, or created by the resignation of a director, may be filled by a quorum of the remaining directors. A quorum for meetings of directors is two directors. If there is no quorum of directors, a special shareholder meeting must be called to fill the vacancy.

The directors supervise the activities and manage the affairs of the Corporation, including acting for, voting on behalf of and representing the Corporation as a parent of Medical Facilities America.

Committees of the Board of Directors

Audit Committee. The Corporation has an audit committee that is comprised of Stephen Dineley (Chair), Marilynne Day-Linton, Irving Gerstein, and Dale Lawr, all of whom are unrelated to and independent of (for regulatory purposes) the Corporation and its direct and indirect subsidiaries, including the MFC Partnerships. A more detailed description of the audit committee is provided in the section entitled "Audit Committee and Auditors' Fees" on page 70 below.

Corporate Governance, Nominating and Compensation Committee. The members of the corporate governance, nominating and compensation committee (the "**CGNC Committee**") are Dale Lawr (Co-Chair), Jeffrey Lozon (Co-Chair), David Bellaire, Marilynne Day-Linton and Irving Gerstein. All of the members of the committee are unrelated to and independent (for regulatory purposes) of the Corporation and its direct and indirect subsidiaries, including the MFC Partnerships.

The committee (i) develops and recommends appropriate corporate guidelines for the Corporation, (ii) annually reviews the performance of the board, its committees and individual directors, (iii) develops and recommends criteria for selecting new board members and identifying and considering candidates, (iv) recommends the director nominees for each annual meeting of shareholders and makes recommendations concerning membership of each committee of the board, (v) recommends the form and quantum of compensation for non-executive directors, committees and chairs of the board and committees, (vi) reviews and oversees the evaluation of the performance of the Corporation's senior executives, (vii) designs and recommends the compensation framework of the Corporation's senior executives, including compensation plans, benefits plans, policies and program, (viii) oversees a succession planning and development with respect to the Corporation's senior executives, and (ix) oversees the executive performance of the Corporation's direct subsidiaries.

Investment Committee. The members of the investment committee are David Bellaire (Chair), Marilynne Day-Linton, Stephen Dineley, Jeffrey Lozon, and Reza Shahim. All of the members of the committee, with the exception of Reza Shahim, are unrelated to and independent (for regulatory purposes) of the Corporation and its direct and indirect subsidiaries, including the MFC Partnerships. Dr. Shahim is non-executive non-independent director. Dr. Shahim is a minority owner of ASH and a member of an ownership group that owns and leases hospital real estate to ASH. As well, Dr. Shahim is a minority member of another ownership group that owns and leases imaging equipment to ASH.

The Investment Committee assesses and makes recommendations to the Corporation's board of directors in respect of management's acquisition and investment recommendations, including assessment of risk and risk mitigation with respect of material investment transactions.

DSU Plan

The board of directors of the Corporation has a DSU Plan providing for the issuance of DS Units to eligible directors of the Corporation. The DSU Plan was implemented for the purpose of attracting and retaining highly

qualified and competent directors for the Corporation. The DSU Plan also serves to align the interests of the directors with shareholders of the Corporation by tying a portion of their compensation to the performance of MFC during the period that they serve as members of its board.

Under the DSU Plan, which is administered by the board of directors of the Corporation, on or before December 31st of each year, each participant that is an eligible member of the DSU Plan may elect to receive, in lieu of a cash payment, all or a portion of their annual director fees for the following fiscal year in DS Units. No less than 50% of the board retainer fees must be received in DS Units. At such time as a holder of DS Units ceases to serve as a director of the Corporation, such holder's entitlement in respect of the DS Units then held will be settled in cash based on a formula tied to the value of the Common Shares at the relevant time.

The following table summarizes the issuance of DS Units during the year ended December 31, 2017:

Date of Issuance	Number of DS Units Issued	Issue Price (Cdn$)	Total Value of DS Units Issued (Cdn$)
January 13, 2017	6,448	17.56	113,227
April 13, 2017	6,410	18.71	119,931
July 14, 2017	8,765	14.78	129,547
October 13, 2017	6,967	15.83	110,288
Total 2017	**28,590**		**472,993**

Management

The Corporation has four executive officers. Robert Horrar is President and Chief Executive Officer, Tyler Murphy is Chief Financial Officer, James Rolfe is Chief Development Officer, and Jimmy Porter is Vice-President, Operations (effective January 1, 2018). They hold similar positions in Medical Facilities America and Medical Facilities Holdings. Robert Horrar and Tyler Murphy also hold similar positions in Medical Facilities IMD Holdings. Further information on each officer of the Corporation is provided in the section entitled "Directors, Officers and Management – Directors and Officers of the Corporation and its Subsidiaries" on page 62 below.

Primary responsibility for managerial and executive oversight of the business of the Corporation's subsidiaries is delegated to and discharged by Medical Facilities Holdings, including but not limited to oversight of the business operations of the MFC Facilities, acquisition activities, budgeting processes and control procedures and policies.

Policies

The board of directors is also responsible for adopting and periodically reviewing and updating the policies of the Corporation. Such policies, among other things:

- articulate the legal obligations of the Corporation, its affiliates and their respective directors, officers and employees with respect to confidential information;
- identify spokespersons of the Corporation who are the only persons authorized to communicate with third parties such as analysts, media and investors;
- provide guidelines on the disclosure of forward-looking information;
- require advance review by senior executives of any selective disclosure of financial information to ensure the information is not material, to prevent the selective disclosure of material information, and to ensure that if selective disclosure does occur, a news release is issued immediately; and
- establish blackout periods immediately prior to and following the disclosure of quarterly and annual financial results and immediately prior to the disclosure of certain material changes, during which

periods the Corporation, its subsidiaries (including the MFC Partnerships), and (pursuant to undertakings in favour of the Corporation) the Subcos and Holding Entities and their respective managers, officers, employees and consultants may not purchase or sell Common Shares or Debentures or securities exchangeable for or convertible into same.

Medical Facilities America

Directors and Officers

Medical Facilities America is governed in accordance with its constating documents and its Management Agreement. The Management Agreement provides for a board of directors consisting of eleven directors of Medical Facilities America with the Corporation having the right to appoint the majority of directors. The board of directors of Medical Facilities America is presently comprised as follows:

- five representatives of the Corporation;
- two representatives of BHSH; and
- two representatives of SFSH.

The MFC Partnerships' representation on the Medical Facilities America board of directors will be adjusted if the Retained Interests are reduced or diluted, as discussed previously.

The board of directors of Medical Facilities America, subject to the provisions of the Management Agreement, has full power to manage the business and affairs of Medical Facilities America, to make all decisions regarding Medical Facilities America and to bind Medical Facilities America.

Medical Facilities America has four officers. Robert Horrar is President and Chief Executive Officer, Tyler Murphy is Chief Financial Officer, James Rolfe is Chief Development Officer, and Jimmy Porter is Vice-President, Operations (effective January 1, 2018). They hold similar positions in the Corporation and Medical Facilities Holdings.

Further information on each director and officer of Medical Facilities America is provided in the section entitled "Directors, Officers and Management – Directors and Officers of the Corporation and its Subsidiaries" on page 62 below.

Medical Facilities Holdings

Directors and Officers

Medical Facilities Holdings is a Delaware corporation and is governed in accordance with its constating documents and applicable law. Medical Facilities Holdings' board of directors replicates the board of directors of Medical Facilities America. Medical Facilities Holdings has four officers. Robert Horrar is President and Chief Executive Officer, Tyler Murphy is Chief Financial Officer, James Rolfe is Chief Development Officer, and Jimmy Porter is Vice-President, Operations (effective January 1, 2018). They hold similar positions in the Corporation and Medical Facilities America.

Further information on each director and officer of Medical Facilities Holdings is provided in the section entitled "Directors, Officers and Management – Directors and Officers of the Corporation and its Subsidiaries" on page 62 below.

Committees

The board of directors has a business development and acquisition committee that assists the board in identifying and pursuing strategic acquisitions.

Certain directors and executive officers of Medical Facilities Holdings also sit as representative members on the respective MFC Partnerships' management committees.

Directors and Officers of the Corporation and its Subsidiaries

The following table sets out the name, province/state and country of residence, position(s) with the Corporation, Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, IMD, PAM and UMASH, and principal occupation during the past five years of directors and executive officers of the Corporation, Medical Facilities America, Medical Facilities Holdings, and Medical Facilities IMD Holdings.

Name and Province/State and Country of Residence	Position(s) / Director Since	Principal Occupation During the Past Five Years
DAVID R. BELLAIRE Georgia, U.S.A.	Director (or manager, as applicable) of MFC since March 2014, MFH and MFA since May 2014 and Medical Facilities IMD Holdings and IMD since January 2016[3][4][5][7][8]	Operating Partner, Waud Capital Partners (Chicago) Senior Advisor, Bain & Company, 2013 – 2016 Senior Partner and Director, Bain & Company, 2004 – 2013
DR. PAUL CINK South Dakota, U.S.A.	Director of MFA since June 2011 and of MFH since April 2012[1]	Ear, Nose and Throat Surgeon
DR. R. BLAKE CURD South Dakota, U.S.A.	Director of MFA since June 2011 and MFH since April 2012[1]	Chief Executive Officer of Sioux Falls Specialty Hospital (since 2015) and Orthopedic Surgeon
MARILYNNE DAY-LINTON Ontario, Canada	Director of MFC, MFA and MFH since January 2013[3][5][6][7][8] Board Chair since May 2016	Corporate Director
STEPHEN DINELEY Ontario, Canada	Director of MFC since February 2016[6][7][8]	Consultant Senior Audit Partner, KPMG LLP, 2000 – 2014
IRVING R. GERSTEIN Ontario, Canada	Director of MFC since March 2004, MFA since June 2011 and MFH since April 2012[3][5][6]	Corporate Director
ROBERT O. HORRAR Tennessee, U.S.A.	President and Chief Executive Officer of MFC, MFA, MFH and Medical Facilities IMD Holdings since October 2017, director of MFC since November 2017, and manager of UMASH and PAM since October 2017	President and Chief Executive Officer President – Division III, Operations, Community Health Systems, Inc., 2016 – 2017 Vice President – Division II, Operations, Community Health Systems, Inc., 2010 – 2016
DALE LAWR Ontario, Canada	Director of MFC since November 2014, MFH and MFA since May 2016[3][5][6]	Corporate Director Chief Risk Officer, Infrastructure Ontario, 2013 – 2015 Chief Administrative Officer, Infrastructure Ontario, 2012 – 2013
JEFFREY C. LOZON Ontario, Canada	Director (or manager, as applicable) of MFC since November 2015, MFH and MFA since May 2016, and Medical Facilities IMD Holdings and IMD since March 2016[3][5][7][8]	Chairman, Lozon Associates Interim President and Chief Executive Officer, 2017 President and Chief Executive Officer, Revera Inc., 2009 – 2014
DR. JEFFREY S. MARRS South Dakota, U.S.A.	Director of MFA and MFH since May 2013[2]	Orthopedic Surgeon
TYLER C. MURPHY Texas, U.S.A.	Chief Financial Officer of MFC, MFA, MFH and Medical Facilities IMD Holdings since January 2017, and manager of UMASH and PAM since December 2016	Chief Financial Officer (since January 2017) Executive Vice-President, Finance, Medical Facilities Corporation, 2016 Vice-President and Treasurer, Tenet Healthcare Corporation, 2009 – 2016
DR. LEW W. PAPENDICK South Dakota, U.S.A.	Director of MFA and MFH since May 2013[2]	Orthopedic Surgeon
JAMES M. PORTER Tennessee, U.S.A.	Vice-President, Operations of MFC, MFA, MFH since January 2018	Vice-President, Operations (since January 2018) Senior Director Finance, Ambulatory Surgery Centers, Community Health Systems, Inc., 2016 – 2017 Senior Director, Strategy and Business Development, Community Health Systems, Inc., 2014 – 2016 Director, Acquisitions and Development, Community Health Systems, Inc., 2012 – 2014
JAMES D. ROLFE Tennessee, U.S.A.	Chief Development Officer of MFC, MFA and MFH, and manager of UMASH and PAM since September 2016	Chief Development Officer Managing Director of Business Development and Transaction Advisory, VMG Health, 2009 – 2016

Name and Province/State and Country of Residence	Position(s) / Director Since	Principal Occupation During the Past Five Years
DR. REZA SHAHIM ..... Arkansas, U.S.A.	Director of MFC since August 2017[7]	Neurosurgeon

(1) Representatives of SFSH on the board of directors of Medical Facilities America and Medical Facilities Holdings.

(2) Representatives of BHSH on the board of directors of Medical Facilities America and Medical Facilities Holdings.

(3) Representatives of the Corporation on the board of directors of Medical Facilities America and Medical Facilities Holdings.

(4) U.S. resident unrelated to and independent of (for regulatory purposes) the Corporation and its direct and indirect subsidiaries, including the MFC Partnerships.

(5) Indicates member of the CGNC Committee of the Corporation.

(6) Indicates member of audit committee of the Corporation.

(7) Indicates member of investment committee of the Corporation.

(8) Indicates member of business development and acquisition committee of Medical Facilities Holdings.

Biographies

David Bellaire is an operating partner with Waud Capital Partners (Chicago) and an investor in and director for several private companies operating at the intersection of technology application and healthcare. He previously was a senior advisor following a decade as senior partner and director at Bain & Company where he held leadership roles in health insurance, provider and related service sectors. Prior to Bain & Company, Mr. Bellaire was EVP and COO of a NASDAQ-listed health technology company, lead partner of Booz Allen Hamilton, SVP at APM, Inc. and Computer Sciences Corp., lead executive for two specialty reinsurance companies sold to an industry consolidator, and faculty member of Northwestern University Medical School. He has served in interim turnaround and merger/integration leadership roles and was the founder/CEO of a prosthetics company. He has served in a number of governance and ownership roles over his career including for a medical information company, toxicology labs, physical therapy company, national specialty pharmacy provider, genomic informatics company, and a pharmaceutical care services provider, among others. Mr. Bellaire received his MBA and graduate (prosthetics/bio-engineering) degrees from Northwestern University.

Paul Cink, M.D., FACS is a practising Ear, Nose and Throat surgeon at and President of the MidWest Ear, Nose & Throat Clinic in Sioux Falls, South Dakota. He is also a Chairman of the Board of Sioux Falls Surgical Physicians. Previously, Dr. Cink practised for thirteen years at the North Central Head & Neck Clinic, also in Sioux Falls, South Dakota. Dr. Cink completed his post-graduate training in surgery and otolaryngology at the University of Texas Southwestern Medical School. Dr. Cink received a bachelor's degree from the University of Houston and a Doctorate of Medicine from Baylor College of Medicine in Houston, Texas.

R. Blake Curd, M.D. is the Chief Executive Officer of Sioux Falls Specialty Hospital and practising orthopedic surgeon specializing in hand, upper extremity and micro vascular surgery. Dr. Curd serves on the Executive Committee of The Orthopedic Institute and is Chairman and is a past Chief of Orthopedic Surgery for Avera-McKennan Hospital and University Health Center in Sioux Falls, South Dakota. Dr. Curd is Clinical Assistant Professor for the University of South Dakota School of Medicine and is a frequent guest lecturer for graduate medical education, community education, and peer surgeon educational meetings. Dr. Curd spent ten years in the United States Air Force serving as a flight surgeon for a B-1 Bomber Squadron and as an orthopedic surgeon. Dr. Curd graduated from the University of Missouri at Kansas City School of Medicine with a Bachelor of Arts in both Biology and Chemistry and Medical Doctorate. Dr. Curd completed his Orthopedic Surgery Residency Training in San Antonio, Texas and completed his fellowship in Hand, Upper Extremity, and Microvascular Surgery at the Indiana Hand Center/Indiana University.

Marilynne Day-Linton is a CPA, CA with board experience on reporting issuer and not-for-profit boards and senior management experience in the travel and travel-related service industries. Ms. Day-Linton was a member of the board of the Greater Toronto Airports Authority, which operates Toronto Pearson International Airport, and chaired its board and audit committee. In 2017, she completed her thirteen-year tenure on the board of St. Joseph's Health Centre Foundation in Toronto and had chaired its board and finance committee. Prior to that, she held senior financial management roles at Signature Vacations Inc., Wardair International, The Gemini Group LP, an electronic

distribution company servicing travel service providers, and obtained her designation working for KPMG as an auditor with clients in a diverse group of industries.

Stephen Dineley, FCPA, FCA is a retired partner with over 30 years of experience in assurance services at KPMG LLP, from which he retired in March 2014. From 1998 to 2000, Mr. Dineley held the position of Chief Financial Officer at Extendicare Inc., one of the leaders in Canada's senior housing sector. Mr. Dineley provides consulting services to an alternate mortgage lender based in Toronto and also provides consulting services on accounting and auditing matters. He also serves as a director for the Bank of New York Trust Company Canada. Mr. Dineley holds an ICD.D designation with the Institute of Corporate Directors.

Irving R. Gerstein, C.M., O.Ont. is a retired executive. Mr. Gerstein is chair of the board of directors of Atlantic Power Corporation (TSX:ATP; NYSE:AT) and lead director of Student Transportation Inc. (TSX:STB; NASDAQ:STB). He previously served as a director of other public corporations, including CTV Inc., Traders Group Limited, Guaranty Trust Company of Canada, Confederation Life Insurance Company, Scott's Hospitality Inc. and Economic Investment Trust Limited, and as an officer and director of Peoples Jewellers Limited. Mr. Gerstein is a Member of the Order of Canada and a Member of the Order of Ontario. He was a member of the Senate of Canada from 2009 to 2016. Mr. Gerstein is an honorary director of Mount Sinai Hospital (Toronto), having previously served as Chairman of the Board, Chairman Emeritus and a director over a period of 25 years. Mr. Gerstein received his BSc. in Economics from the University of Pennsylvania (Wharton School of Finance and Commerce).

Robert O. Horrar is President and Chief Executive Officer of the Corporation, Medical Facilities America, Medical Facilities Holdings and Medical Facilities IMD Holdings. Mr. Horrar joined the Corporation in May 2017 initially as Chief Operating Officer. Mr. Horrar is a seasoned healthcare leader with more than 25 years of experience in health plan and hospital operations. He was formerly with Community Health Systems, Inc. which he joined in 1998 as Vice-President of Business Development, ultimately reaching the position of Division President responsible for overseeing the operations of affiliated hospitals in Indiana, Tennessee, and West Virginia. Before Community Health Systems, Mr. Horrar was with Humana, Inc. for over 11 years and held several key management positions, including Executive Director for Nevada operations. Mr. Horrar holds a Bachelor of Science degree in Economics from Centre College in Kentucky and a Master of Science degree in HealthCare Administration from Trinity University in Texas.

Dale Lawr is a CPA, CA with executive experience in a broad range of organizations in Canada and the United States, including public and private companies and a crown corporation. Until March 2015, Ms. Lawr was Chief Risk Officer at Infrastructure Ontario, which she joined in 2011 as Chief Financial Officer. Previously, Ms. Lawr was with Altus Group Limited (TSX:AIF), where she initially served as Chief Financial Officer and then as EVP Finance, Strategic Initiatives. Previously, Ms. Lawr lived in Chicago, where she served as Chief Financial Officer of RTC Industries Inc., a retail design firm; Vice-President Finance of Frankel & Co., a national marketing services agency and a business unit of Publicis SA; and Senior Manager and Director of Finance for Accenture in the firm's Chicago and Toronto offices. Ms. Lawr holds an MBA from Rotman School of Management, University of Toronto and an ICD.D designation with the Institute of Corporate Directors. Ms. Lawr is on the board of directors and chairs the finance, audit and risk committee for the Ontario Institute for Cancer Research.

Jeffrey Lozon is a Chairman of Lozon Associates advisory services and a corporate director. Until April 2014, he was President and Chief Executive Officer of Revera Inc., a leading provider of seniors' accommodation, care and services with 250 sites and 30,000 employees in Canada and the United States. Prior to joining Revera in 2009, Mr. Lozon held a 17-year tenure as President and Chief Executive Officer of St. Michael's Hospital in Toronto. He was previously seconded to the position of Deputy Minister of Health and Long-Term Care for the Province of Ontario from 1999 to 2000. He has also served on a number of national and provincial committees and organizations, including Chairing the Canadian Partnership Against Cancer and Vice Chair of Canada Health Infoway. Mr. Lozon holds an honourary Doctor of Civil Laws from Bishops University, a Masters of Health Services Administration from the University of Alberta and a Bachelor of Arts (Honours) from the University of Guelph. In 2009, he was appointed as a Member to the Order of Canada.

Jeffrey S. Marrs, M.D. is a practicing orthopedic surgeon specializing in total joint replacement, partial joint replacement, and treatment of musculoskeletal injuries. Dr. Marrs joined Black Hills Orthopedic and Spine Center clinic in 2002. He completed his orthopedic residency at Mayo Graduate School of Medicine, Rochester, Minnesota.

Tyler C. Murphy is the Chief Financial Officer of the Corporation, Medical Facilities America, Medical Facilities Holdings and Medical Facilities IMD Holdings. Mr. Murphy joined the Corporation in November 2016, initially as Executive Vice President, Finance. Mr. Murphy has over seventeen years of experience in senior financial management in the healthcare industry and, prior to joining Medical Facilities, served as Vice-President and Treasurer with one of the largest publicly-traded healthcare companies in the United States. Prior to this he was with another large investor-owned organization as Senior Vice-President, responsible for treasury, risk management and investor relations. He brings to the Corporation expertise in finance, accounting, investments, as well as executing on and integrating merger and acquisition targets. Mr. Murphy holds a Bachelor of Science degree in Business Administration from Auburn University and an MBA from the University of Alabama at Birmingham.

Lew W. Papendick, M.D. is a practicing orthopedic surgeon specializing in sports medicine with a special interest in the care of knee and shoulder pathology. Dr. Papendick joined Black Hills Orthopedic and Spine Center clinic in 1989. He is fellowship trained in Sports Medicine and Arthroscopic Surgery from Mississippi Sports Medicine and Orthopedic Clinic. He is a Chairman of Management Committees of both Black Hills Surgical Hospital and Black Hills Surgical Physicians. Dr. Papendick served as Team Physician for over twenty years at Chadron State University and led the development of a sports medicine program for the care of regional athletes. Dr. Papendick has also published several research articles.

James M. Porter is Vice-President, Operations of the Corporation, Medical Facilities America and Medical Facilities Holdings. Mr. Porter joined the Corporation on January 1, 2018. Mr. Porter is a healthcare executive with significant finance, transaction, business development, data analysis and operations experience. He was formerly with Community Health Systems, Inc. ("CHS") which he joined in 2012 as Director, Acquisitions and Development, ultimately reaching the position of Senior Director Finance, Ambulatory Surgery Centers ("ASC") responsible for leading the financial operations of CHS' ASC division. Before CHS, Mr. Porter was a Senior Manager, Transaction Advisory Services – Healthcare with Ernst & Young which he joined in 2002. Mr. Porter holds a Masters of Accountancy and Bachelors of Business Administration, Accounting from the University of Georgia in Athens, Georgia.

James D. Rolfe is Chief Development Officer of the Corporation, Medical Facilities America and Medical Facilities Holdings. Mr. Rolfe joined the Corporation in September 2016. Prior to that, Mr. Rolfe was Managing Director of Business Development and Transaction Advisory for one of the largest healthcare valuation and transaction advisory firms in the U.S. and worked with many large proprietary for-profit and not-for-profit health systems. Prior to this role, he was Vice-President of Acquisitions and Development for one of the largest publicly-traded healthcare systems in the United States. He has been involved in over 45 transactions totaling $2.5 billion. These transactions include the acquisition/divestiture of acute care hospitals, outpatient facilities, and physician practices as well as physician joint ventures in hospitals and outpatient facilities. In total he has over 25 years of experience in the financial services and healthcare sectors and holds a BBA from the University of Mississippi.

Reza Shahim, M.D. is a neurosurgeon specializing in all aspects of neurosurgical care and minimally invasive spine surgery. Dr. Shahim practices at Neurological Surgery Associates and Arkansas Surgical Hospital, where he also serves on the Board of Managers. Dr. Shahim is board certified by the American Board of Neurological Surgery and is a member of the Pulaski County Medical Society. He received his Medical Degree in 1995 from the University of Arkansas for Medical Sciences and acquired his Neurosurgical Training at the University of Kentucky Medical Center in Lexington, Kentucky.

Management of the MFC Partnerships

Each MFC Partnership (other than UMASH and MFC Nueterra ASCs) is governed by its Partnership Agreement. The management committee for each MFC Partnership is comprised of individuals appointed by the management committee of the applicable Subco or Holdco and one representative of Medical Facilities Holdings (except for DPSC as Medical Facilities Holdings' rights under the DPSC Partnership Agreement terminated in connection with the DPSC Transaction). Each MFC Partnership's business and affairs are managed by its management committee, subject to the terms of its governing Partnership Agreement. The terms of the Partnership Agreements provide that certain matters will be subject to the approval of Medical Facilities Holdings' board of directors, including any reduction in distributions, certain budgeting matters, material deviations from budget and specified fundamental transactions.

UMASH and PAM are each governed by its operating agreement. The board of managers of each of UMASH and PAM is comprised of six persons, four of whom are appointed by PAM (in the case of UMASH) and Medical Facilities Holdings (in the case of PAM) and two of whom are appointed by the other members. Through its majority ownership of PAM, the PAM appointees to the UMASH board are ultimately determined by Medical Facilities Holdings. The board of managers of UMASH and PAM have the authority to manage UMASH and PAM, subject to certain decisions that require unanimous approval of the board and thus are limitations on Medical Facilities Holdings' authority, as outlined above.

MFC Nueterra ASCs are each governed by their respective MFC Nueterra ASC Operating Agreements, as well as a management services agreement between MFC Nueterra Partnership Holding Company and corresponding MFC Nueterra ASC subsidiary. Each Nueterra ASC is governed by a board of directors, the majority of which in each case is appointed by the MFC Nueterra Partnership Holding Company, which is wholly-owned by MFC Nueterra Partnership. A majority of directors is generally required to implement a decision of the board.

Furthermore, pursuant to the MFC Nueterra Partnership MSA, the Nueterra Manager provides managerial services to the MFC Nueterra ASCs on behalf of each MFC Nueterra Partnership Holding Company as each MFC Nueterra Partnership Holding Company is required to do pursuant to site-specific management agreements or the applicable MFC Nueterra ASC Operating Agreement.

Shareholdings of Directors and Officers

The directors and executive officers of the Corporation, Medical Facilities America, Medical Facilities Holdings and Medical Facilities IMD Holdings hold, either directly or indirectly through their ownership of Exchangeable Interests, approximately 447,336 Common Shares in the aggregate (1.1% of all Common Shares on a fully diluted basis, which includes the number of Common Shares issued and outstanding as of December 31, 2017, the number of Common Shares underlying the stock options granted to the executive officers of the Corporation as of December 31, 2017, the number of Common Shares issuable if all of the outstanding Debentures were converted into Common Shares prior to the Debenture Maturity Date, and the number of Common Shares potentially issuable for the Exchangeable Interests).

The stated number of Common Shares owned, directly or indirectly or under the control of a director or an executive officer, including by associates or affiliates, has been furnished by the respective directors and executive officers as at December 31, 2017.

Insurance Coverage for the Corporation and Related Entities and Indemnification

The Corporation has obtained policies of liability insurance for the directors and officers of the Corporation and its direct and indirect subsidiaries. The aggregate limit of liability applicable to the insured directors and officers under the policies is $65 million including defence costs. Under the policies, each entity has reimbursement coverage to the extent that it has indemnified its directors and officers. The policies include securities claims coverage, insuring against any legal obligation to pay on account of any securities claims brought against the Corporation and its direct and indirect subsidiaries. The aggregate limit of liability is shared among the Corporation and its direct and indirect subsidiaries and any of their respective directors and officers so that the limit of liability is not exclusive to either of the entities or their respective directors and officers.

The by-laws of the Corporation and its direct and indirect subsidiaries and the Partnership Agreements for each MFC Partnership provide for the indemnification of their respective directors, managers and officers from and against liability and costs in respect of any action or suit brought against them in connection with the execution of their duties or office, subject to certain limitations.

Long-Term Incentive Plans

Restricted Share Unit Plan

The board of directors of the Corporation has adopted a Restricted Share Unit Plan (the "**RSU Plan**") for key employees (as defined in the RSU Plan). The purpose of the RSU Plan is to (i) reward key employees of the Corporation for the creation of economic value for the shareholders of the Corporation, (ii) align the interests of key

employees of the Corporation with those of the Corporation's shareholders, and (iii) provide key employees of the Corporation with total compensation which is competitive with that of similar positions in markets where the Corporation competes for managerial and professional talent.

Eligibility

Key employees are eligible to participate in the RSU Plan ("**Eligible Participants**"). The CGNC Committee may from time to time determine the number of restricted share units (the "**RSUs**") to be granted to Eligible Participants, or it may also delegate to management of the Corporation such determination and the allocation of RSUs among Eligible Participants. The CGNC Committee has discretion to establish at the time of each grant, within the restrictions set forth in the RSU Plan, the date of grant, the vesting date, the minimum level of performance which must be attained over a specific time period, as an additional condition for the vesting of the RSUs, and other particulars applicable to awards granted thereunder.

Assignability

Rights and privileges granted under the RSU Plan are non-assignable and non-transferable, in whole or in part, either directly or by operation of law otherwise than by will or pursuant to the laws of succession.

Vesting

RSUs granted to an Eligible Participant (an "**Award**") will vest three years following the date on which such RSUs are granted, or on such earlier date or series of earlier dates, as may be determined by the CGNC Committee and specified in the award letter (as defined in the RSU Plan). In no case will the vesting date of an Award occur more than three years after the date such Award is granted. RSUs vesting incrementally over three years will be administered as if each increment were a distinct, smaller Award with its own vesting date.

The RSU Plan provides that Awards will vest before their vesting date or expire, as the case may be, in several circumstances. Awards will vest in the case of death, retirement, resignation due to long-term disability, or termination without cause in the event of a change of control. Awards will expire on voluntary termination of employment, or termination for cause. In the case of death of a RSU holder or termination of a RSU holder's employment without cause, the RSU holder (or his or her legal representative, as applicable) will be entitled to receive cash settlements based on a pro-rated vesting calculation as specified in the RSU Plan.

Cash Settlement

Unless an Award has expired prior to the vesting date, and subject to certain provisions in the RSU Plan, the Corporation will settle an Award as reasonably promptly as possible following the end of the vesting period of such Award by paying to the RSU holder (or, if deceased, his or her legal representative) an amount in cash equal to: (i) the number of RSUs forming part of the vested Award, adjusted pursuant to the RSU Plan, multiplied by (ii) the weighted average trading price per common share of the Corporation on the Toronto Stock Exchange for the five days preceding the date on which an RSU is vested. The RSU Plan is non-dilutive and will not rely upon Common Shares from treasury, nor are there any corresponding Common Shares reserved in treasury for purposes of the RSU Plan.

Amendment

The CGNC Committee may amend, suspend or terminate the RSU Plan in whole or in part at any time and from time to time, provided no such amendment, suspension or termination impairs the rights of any RSU holder accrued to the date of the amendment, suspension or termination without the consent or deemed consent of the RSU holder.

2018 Changes

Effective 2018, annual RSU grants will be replaced by annual performance share unit grants under the Corporation's Performance Share Unit Plan ("PSU Plan"), which the board of directors adopted in March 2018. The objectives and the terms of the PSU Plan are the same as those of the RSU Plan, but performance share units have an

added feature of vesting being conditional on corporate performance against targets over a three-year period. The RSU Plan will remain in force for the RSUs which were previously granted under the RSU Plan or any ad-hoc RSU grants.

Stock Option Plan

The board of directors of the Corporation has adopted a Stock Option Plan (the "**Stock Option Plan**") which received shareholder and regulatory approval in May 2017. The purposes of the Stock Option Plan are to (i) reward key employees (as defined in the Stock Option Plan) of the Corporation for the creation of economic value for the shareholders; (ii) align the interests of key employees of the Corporation with those of the shareholders; and (iii) provide key employees of the Corporation with total compensation which is competitive with that of similar positions in markets where the Corporation competes for managerial and professional talent. The Corporation makes grants of options under the Stock Option Plan only upon the initial engagement of key employees and not as an element of regular or ongoing compensation.

Eligibility

Employees of the Corporation who contribute significantly to the financial success of the Corporation are eligible to voluntarily participate in the Stock Option Plan (for greater certainty, non-employee directors are not eligible to participate). The CGNC Committee is generally responsible for administering the Stock Option Plan and the board of directors will make the final determination, at its discretion, as to who is eligible to receive options under the Stock Option Plan.

Assignability

Options granted pursuant to the Stock Option Plan, or any right in respect thereof, may not be assigned or transferred, other than by will or pursuant to the laws of succession. Options may not be exercised by anyone other than the person to whom an option has been granted pursuant to the Stock Option Plan (the "**Optionee**").

Shares Offered

The total number of authorized and unissued Common Shares of the Corporation available for options under the Stock Option Plan is equal to 3,100,000.

The Stock Option Plan provides that any one individual cannot receive options under the Stock Option Plan which will entitle such individual to receive more than 5% of the number of Common Shares issued and outstanding. Common Shares in respect of which options are granted but not exercised prior to the termination of such options due to the expiration, termination or lapse of such options or otherwise, are to be available for new grants of options pursuant to the provisions of the Stock Option Plan.

Exercise Price

The exercise price for an option granted pursuant to the Stock Option Plan will be determined by the board of directors and may not be less than the volume weighted average trading price per common share of the Corporation on the Toronto Stock Exchange for the five days preceding the date on which the option is granted.

Vesting

Unless otherwise determined by the board of directors, options granted pursuant to the Stock Option Plan will be subject to the vesting schedule specified in the option agreement (the "**Option Agreement**") between the Corporation and the Optionee. The vesting schedule in the Option Agreement will be determined by the board of directors in order to fulfil the purposes of the Stock Option Plan. The board of directors expects that options will typically vest after five years of employment subject to certain early vesting triggers.

Term

Unless otherwise provided in the Stock Option Plan or the Option Agreement, each option may be exercised only during the period commencing as per the vesting schedule specified in the Option Agreement and expiring on the last day of the tenth year following the date on which the option is granted (the "**Option Period**"). If the Option Period expires during a period self-imposed by the Corporation during which directors, officers and certain employees of the Corporation shall not trade the securities of the Corporation (a "**Blackout Period**"), the expiry of the Option Period shall be extended for ten business days after the end of the Blackout Period.

Cessation

Leaves, Retirement or Permanent Long-Term Disability

If an Optionee, before the expiration of the Option Period: (i) is granted authorized leave of absence for sickness or other reasons; (ii) becomes a retiree (as defined in the Stock Option Plan); or (iii) voluntarily terminates his or her employment as a result of permanent Long-Term Disability (as defined in the Stock Option Plan), the Optionee will be entitled to exercise his or her options in accordance with the regular vesting and exercise schedule.

Death

If an Optionee dies before the expiration of the Option Period, his or her legal representatives will be entitled to exercise his or her vested options within a period of one year following such death. A pro-rata amount of the unvested options will vest as of the date of death based upon the length of time between the grant date and death as a percentage of the length of time between the grant date and the vesting date of the options.

Termination of Employment or Resignation

Except as described above or otherwise provided in the Option Agreement or an employment agreement in respect of options granted prior to the effective date of the Stock Option Plan, if an Optionee's employment is terminated, or if an Optionee resigned from his or her employment with the Corporation, all of the Optionee's unvested options will expire effective on the date of such termination or resignation. The Optionee will have a period of 30 days from the date of such termination or resignation to exercise his or her unexercised vested options.

If an Optionee's employment is terminated without cause within twenty-four calendar months following a change of control, as defined in the Stock Option Plan: (i) each unexercised vested option held by the Optionee will remain exercisable for a period of twenty-four calendar months from the date of termination, but not later than the end of the Option Period; and (ii) each unvested option then held by the Optionee will become exercisable upon such termination and will remain exercisable for a period of twenty-four calendar months from the date of termination, but not later than the end of the Option Period.

Competing Activities

The rights of an Optionee (or his or her legal representatives) with respect to his or her options in the event of retirement, permanent long-term disability, death, termination of employment or resignation are subject to the Stock Option Plan's provisions regarding competing activities.

The unexercised vested options of an Optionee will be forfeited and his or her unvested options will expire immediately, if: (i) during the Optionee's employment with the Corporation or at any time within the two-year period following the end of such employment, the Optionee, without the prior written consent of the Corporation: (a) engages in any activity that directly or indirectly competes with any business carried on by the Corporation; (b) directly or indirectly acts as a consultant to any other person, firm or corporation, who or which competes with any business carried on by the Corporation; or (c) engages in any other activity which is prejudicial to the interests of the Corporation; (ii) during the Optionee's employment with the Corporation or at any time thereafter, the Optionee discloses any confidential information, trade secrets, records, intellectual property or other private affairs of the Corporation to any person, without the prior written consent of the Corporation; or (iii) the Optionee's employment with the Corporation is terminated for cause (as defined in the Stock Option Plan).

Insider Participation Limit

The number of Common Shares issuable to insiders, at any time, and the number of Common Shares issued to insiders within any one-year period, in each case under the Stock Option Plan, or when combined with all of the Corporation's other security-based compensation arrangements, shall not exceed 10% of the issued Common Shares.

Amendment

The board of directors has the sole discretion, subject to receipt of requisite regulatory approval where required, to make the following amendments, without having to obtain shareholder approval. Such changes include, without limitation: (i) amendments of a "housekeeping" or clerical nature; (ii) amendments clarifying any provision of the Stock Option Plan; (iii) a change to the vesting provisions of an option; (iv) a change to the termination provisions of an option which does not entail an extension beyond the original Option Period, as extended by the Blackout Extension Term (as defined in the Stock Option Plan), if applicable; (v) a change to the number of options granted to an Optionee and the options' exercise price, in the event of a declaration of a stock dividend or a subdivision, consolidation or reclassification, or other change or action affecting the Common Shares; and (vi) suspending or terminating the Stock Option Plan.

The Stock Option Plan provides that shareholder approval will be required in the case of: (i) any amendments to the number of Common Shares issuable under the Stock Option Plan subject to the terms of the Stock Option Plan; (ii) any change which would allow non-employee directors to participate in the Stock Option Plan; (iii) any amendment which would permit any option granted under the Stock Option Plan to be transferable or assignable other than by will or pursuant to the laws of succession; (iv) any reduction in the exercise price of an option after the option has been granted or any cancellation of an option and the substitution of that option by a new option with a reduced exercise price (other than in connection with a declaration of a stock dividend or a subdivision, consolidation or reclassification, or other change or action affecting the Common Shares); (v) any extension to the term of an option beyond the original Option Period, unless the term is being extended by the Blackout Extension Term (as defined in the Stock Option Plan); (vi) any increase to the insider participation limit referenced above subject to the terms of the Stock Option Plan; and (vii) any change to the Stock Option Plan's amendment provision other than amendments of a "housekeeping" or clerical nature or to clarify such provision.

AUDIT COMMITTEE AND AUDITORS' FEES

The Corporation established an audit committee comprised of four directors: Stephen Dineley (Chair), Marilynne Day-Linton, Irving Gerstein and Dale Lawr, each of whom is "independent" of the Corporation, and its direct and indirect subsidiaries, including the MFC Partnerships, and "financially literate" within the meaning of National Instrument 52-110, *Audit Committees*. The audit committee is responsible for oversight of the accounting and financial reporting practices and procedures of the Corporation, monitoring the adequacy of internal accounting controls and procedures and reviewing the quality and integrity of financial statements of the Corporation. The independent auditors of the Corporation report directly to the audit committee. In addition, the audit committee is responsible for reviewing and approving the auditors' examination and for recommending to the board of directors the selection of independent auditors of the Corporation. The charter of the audit committee is attached hereto as Appendix "A".

Relevant Education and Experience of Audit Committee Members

The following is a brief summary of the education and experience of each member of the audit committee that is relevant to the performance of his or her responsibilities as a member of the audit committee, including any education or experience that has provided the member with an understanding of the accounting principles used by the Corporation to prepare its annual and interim financial statements.

Audit Committee Member	Relevant Education and Experience
Stephen Dineley (Chair)	Mr. Dineley, FCPA, FCA is a retired partner with over 30 years of experience who specialized in assurance services at KPMG LLP. As an audit partner, Mr. Dineley mostly worked in the public company sphere and as such reported to audit committees for various clients on a quarterly basis. From 1998 to 1999, Mr. Dineley was chair of the audit committee of Gas Management Income Fund, and from 1998 to 2000, held

Audit Committee Member	Relevant Education and Experience
	the position of Chief Financial Officer at Extendicare Inc., one of the leaders in Canada's senior housing sector. Mr. Dineley also chairs the audit committee and governance committee of the Bank of New York Trust Company Canada.
Marilynne Day-Linton	Ms. Day-Linton is a Chartered Professional Accountant (CPA/CA). She has served on the Audit Committee of the Corporation since joining the board in 2013. She previously served as a chair of the audit committee of the Greater Toronto Airports Authority, a reporting issuer which operates Toronto Pearson International Airport. Ms. Day-Linton also has held several senior financial roles in industry and worked for KPMG LLP as an auditor with clients in several industries, including telecommunications, construction and hospitality.
Irving Gerstein	Mr. Gerstein is a member of the audit committees of two other public corporations, Atlantic Power Corporation (TSX:ATP; NYSE:AT) and Student Transportation Inc. (TSX:STB; NASDAQ:STB). These positions, in conjunction with his economics background and his previous experience as a director of several public corporations (as more fully described in the section entitled "Directors, Officers and Management – Directors and Officers of the Corporation and its Subsidiaries" on page 62 above) have enabled him to develop a strong understanding of accounting principles sufficient to ensure his financial literacy.
Dale Lawr	Ms. Lawr is a CPA, CA with executive experience in a broad range of organizations. Until March 2015, Ms. Lawr was Chief Risk Officer at Infrastructure Ontario, which she joined in 2011 as Chief Financial Officer. Ms. Lawr has also served as Chief Financial Officer of Altus Group Limited (TSX:AIF) and RTC Industries Inc., a retail design firm, Vice-President Finance of Frankel & Co., a national marketing services agency and a business unit of Publicis SA, and Senior Manager and Director of Finance for Accenture in the firm's Chicago and Toronto offices. Ms. Lawr also worked for Ernst & Young and Grant Thornton as an auditor with clients in several industries. Ms. Lawr chairs the finance, audit and risk committee for the Ontario Institute for Cancer Research.

Non-Audit Services

The Corporation's audit committee has adopted specific policies and procedures for the engagement of external auditors for all services, including non-audit services. The policies generally require audit committee approval for all such engagements.

External Auditors Service Fees

The table below provides greater disclosure of the services provided and fees earned by the Corporation's external auditors over the two most recently completed fiscal years, dividing the services into the three categories of work performed.

Type of Work	2017 Fees[1]			2016 Fees[1]	
Audit fees[2]	Cdn$	180,000	(i)	Cdn$	172,0000
	US$	296,500	(ii)	US$	283,550
	US$	17,700	(iii)	US$	17,700
	Cdn$	132,000	(iv)	Cdn$	132,000
	Cdn$	82,000	(v)	Cdn$	48,000
	US$	8,000	(vi)	US$	25,000
Tax fees[3]	Cdn$	45,000		Cdn$	70,000
Other fees[4]	Cdn$	6,375		Cdn$	28,850

(1) Fees shown are net of Canadian Public Accountability Board's participation fees, administrative surcharges, disbursements and harmonized sales tax.

(2) For the year ended December 31, 2017, audit fees billed for professional services rendered by the auditors: (i) for the audit of the Corporation's consolidated financial statements for the year ended December 31, 2017; (ii) for the audit of five MFC Partnerships for the

year ended December 31, 2017; (iii) for the review of an MFC Partnership for the year ended December 31, 2017; (iv) for the review of the interim consolidated financial statements of the Corporation for Q1, Q2 and Q3 2017; (v) for additional 2016 audit procedures in respect of entities acquired in 2016; and (vi) for additional audit procedures of MFC Partnerships for the year ended December 31, 2016.

(3) Tax fees billed for professional services rendered by the auditors for general tax compliance.

(4) Tax fees billed for professional services rendered by the auditors for general tax advice.

Audit Committee Oversight

At no time since the commencement of the Corporation's most recently completed financial year has a recommendation of the audit committee to nominate or compensate external auditors not been adopted by the board of directors of the Corporation.

RISK FACTORS

Risks Related to the Business and the Industry of the MFC Partnerships

Reliance on Third-Party Payors for Revenue and Profitability

The revenue and profitability of the MFC Partnerships depend heavily on payments from third-party payors, including government healthcare programs (Medicare and Medicaid) and managed care organizations. Payments from government and private insurance payors represent a significant portion of the revenues of the MFC Partnerships. If payments from these third-party payors were reduced or eliminated, the revenue and profitability of the MFC Partnerships may be adversely affected.

Details regarding some of the key third-party payors are described below.

Medicare and Medicaid Programs

Medicare and Medicaid are the commonly used names for reimbursement or payment programs governed by certain provisions of the United States federal *Social Security Act*. Medicare is an exclusively federal program, while Medicaid is a combined federal and state program. Medicare provides certain healthcare benefits primarily to beneficiaries who are 65 years of age or older. Medicaid is designed to provide certain healthcare benefits to low-income individuals.

Healthcare providers have been affected significantly by recent changes in healthcare laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to limit or reduce healthcare costs, particularly costs paid under the Medicare and Medicaid programs. Diverse and complex mechanisms to limit the amount of money paid to healthcare providers under both the Medicare and Medicaid programs have been enacted and have caused significant reductions in payments to healthcare providers from these programs including the MFC Partnerships. In addition, the United States Congress has reduced the level of reimbursement by Medicare to ASCs. In the future, the United States Congress may consider a reduction in payment to specialty hospitals for Medicare services. The efforts to reduce the costs of the Medicare and Medicaid programs are likely to continue, and there can be no assurance that such efforts will not adversely affect the financial condition of the MFC Partnerships.

Managed Care Plans/Third-Party Payors

Providers of managed care plans and third-party commercial health insurance plans generally seek to enter into agreements with healthcare providers which provide for discounts and other economic incentives to reduce or limit the cost and utilization of the healthcare services which are paid for under those plans. As a result, payments to healthcare providers from managed care plans and third-party commercial health insurance plans typically are lower than billed charges from the provider.

Each of the MFC Hospitals has entered into a number of contracts with managed care providers and third-party commercial health insurance plans. There can be no assurance that the MFC Hospitals will maintain their current contracts or obtain other similar contracts in the future. In addition, Management expects that managed care

providers and third-party commercial health insurance plans will continue to focus on cost containment measures and this could have a negative impact on the revenues and profitability of the MFC Hospitals in the future.

Licensing, Certification and Accreditation Requirements

Healthcare facilities, such as the MFC Facilities, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements imposed by Medicare, Medicaid, state licensing authorities and private payors. Receipt and renewal of such licenses, certifications and accreditations are often based on inspections, surveys, audits, investigations or other reviews, some of which may require affirmative compliance actions by the MFC Partnerships that could be burdensome and expensive.

Management believes that the MFC Partnerships are currently in material compliance with all applicable licensing, certification and accreditation requirements. The applicable standards may change in the future and there can be no assurance that the MFC Partnerships will be able to maintain all necessary licenses or certifications or that they will not be required to incur substantial costs in doing so. The failure to maintain all necessary licenses, certifications and accreditations, or the requirement to incur substantial costs to maintain them, could have a material adverse effect on the business of the MFC Partnerships.

In addition, in order to perform medical procedures in the states where MFC Facilities operate, physicians must be licensed by the applicable state board of medical and osteopathic examiners. There can be no assurance that any particular physician that has medical staff privileges at the MFC Facilities will not have their license suspended or revoked by the applicable state board of medical and osteopathic examiners. If such a license is suspended or revoked, the physician will not be able to perform surgical procedures at the MFC Facilities which may have a material adverse impact on the operations and business of that MFC Partnerships.

Regulatory Requirements

The regulatory requirements of the MFC Facilities are fundamental to the operation of the hospitals and financial performance of the MFC Partnerships.

There are a number of United States federal and state regulatory initiatives which specifically apply to healthcare providers, including the MFC Partnerships. Among the most significant are:

- the federal Anti-Kickback Statute;
- the federal Stark Law;
- the PPACA;
- the *False Claims Act*; and
- the federal rules relating to management and protection of patient records and patient confidentiality.

Investors are encouraged to read this Annual Information Form's detailed description of the requirements of the Anti-Kickback Statute, the Stark Law, the PPACA and the rules relating to patient records and confidentiality as well as the detailed discussion in the section entitled "Description of the Business – Regulation" beginning on page 27 above.

While Management believes the MFC Partnerships are currently in compliance with the requirements of these regulatory initiatives and expects such compliance will continue in the future, there can be no assurance that the MFC Partnerships will not violate the requirements of one or more of these laws or that they will not have to expend significant amounts to ensure compliance or to defend allegations of non-compliance. A violation of these requirements could subject the MFC Partnerships to criminal or civil penalties and/or exclusion from future participation in programs such as Medicare or Medicaid. Any of these outcomes could have a material adverse impact on the business of the MFC Partnerships.

In addition to the regulatory initiatives described above, healthcare facilities, including the MFC Hospitals and MFC Surgical Centers, are subject to a wide variety of federal, state, and local environmental and occupational health and safety laws and regulations that affect their operations, facilities, and properties. Violations of these laws could subject the MFC Partnerships to liability for investigating and remedying any contamination by hazardous substances, as well as civil or other damages and penalties. Typical hospital operations include the handling, use, storage, transportation, disposal and discharge of hazardous, infectious, toxic, radioactive, flammable, and other hazardous materials, wastes, pollutants, or contaminants. Although Management believes the MFC Partnerships are currently in material compliance with all applicable environmental laws and regulations, and expects such compliance will continue in the future, there can be no assurance that the MFC Partnerships will not violate the requirements of one or more of these laws or that it will not have to expend significant amounts to ensure compliance. A violation of these requirements could have a material adverse impact on the business of the MFC Partnerships.

Dependence on Physician Relationships

The success of each MFC Partnership depends, in part, on the ability of that MFC Partnership to attract surgeons and other physicians in the MFC Partnership's service area to perform surgical procedures at the MFC Facility. Although the MFC Partnerships have had success in attracting surgeons and other physicians in the past, there can be no assurance that such success will continue in the future. In addition, there can be no assurance that physician groups performing procedures at the MFC Facilities will maintain successful medical practices or that one or more key members of a particular physician group will continue practicing with that group or that the members of that group will continue to perform procedures at the MFC Facilities at current levels, or at all.

Lack of Diversification in the Business of the Corporation and the MFC Partnerships

The only business of the MFC Partnerships is the operation of the five MFC Hospitals and eight MFC Surgical Centers. The MFC Partnerships and the Corporation are, therefore, dependent upon the success of these thirteen facilities. Investors will not have the benefit of any further diversification of operations or risk.

Litigation, Professional Liability Claims and Availability of Insurance

The MFC Partnerships are, from time to time, subject to litigation claims in the ordinary course of their business. In particular, the MFC Partnerships can be subject to claims relating to actions of medical personnel performing services at the MFC Partnerships. Historically, the MFC Partnerships have been able to obtain what Management believes is adequate insurance to cover these risks. However, the cost of this insurance is increasing and there can be no assurance that the MFC Partnerships will be able to obtain adequate insurance in the future on economically reasonable terms, or at all. If the insurance which the MFC Partnerships have in place from time to time is not sufficient to cover claims which are made, the resulting shortfall could have a material adverse impact on the business and operations of the MFC Partnerships.

Access to Capital Resources for Expansion of Facilities

The growth strategy of the MFC Partnerships includes expanding the procedures offered by each MFC Facility and increasing capacity available for use at the MFC Facilities. Any such expansions will require additional capital which may be funded through additional debt or equity financings. To the extent that financing is raised through the issuance of Common Shares or other securities of the Corporation, current holders of Common Shares may experience ownership dilution. To the extent debt is incurred, either the Corporation or the MFC Partnerships may incur significant interest expense and may be subject to covenants in the related debt agreements that affect the conduct of business. Without sufficient capital resources to implement this strategy, the MFC Partnerships' future growth could be limited and operations impaired. There can be no assurance that additional financing will be available to fund this growth strategy or that, if available, the financing will be on terms that are acceptable to the MFC Partnerships and the Corporation.

Regulations Affecting Expansion of Facilities

In some states, prior regulatory approval is required for the expansion of healthcare facilities or the services those facilities offer. In granting such approvals, regulators may consider, among other things, the need for additional or expanded healthcare facilities or services in the local area.

If the MFC Partnerships are unable to obtain required approvals, they may not be able to expand current facilities or expand the breadth of services offered. This could have a material adverse impact on the growth strategy and the business of the MFC Partnerships.

The PPACA also places significant restrictions on expansion. Refer to the discussion of PPACA in the section entitled "Description of the Business – Regulation" beginning on page 27 above.

Competition from Other Healthcare Providers

The healthcare business is highly competitive. The MFC Partnerships compete with other healthcare providers (primarily traditional hospitals, specialty surgical hospitals and ASCs) in recruiting physicians to utilize their facilities and in contracting with managed care payors in each of their markets. Some of the competing facilities have long-standing and well-established relationships with physicians and third-party payors. Some are also significantly larger than the MFC Partnerships and have access to more marketing and other resources than are available to the MFC Partnerships. In addition, other healthcare facilities may not allow physicians who are on the medical staff of the MFC Partnerships to have medical privileges at their facilities. This restriction on a physician's practice may cause physicians to not seek medical staff privileges at the MFC Partnerships and may restrict the MFC Partnerships' ability to attract new or additional doctors to practice at their facilities.

If the MFC Partnerships are unable to compete effectively with these entities to recruit new physicians or enter into arrangements with managed care payors, the ability of the MFC Partnerships to implement their growth strategies successfully could be adversely affected.

Cyber Security Incidents

As providers of healthcare services, information technology is a critical component of the day-to-day operation of the MFC Partnerships. The MFC Partnerships rely on information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information, and proprietary and confidential business performance data. The MFC Partnerships utilize electronic health records and other health information technology, along with additional technology systems, in connection with their operations, including for, among other things, billing and supply chain and labor management. As described in the section entitled "Description of the Business – Regulation" beginning on page 27 above, MFC Partnerships are subject to compliance with HITECH. As such, MFC Partnerships have privacy and security processes in place to protect sensitive health and business information. The systems used by the MFC Partnerships, in turn, interface with and rely on third-party systems. Additionally, HITECH requires third-party vendors (business associates) of MFC Partnerships to comply with the same privacy and security measures whenever the sensitive information is stored or transmitted. Incident response policies and processes are in place at MFC Partnerships that provide for prompt identification and management of security incidents to facilitate maintenance and/or restoration of business continuity. The Corporation is not aware of the MFC Partnerships having experienced a material breach of cyber security.

The preventive actions taken to reduce the risk of such incidents and protect information technology may not be sufficient in the future. As cyber security threats continue to evolve, the MFC Partnerships may not be able to anticipate certain attack methods in order to implement effective protective measures, and may be required to expend significant additional resources to continue to modify and strengthen security measures, investigate and remediate any vulnerabilities in information systems and infrastructure, or invest in new technology designed to mitigate security risks. Third parties to whom the MFC Partnerships outsource certain functions, or with whom their systems interface, are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting a third-party service provider or partner could harm the Corporation's business even if the Corporation does not control the service that is attacked. Further, successful cyber-attacks at other healthcare services companies, whether or not the Corporation is impacted, could lead to a

general loss of customer confidence in the industry that could negatively affect the Corporation, including harming the market perception of the effectiveness of the MFC Partnerships' security measures or of the healthcare industry in general, which could result in reduced use of the MFC Partnerships' services. Although the Corporation and MFC Partnerships have insurance against some cyber risks and attacks, it may not be sufficient to offset the impact of a material loss event. Any cyber security breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact the ability of the MFC Partnerships to conduct normal business operations (including the collection of revenues), and could result in potential liability under privacy, security, consumer protection or other applicable laws, regulatory penalties, negative publicity and damage to the Corporation's reputation, any of which could have a material adverse effect on the Corporation's business, financial position, results of operations or cash flows.

Other Risk Factors

In addition to the foregoing risk factors, the following additional risk factors may affect the operations of the MFC Partnerships.

- The MFC Partnerships are employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary and other types of workers in a single operation. As with other employers, the MFC Partnerships bear a wide variety of risks in connection with their employees. These risks include work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance, and such risks, alone or in combination, could have material adverse consequences to the financial condition or operations of the MFC Partnerships.

- Certain key physicians at the MFC Facilities are not investors and, as a result, are not subject to the non-competition and non-solicitation agreements described above.

- The occurrences of natural disasters may damage some or all of the MFC Facilities, interrupt utility service to some or all of the MFC Facilities or otherwise impair the operation of some or all of the MFC Facilities operated by the MFC Partnerships or the generation of revenues from the MFC Facilities.

- Scientific and technological advances, new procedures, drugs, preventive medicine, occupational health and safety and outpatient healthcare delivery may reduce utilization and revenues of the MFC Partnerships. Technological advances in recent years have accelerated the trend toward the use by hospitals and surgical centers 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 utilization, but the ability of the MFC Facilities to offer the equipment or services may be subject to the availability of equipment or specialists, governmental approval or the ability to finance these acquisitions or operations.

- Reduced demand for the MFC Facilities' services that might result from decreases in population in the service areas of the MFC Facilities.

- The United States has from time to time experienced a severe shortage of nursing staff. The failure of the MFC Facilities to hire and retain qualified personnel could have a material adverse impact on the operations and business of the MFC Facilities.

- Increased unemployment or other adverse economic conditions in the MFC Facilities' service areas may impact the volume of services performed, cause shifts to payors with lower reimbursements (e.g., Medicare) and/or result in higher uncollectible accounts.

Risks Related to the Structure of the Corporation

The Corporation is Dependent on the MFC Partnerships for all Cash Available for Distribution

The Corporation is dependent on the operations and assets of the MFC Partnerships through its indirect ownership of between 40.14% and 65.00% of those partnerships. Dividends to holders of Common Shares are dependent on the ability of Medical Facilities America to make distributions to the Corporation, which in turn is dependent on the ability of Medical Facilities Holdings to make distributions to Medical Facilities America, which in turn is dependent on the ability of the MFC Partnerships to make distributions to Medical Facilities Holdings. The actual amount of cash available for distribution to holders of Common Shares will depend on numerous factors relating to each of the MFC Partnerships, including profitability, changes in revenues, fluctuations in working capital, the sustainability of operating income margins, capital expenditure levels, applicable laws and contractual restrictions contained in the instruments governing any indebtedness. Any reduction in the amount of cash available for distribution, or actually distributed, by the MFC Partnerships or Medical Facilities Holdings or Medical Facilities America will reduce the amount of cash available for the Corporation to make dividend payments to holders of Common Shares. As a result, cash distributions by the Corporation are not guaranteed and will fluctuate with the performance of the MFC Partnerships.

Limited Controls

The Corporation has (subject to increase on the exchange of Exchangeable Interests) indirect interests between 40.14% and 65.00% in MFC Partnerships through its indirect subsidiary, Medical Facilities Holdings. Medical Facilities Holdings is a wholly-owned subsidiary of Medical Facilities America which exercises its control of each MFC Partnership through its contractual rights. However, except with respect to UMASH and MFC Nueterra ASCs, Medical Facilities Holdings has the right to appoint only one member to each MFC Partnership's management committee and, as such, except in the circumstances of a default and through the exercise of its contractual rights, it does not have the ability to direct day-to-day management of the MFC Partnerships.

Distribution of all Available Cash May Restrict Potential Growth of the MFC Partnerships and the Corporation

The payout by the MFC Partnerships of substantially all of their operating cash flow will make additional capital and operating expenditures dependent on increased cash flow or additional financing in the future. Lack of these funds could limit the future growth of each MFC Partnership and its cash flow. In addition, the Corporation may be precluded from pursuing otherwise attractive acquisitions because they may not be accretive to the Corporation on a short-term basis.

Future Distributions are not Guaranteed

The Corporation's, Medical Facilities America's, Medical Facilities Holdings', the MFC Partnerships' and PAM's boards of directors or managers, as applicable, may, in their respective discretion, amend or repeal their existing distribution policies. Future distributions from these entities, if any, will depend on, among other things, the results of operations, cash requirements, financial condition, contractual restrictions, business opportunities, provisions of applicable law and other factors that the boards of directors or managers, as applicable, may deem relevant. Any of these boards of directors or managers, as applicable, may decrease the level of distributions provided for in their existing distribution policies or entirely discontinue distributions.

Exchange Rate Fluctuations May Impact the Amount of Cash Available for Distribution by the Corporation

The Corporation's dividend payments to holders of Common Shares are denominated in Canadian dollars. Conversely, all of the MFC Partnerships' revenues and expenses, together with distributions received by the Corporation from Medical Facilities America, by Medical Facilities America from Medical Facilities Holdings and by Medical Facilities Holdings from the MFC Partnerships, are denominated in U.S. dollars. As a result, the Corporation is exposed to currency exchange rate risks.

Although the Corporation may enter into hedging arrangements to mitigate this exchange rate risk, there can be no assurance that these arrangements are sufficient to fully protect against this risk. If the hedging transactions do not fully protect against this risk, a change in the currency exchange rate between U.S. and Canadian

dollars could have a material adverse effect on the Corporation's ability to maintain a consistent level of distributions in Canadian dollars.

Substantial Indebtedness Could Negatively Impact the Business of the Corporation and the MFC Partnerships

The degree to which the Corporation is leveraged on a consolidated basis could have important consequences to the holders of the Common Shares, including:

- the Corporation's, Medical Facilities America's, Medical Facilities Holdings' and the MFC Partnerships' ability in the future to obtain additional financing for working capital, capital expenditures or other purposes may be limited;
- the Corporation or MFC Partnerships being unable to refinance indebtedness on terms acceptable to the Corporation or at all;
- a significant portion of the Corporation's cash flow (on a consolidated basis) from operations is likely to be dedicated to the payment of the principal of and interest on its indebtedness, thereby reducing funds available for future operations, capital expenditures and/or dividends on its Common Shares; and
- the MFC Partnerships may be vulnerable to economic downturns and be limited in their ability to withstand competitive pressures.

Restrictive Covenants in Credit Facilities Could Impact the Business of the Corporation and the MFC Partnerships

The credit facilities contain restrictive covenants that limit the discretion of the MFC Facility Management with respect to certain matters. The ability of the MFC Partnerships to make distributions will be subject to the restrictive covenants contained in each credit facility.

Future Issuances of Common Shares Could Result in Dilution

The Corporation's articles of incorporation authorize the issuance of an unlimited number of Common Shares for that consideration and on those terms and conditions as are established by the board of directors without the approval of any shareholders. Additional Common Shares may be issued by the Corporation pursuant to the conversion of Debentures, the exercise of stock options, Exchange Agreements or in connection with a future financing or acquisition by the Corporation. The issuance of additional Common Shares may dilute an investor's investment in the Corporation and reduce dividends per Common Share.

Limitations on Enforcement of Certain Civil Judgments by Canadian Investors

Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings and MFC Nueterra Partnership are organized under the laws of the State of Delaware and each MFC Partnership is formed under the laws of Arkansas, Indiana, Oklahoma, South Dakota or Delaware, as applicable. All of the assets of the MFC Partnerships are located outside of Canada and certain of the directors and officers are residents of the United States. As a result, it may be difficult or impossible for investors to effect service within Canada upon Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership, the MFC Partnerships or their directors and officers who are not residents of Canada or to realize against them in Canada upon judgments of courts of Canada predicated upon the civil liability provisions of applicable Canadian provincial securities laws.

Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership, and each MFC Partnership have been advised by counsel in the United States that there is some doubt as to the enforceability in the United States by a court in original actions, or in actions to enforce judgments of Canadian courts, of civil liabilities predicated upon such applicable Canadian provincial securities laws.

In addition, each MFC Original Partnership has agreed to indemnify the Corporation for breaches of representations and warranties given by them under the Investment Agreement. However, the indemnification

obligations are limited as described in the Investment Agreement (a copy of which may be found on SEDAR at www.sedar.com) and, accordingly, the Corporation may not be able to recover the full amount of any losses or damages suffered by it as a result of such breach to the detriment of the Corporation and ultimately holders of Common Shares of the Corporation. Further, the Corporation indirectly owns between 51.00% and 65.00% of MFC Original Partnerships which will further reduce any recovery. Finally, there can be no assurance that the MFC Original Partnerships will have sufficient assets to satisfy any indemnification liability.

Investment Eligibility and Canadian Federal Income Tax Risks

There can be no assurance that the Common Shares will continue to be qualified investments for trusts governed by registered retirement savings plans, registered retirement income funds, deferred profit sharing plans, registered education savings plans, tax-free savings accounts and registered disability savings plans under the Tax Act. The Tax Act imposes penalties for the acquisition or holding of non-qualified or ineligible investments.

The Corporation is Subject to Canadian Tax

As a Canadian corporation, the Corporation is generally subject to Canadian federal, provincial and other taxes. The Corporation is required to include in computing its taxable income the interest received by the Corporation on the Promissory Notes. Management expects that the Corporation's existing tax attributes will be available currently to offset this income inclusion such that it will not result in a current material liability for Canadian taxes. However, once the Corporation fully utilizes its existing tax attributes (or if, for any reason, these attributes were not available to the Corporation), the Corporation's Canadian tax liability would materially increase. Although Management intends to explore potential opportunities in the future to preserve the tax efficiency of the Corporation's structure, no assurances can be given that the Corporation's Canadian tax liability will not materially increase at that time.

There can be no assurance that Canadian federal income tax laws and Canada Revenue Agency administrative policies respecting the Canadian federal income tax consequences generally applicable to the Corporation or to a holder of Common Shares will not be changed in a manner which adversely affects holders of the Common Shares.

Certain U.S Federal Income Tax Issues

Medical Facilities America is subject to U.S. federal income tax on its income at regular corporate rates (21% as of January 1, 2018) and is also subject to certain U.S. state and local taxes. Medical Facilities America will claim interest deductions for the interest paid on the Promissory Notes in computing its taxable income for U.S. federal income tax purposes. To the extent this interest expense deduction is disallowed or is otherwise not deductible, the U.S. federal income tax liability of Medical Facilities America will increase, which could materially affect the after-tax cash available to distribute to the Corporation and therefore to holders of Common Shares. While the Corporation has received advice from an independent third party, based on certain representations by the Corporation and Medical Facilities America and determinations made by the Corporation's independent financial advisors, that the Promissory Notes should be treated as debt for U.S. federal income tax purposes, it is possible that the IRS could successfully challenge that position and assert that the Promissory Notes should be treated as equity rather than debt for U.S. federal income tax purposes.

The determination of whether the Promissory Notes are debt or equity for U.S. federal income tax purposes is based on an analysis of the facts and circumstances. There is no clear statutory definition of debt for U.S. federal income tax purposes, and historically its characterization has been governed by principles developed in case law, which analyzes numerous factors that are intended to identify the economic substance of the purported creditor's interest in the corporation. Not all courts have applied this analysis in the same manner, and some courts have placed more emphasis on certain factors than other courts have. In addition, on October 13, 2016, the IRS issued final and temporary regulations that address the treatment of certain related-party debt for U.S. federal income tax purposes. These regulations apply to certain debt instruments issued by domestic (i.e., U.S.) corporations, and could apply to the Promissory Notes if those instruments are modified or if new debt instruments are issued by Medical Facilities America. Moreover, subsequent changes in fact or subsequent actions or inactions by the Corporation or Medical Facilities America could impact this analysis or could be used by the IRS to call into question this analysis or the facts.

Alternatively, the IRS could argue that the interest on the Promissory Notes exceeds an arm's length rate, in which case only the portion of the interest expense that does not exceed an arm's length rate may be deductible and the remainder would be subject to U.S. withholding tax to the extent that Medical Facilities America had current or accumulated earnings and profits. The Corporation has received advice from independent financial advisors that the interest rates on the Promissory Notes are commercially reasonable in the circumstances. However, the advice received by the Corporation is not binding on the IRS.

Furthermore, pursuant to the U.S. federal tax law changes enacted on December 21, 2017, (Public law no. 115-97, more commonly known by the name of "*The Tax Cuts and Jobs Act*" or "**TCJA**"), Medical Facilities America's deductions attributable to the interest expense on the Promissory Notes (the interest paid by Medical Facilities America on all debt, including the Promissory Notes, less its interest income) will be limited to 30% of adjusted taxable income, which generally means earnings before interest, taxes, depreciation and amortization for the next four years (2018 – 2021), and earnings before interest and taxes thereafter (2022 and beyond). Any disallowed interest expense may currently be carried forward to future years. This limitation applies to newly issued loans as well as those originated before 2018. Furthermore, other limitations on the deductibility of interest under U.S. federal income tax laws, potentially including limitations applicable to certain high-yield debt obligations, could apply under certain circumstances to defer and/or eliminate all or a portion of the interest deduction that Medical Facilities America would otherwise be entitled to with respect to interest on such indebtedness.

A successful challenge of this position taken by Medical Facilities America with respect to interest deductibility would increase the U.S. federal income tax liability of Medical Facilities America for the applicable open tax years, which would affect the ability of Medical Facilities America to make interest and principal payments on the Promissory Notes and would reduce the amount of after-tax cash generated by Medical Facilities America that could otherwise be available to make distributions to the Corporation. In addition, payments of interest would be re-characterized as non-deductible equity distributions and would be subject to U.S. withholding tax to the extent Medical Facilities America had current or accumulated earnings and profits.

It should be noted that the sweeping changes in the TJCA have other elements that may be beneficial to Medical Facilities America, but there are provisions that may be adverse to Medical Facilities America. The extent to which these changes will result in a net benefit or detriment to Medical Facilities America is uncertain at this time, however, due to the newness of the legislation and the need for significant further guidance from the U.S. Treasury and the IRS. There may also be changes made legislatively to the provisions of the TCJA to correct technical defects in the law.

United States Investment Company Act of 1940

While the Corporation believes that through its subsidiaries and affiliates it is actively engaged in operating businesses and does not meet the definition of an investment company for purposes of the *United States Investment Company Act* of 1940 (the "**1940 Act**"), depending on the composition and valuation of the Corporation's assets and the sources of the Corporation's income from time to time, the Corporation could fall within the technical definition of the term "investment company" in the 1940 Act. Moreover, the determination of whether a company like the Corporation is an investment company involves complex analysis of regulations and facts, and the Corporation has not sought and does not anticipate seeking confirmation from the Securities and Exchange Commission (the "**SEC**") that it agrees with the Corporation's analysis. If the SEC were to disagree with the Corporation's analysis or the Corporation otherwise were to determine that it is an investment company as defined in the 1940 Act, the Corporation may, among other steps, prudently acquire or sell assets in order to avoid remaining an "investment company" as defined under the 1940 Act. Such acquisitions or sales could be on terms other than those on which it would otherwise acquire or sell such assets or the timing of such transactions could be disadvantageous to the Corporation. If the Corporation were unable to avoid being an investment company and were therefore required to register as such under the 1940 Act, the Corporation would become subject to substantial regulation with respect to its capital structure (including its ability to use leverage), management, operations, transactions with affiliated persons, portfolio composition (including restrictions with respect to diversification), and other matters.

Corporation May Not be Able to Make all Principal Payments on the Debentures

The Debentures will mature on December 31, 2019. The Corporation may not be able to refinance the principal amounts of the Debentures in order to repay the principal outstanding or may not have generated enough

cash from operations to meet these obligations. There is no guarantee that the Corporation will be able to repay the outstanding principal amounts upon maturity of the Debentures.

As a result of the subordinated nature of the Debentures provided by the Corporation, upon any distribution to creditors of the Corporation or the MFC Partnerships in a bankruptcy, liquidation or reorganization or similar proceeding relating to the MFC Partnerships or their property or assets, the holders of such entities' senior indebtedness will be entitled to be paid in full in cash before any payment may be made with respect to the Debentures. There may not be sufficient funds to pay all of the Corporation's and MFC Partnerships' secured creditors and the holders of the Debentures and such holders may, in such circumstances, receive less, rateably than the holders of senior indebtedness.

On a consolidated basis as of December 31, 2017, the Debentures would have ranked subordinate to $112.8 million of outstanding senior indebtedness, on a consolidated basis, all of which would have been secured.

The Non-Solicitation and Non-Competition Agreements of the Existing Partners May Not be Enforceable

Each Subco, Holding Entity and member of each Holding Entity has entered into a non-solicitation and non-competition agreement in favour of the Corporation, Medical Facilities Holdings or its predecessor and Medical Facilities America, as applicable. The non-solicitation and non-competition agreements may not be enforceable under South Dakota law. As a general rule under South Dakota law, non-solicitation and non-competition agreements are not enforceable, unless the agreement fits within a statutory exception, which statutory exceptions are narrowly construed. The Corporation cannot provide any assurance that these agreements will be enforceable and, if they are not enforceable, the Existing Partners could own and operate alternative surgical facilities in the markets where the MFC Partnerships are located which may materially adversely affect the operations and business of the MFC Partnerships.

The Market Price for the Common Shares or Debentures May be Volatile

The market price for Common Shares or Debentures may be subject to general volatility. Factors such as variations in the Corporation's financial results, announcements by the Corporation, the MFC Partnerships or others, developments affecting the business and customers, general interest rate levels, the market price of the Common Shares and general market volatility could cause the market price of the Common Shares or the Debentures to fluctuate significantly.

In addition, future sales or the availability for sale of substantial amounts of Common Shares or a significant principal amount of Debentures in the public market could adversely affect the prevailing market price of the Common Shares and/or the Debentures and could impair the Corporation's ability to raise capital through future sales of its securities.

MARKET FOR SECURITIES

The Common Shares are listed and posted for trading on the TSX under the ticker symbol "DR".

The monthly price ranges and volumes of trading of the outstanding Common Shares as reported by the TSX over the 2017 fiscal year are set forth in the following table:

Period	High	Low	Volume
2017	**$**	**$**	
January	19.81	17.48	92,386
February	19.47	18.10	57,957
March	19.90	17.80	89,092
April	18.96	16.00	142,591
May	17.15	15.96	95,461
June	16.65	14.23	127,872

Period	High	Low	Volume
2017	**$**	**$**	
July	14.64	12.80	99,628
August	15.59	11.14	211,366
September	15.96	14.63	106,339
October	15.94	13.26	136,975
November	13.99	12.30	221,113
December	14.24	12.50	117,703

The Debentures are listed and posted for trading on the TSX under the ticker symbol “DR.DB.A”.

The monthly price ranges and volumes of the Debentures on the TSX over the 2017 fiscal year are set forth in the following table:

Period	High	Low	Volume
2017	**$**	**$**	
January	108.00	104.50	1,399
February	108.95	106.01	167
March	109.00	104.50	626
April	106.00	102.00	293
May	104.00	102.75	261
June	103.00	100.00	739
July	102.51	101.66	600
August	103.24	101.25	294
September	103.00	101.85	266
October	102.50	100.49	317
November	102.00	101.00	254
December	101.75	100.50	586

There were no securities of the Corporation that were issued during the most recently completed fiscal year.

INTEREST OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS

To the knowledge of the Corporation, except as may be described elsewhere in this Annual Information Form, no director, manager or executive officer of the Corporation or any of its subsidiaries, no person or company that is the direct or indirect beneficial owner of, or who exercises control or direction over, more than 10% of any class or series of the outstanding voting securities of the Corporation and no associate or affiliate of any of the foregoing persons or companies, has or has had any material interest, direct or indirect, in any material transaction that has materially affected or will materially affect the Corporation since the closing of the IPO on March 29, 2004.

TRANSFER AGENT AND REGISTRAR

The transfer agent and registrar for the Common Shares and Debentures is Computershare Investor Services Inc. located in Vancouver, British Columbia (Common Shares) and Toronto, Ontario (Debentures).

MATERIAL CONTRACTS

The only material contracts, other than contracts entered into in the ordinary course of business, to which the Corporation, Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership or the MFC Partnerships are a party as at December 31, 2017 (which material contracts are described herein and available for review on SEDAR at www.sedar.com) are the following:

- Original Exchange Agreement;
- OSH Exchange Agreement;
- ASH Exchange Agreement;
- Subco and Holdco Operating Agreements;
- Non-Solicitation and Non-Competition Agreements;
- Partnership Agreements;
- Debenture Indenture related to Debentures;
- Management Agreement;
- Second Amended and Restated Credit Agreement in respect of Credit Facility;
- Asset Purchase Agreement and Amendment to Asset Purchase Agreement in respect of DPSC Transaction;
- UMASH and PAM Operating Agreements;
- Purchase Agreement in respect of UMASH;
- Purchase Agreement in respect of the UMASH real estate;
- Purchase Agreement and Amendment to Purchase Agreement in respect of MFC Nueterra ASCs;
- MFC Nueterra Partnership Operating Agreement and first amendment to MFC Nueterra Partnership Operating Agreement; and
- MFC Nueterra Partnership Management Services Agreement.

LEGAL PROCEEDINGS

In the ordinary course of business, the Corporation, Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership and each MFC Partnership may, from time to time, be subject to various pending and threatened lawsuits in which claims for monetary damages are asserted. None of the Corporation, Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership, or the MFC Partnerships is involved in any legal proceedings which have a material effect on the Corporation. To the knowledge of Management, no legal proceedings of a material nature involving the Corporation, Medical Facilities America, Medical Facilities Holdings, Medical Facilities IMD Holdings, MFC Nueterra Partnership, or the MFC Partnerships have been pending or threatened by any individuals, entities or governmental authorities.

INTERESTS OF EXPERTS

The Corporation's auditors are KPMG LLP who have prepared the Independent Auditors' Report to Shareholders in respect of the Corporation's audited annual consolidated financial statements for the year ended December 31, 2017. KPMG LLP are independent of the Corporation in accordance with the Rules of Professional Conduct/Code of Ethics of various institutes/orders.

ADDITIONAL INFORMATION

Additional information including directors' and officers' remuneration and indebtedness and the principal holders of the Corporation's securities, is contained in the Corporation's Management Information Circular dated March 31, 2017 relating to the annual meeting of shareholders of the Corporation held on May 11, 2017. Additional financial information is provided in the Corporation's financial statements and management's discussion and analysis of the Corporation's financial condition and results of operations for its most recently completed financial year. Copies of such documents and any additional information relating to the Corporation may be found on SEDAR at www.sedar.com or the Corporation's website at www.medicalfacilitiescorp.ca. In the alternative, copies may be obtained from the Chief Financial Officer upon written request.

SCHEDULE "A"

AUDIT COMMITTEE CHARTER

I. PURPOSE

1.1 The Audit Committee of Medical Facilities Corporation (the "**Corporation**") is appointed by the board of directors of the Corporation (the "**Board**") to assist the Board in its oversight of the Corporation's financial reporting process, including:

(a) The quality, objectivity and integrity of the financial reporting by the Corporation.

(b) The compliance by the Corporation with legal and regulatory requirements in respect of public financial disclosures.

(c) The qualifications, independence and performance of the Corporation's independent auditor.

(d) The integrity of the Corporation's financial reporting control processes and the performance of the Corporation's Chief Financial Officer on financial reporting matters.

(e) The review and approval of management's identification of principal financial risks and monitoring the processes which manage such risks.

1.2 The Audit Committee is to provide an avenue for free and open communication between the independent auditor, financial management, other employees and the Board concerning accounting and auditing matters.

1.3 The Audit Committee is directly responsible for the oversight of the relationship with the independent auditor, for recommending to the Board the nomination and compensation of the independent auditor and for the oversight of the performance and results of audit and audit related engagements.

1.4 The Audit Committee is not responsible for:

(a) Planning or conducting audits.

(b) Certifying or determining the completeness, fairness or accuracy of the Corporation's financial reporting or that the financial statements are in accordance with generally accepted accounting principles ("**GAAP**"). The fundamental responsibility for the Corporation's financial statements and financial disclosure rests with management.

(c) Guaranteeing the report of the Corporation's independent auditor.

(d) Conducting investigations, adjudicating disagreements (if any) between management and the independent auditor or ensuring compliance with applicable legal and regulatory requirements.

II. REPORTS

2.1 The Audit Committee shall report to the Board on a regular basis and, in any event, before the public disclosure by the Corporation of its quarterly and annual financial results. The reports of the Audit Committee shall include any issues of which the Audit Committee is aware with respect to the quality or integrity of the Corporation's financial statements, its compliance with legal or regulatory requirements, and the performance and independence of the Corporation's independent auditor.

2.2 The Audit Committee shall also approve, as required by applicable law, any Audit Committee report required for inclusion in the Corporation's publicly filed documents, including this mandate.

III. COMPOSITION

3.1 The members of the Audit Committee shall be three or more Board members who are appointed and may be removed by the Board on the recommendation of the Corporation's Corporate Governance, Nominating and Compensation Committee. The Chair of the Audit Committee shall be designated by the Board. Each member of the Audit Committee shall meet the independence and experience requirements of any directly relevant regulatory authority or stock exchange on which the Corporation is listed and, without limitation, shall be financially literate (or acquire such literacy within a reasonable period after appointment). A majority of the members of the Audit Committee shall be "resident Canadians", as contemplated by the *Business Corporations Act* (Ontario).

IV. RESPONSIBILITIES

4.1 **Independent Auditor**

The Audit Committee shall:

(a) Recommend to the Board the appointment of the independent auditor.

(b) Obtain confirmation from the independent auditor that it ultimately is accountable, and will report directly, to the Board.

(c) Review and approve the independent auditor's annual engagement letter and the proposals for related fees and review and discuss with the auditor the audit plans, the planned scope, areas of particular focus, materiality levels, the experience and qualifications of the senior members of the audit team and other matters of significance to the committee or auditor.

(d) Review all reports and recommendations from the independent auditor and help to resolve any disagreements between management and the independent auditor regarding financial reporting.

(e) Adopt policies and procedures for the pre-approval by the Audit Committee of the retention of the independent auditor by the Corporation and any of its subsidiaries for all audit and permitted non-audit services (subject to any regulatory restrictions on such services) including procedures for the delegation of authority to provide such approval to one or more members of the Audit Committee.

(f) At least annually, review the qualifications and independence of the independent auditor. In doing so, the Audit Committee should, among other things:

(i) review a report by the independent auditor describing: i) its internal quality-control procedures, ii) any material issues raised by recent firm-wide internal quality-control reviews, peer or professional body reviews of the independent auditor, iii) any material issues raised by any inquiry or investigation by governmental or professional authorities within the preceding five years respecting one or more independent audits carried out by the independent auditor, iv) any steps taken to deal with issues identified in ii) and iii) above, and v) all relationships between the independent auditor and the Corporation; and

(ii) review periodic reports from the independent auditor regarding its independence and actively discuss with the auditor whether there are any non-audit services or relationships that may affect the objectivity and independence of the independent auditor and, if so, recommend that the Board take appropriate action to satisfy itself of the independence of the independent auditor.

(g) Review and approve from time to time the Corporation's Enterprise Risk Framework ("**ERF**") and related policies that establish the appropriate approval levels for decisions and other measures to manage risk to which the Corporation is exposed; review the Corporation's risk profile and monitor the Corporation's major risks as set out in the ERF.

4.2 **Financial Statements and Related Financial Disclosures**

The Audit Committee shall, as it determines to be appropriate,:

(a) Review with management and, where appropriate, with the independent auditor:

(i) the Corporation's annual audited financial statements and quarterly financial statements and the Corporation's accompanying disclosure of management's discussion and analysis and, in advance of public disclosure, make recommendations to the Board as to their approval and publication;

(ii) press releases which include financial information (such as earnings press releases), as well as financial information and any earnings guidance provided to analysts and rating agencies, recognizing that this review and discussion may be done generally (consisting of a discussion of the types of information to be disclosed and the types of presentations to be made) and need not always take place in advance of the disclosure of each release or provision of guidance;

(iii) any significant financial reporting issues, estimates and judgments made in connection with the preparation of the Corporation's financial statements, including any significant changes in the selection or application of accounting principles, any major issues regarding auditing principles and practices, and the adequacy of internal controls that could significantly affect the Corporation's financial reporting;

(iv) all critical accounting policies and practices used, including their application to unusual and material related party transactions;

(v) all alternative treatments of financial information within GAAP that have been discussed with management, ramifications of the use of such alternative disclosures and treatments, and the treatment preferred by the independent auditor;

(vi) the use of "pro forma" or "adjusted" or other non-GAAP information;

(vii) the effect of regulatory and accounting initiatives, as well as any off-balance sheet structures, transactions, arrangements and obligations (contingent or otherwise), on the Corporation's financial reports;

(viii) any disclosures concerning any weaknesses or any deficiencies in the design or operation of internal financial controls or disclosure controls made to the Audit Committee by the Chief Executive Officer and the Chief Financial Officer during their approval process for forms filed with applicable securities regulators;

(ix) the adequacy of the Corporation's internal accounting controls and its financial, auditing and accounting organizations and personnel and any special steps adopted in light of any material control deficiencies; and

(x) the Corporation's guidelines and policies with respect to risk assessment, the Corporation's major financial risk exposures and the steps management has taken to monitor and control such exposures.

(b) Review with the independent auditor:

(i) the quality, as well as the acceptability of the accounting principles that have been applied and of significant judgements made in estimating amounts;

(ii) accounting and/or auditing issues related to the Corporation which were discussed by the auditors with their national office;

(iii) any problems or difficulties the independent auditor may have encountered during the provision of its audit-related services, including any restrictions on the scope of activities or access to requested information and any significant disagreements with management, any management letter provided by the independent auditor or other material communication (including any schedules of unadjusted differences) to management and the Corporation's response to that letter or communication;

(iv) any changes to the Corporation's significant auditing and accounting principles and practices suggested by the independent auditor or other members of management;

(v) other matters required to be communicated to the Audit Committee under generally accepted auditing standards; and

(vi) the adequacy of procedures for the preparation of the Corporation's public disclosure of financial information extracted or derived from the Corporation's financial statements.

(c) Review the hiring and/or the termination of the Chief Financial Officer, the chief internal auditor, if one is appointed, the mandates of such officers and the adequacy of the human resources dedicated to financial and accounting functions, and communicate the results of the review to the Corporation's Corporate Governance, Nominating and Compensation Committee.

4.3 **Compliance Procedures**

The Audit Committee shall, as it determines appropriate,:

(a) Obtain reports from management and/or the independent auditor that the Corporation and its subsidiary/foreign affiliated entities are in conformity with applicable legal requirements including disclosures of insider and affiliated party transactions.

(b) Review with management and the independent auditor any correspondence with regulators or governmental agencies and any employee complaints or published reports, which raise material issues regarding the Corporation's financial statements or accounting policies.

(c) Advise the Board with respect to the Corporation's policies and procedures regarding compliance with applicable laws and regulations affecting financial reporting and compliance with internal policies relating to employee conduct, conflicts and integrity.

(d) Review with the Corporation's in-house or outside counsel legal matters that may have a material impact on financial statements, the Corporation's compliance policies and any material reports or inquiries received from regulators or governmental agencies.

(e) Review and approve the Corporation's hiring policies regarding partners, employees, and former partners and employees of the present and former external auditor of the Corporation.

(f) Establish procedures for:

(i) the receipt, retention and treatment of complaints regarding accounting, internal accounting controls or auditing matters; and

(ii) the confidential, anonymous submission by employees of the Corporation with concerns regarding any accounting or auditing matters.

(g) Review the expense accounts of senior officers of the Corporation and the Corporation's wholly-owned subsidiary, Medical Facilities America, Inc., as designated by the Board at least annually and the processes for their approval and reimbursement.

4.4 **Delegation**

To avoid any confusion, the Audit Committee responsibilities identified above are the responsibilities of the Audit Committee and may not be allocated to a different committee.

V. MEETINGS

5.1 The Audit Committee shall meet at least quarterly and more frequently as circumstances require. A quorum will consist of a majority of the members present in person or by telephone and all decisions of the Committee require a majority of those present at a meeting of the Committee at which a quorum is present.

5.2 Minutes shall be maintained for all meetings together with materials relating to those meetings and copies will be provided to the Board.

5.3 Periodically, the Audit Committee shall meet separately with management, the independent auditors and any internal auditor. At its own discretion, the Committee may request any officer or employee of the Corporation or the Corporation's outside counsel or independent auditor to attend meetings of the Audit Committee or with any members of, or advisors to, the Audit Committee.

5.4 Except as otherwise provided above, the Audit Committee may form and delegate authority to individual members and/or subcommittees where the Audit Committee determines it is appropriate to do so. All matters dealt with by delegation shall be promptly reported to the full Committee, no later than the subsequent meeting of the full Committee.

VI. INDEPENDENT ADVICE

6.1 In discharging its mandate, the Audit Committee shall have the authority to retain and compensate, at the expense of the Corporation, special legal, accounting or other advisors as the Audit Committee, in its sole discretion, determines to be necessary to permit it to carry out its duties.

VII. ANNUAL EVALUATION

7.1 At least annually, the Audit Committee shall, in a manner it determines to be appropriate,:

(a) Perform a review and evaluation of the performance of the Audit Committee and its members, including the compliance of the Audit Committee with this charter.

(b) Review and assess the adequacy of its charter and recommend to the Board any improvements to this charter that the Audit Committee determines to be appropriate.