HFMA Arkansas Chapter
Current Topics in Healthcare Financing

October 30, 2014

Presenters’ Contact Information

Ken Downey
Managing Director
Ponder & Co.
10 Cadillac Drive, Suite 440
Brentwood, TN 37215
(615) 613-0213
kdowney@ponderco.com

John Cheney
Managing Director
Ponder & Co.
105 Saint Dunstans Road
Baltimore, Maryland 21212
(410) 435-6745
jcheney@ponderco.com
# Presentation Objectives

1. Provide a Tax-exempt Bond Market Update (John)

2. Report on Hospital Merger & Acquisition Activity and Trends (Ken)

## Bond Market Update
Tax-exempt Bond Market in 2014

Beginning of 2014
- Consensus forecasts called for increasing interest rates - as the economy continued to strengthen

Current market conditions different (October 2014)
- Tax-exempt bond interest rates (30-year MMD) have dropped over 176 basis points on the year – due to:
  - Drop in US Treasury bond yields (30-year rate down 94 basis points)
  - Weaker economic data than expected (US and abroad)
  - Heightened geopolitical risks
- Tax-exempt “new issue” bond supply is down over 10.7% through September 2014
- Direct retail demand and bond fund flows have turned positive
  - Redemptions, scheduled principal and interest payments on existing bonds create additional flows
  - Credit spreads for hospital revenue bonds continue to narrow on low supply and strong demand
  - Healthcare industry changes not a factor for investors

Interest rate expectations for remainder of 2014 (and next year)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current</th>
<th>2014Q4</th>
<th>2015Q1</th>
<th>2015Q2</th>
<th>2015Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fed Fund Rate</td>
<td>0.25%</td>
<td>0.25%</td>
<td>0.25%</td>
<td>0.25%</td>
<td>0.25%</td>
</tr>
<tr>
<td>3-Month LIBOR</td>
<td>0.23%</td>
<td>0.29%</td>
<td>0.35%</td>
<td>0.52%</td>
<td>0.79%</td>
</tr>
<tr>
<td>2YR T-Note</td>
<td>0.17%</td>
<td>0.71%</td>
<td>0.92%</td>
<td>1.16%</td>
<td>1.42%</td>
</tr>
<tr>
<td>3YR T-Note</td>
<td>2.19%</td>
<td>2.67%</td>
<td>2.89%</td>
<td>3.06%</td>
<td>3.23%</td>
</tr>
<tr>
<td>10YR T-Note</td>
<td>2.97%</td>
<td>3.42%</td>
<td>3.59%</td>
<td>3.79%</td>
<td>3.94%</td>
</tr>
</tbody>
</table>

1) MMD is the Municipal Market Data index based on “AAA” rated General Obligations (“GO”) bonds. A GO is a common type of municipal bond that is secured by a state or local government’s pledge to use available resources, including tax revenues, to repay bond holders.
Long Term Interest Rate Environment

Tax-exempt interest rates have declined significantly over the past several months

The 30-year MMD Index is 176 bps lower since its peak in September 5, 2013

MMD is the Municipal Market Data index based on triple-A rated General Obligations ("GO") bonds. A GO is a common type of municipal bond that is secured by a state or local government's pledge to use available resources, including tax revenues, to repay bond holders.

Source: Thomson Municipal Market Monitor.

Bond Market Factors: Mutual Fund Demand

Long-term tax-exempt bond funds experienced cash outflows in 2013

- Low absolute yield levels and improved performance of stock market caused outflows
- Bond fund outflows suppressed the demand for tax-exempt debt in 2013
- Lower demand has generated upward pressure on yields to attract buyers

2014 – Modest fund inflows returned to bond funds

Source: Investment Company Institute
Bond Ratings for Healthcare Entities

Credit spreads have narrowed since the start of the financial crisis in September 2008 and have even dropped below pre-crisis levels over the last few months.

Healthcare bonds are viewed as riskier investments.

- Investors demanding higher yields due to perceived vulnerability to reimbursement changes and cost pressures in the healthcare industry.

Pricing of Recent “A” Rated Tax-exempt Healthcare Revenue Bond Issues

With MMD and credit spreads near historic lows, “A” rated borrowers have been able to achieve a low cost of funding across the yield curve.
Pricing of Recent “BBB” Rated Tax-exempt Healthcare Revenue Bond Issues

Interest Rate (Yield) for Final Bond Maturity of Each Issue (Shown Below)

Source: Ponder & Co.; Thomson Municipal Market Monitor. Reference MMD is based off of the final maturity of each issue. Represents “yield to worst” for final maturity of each bond issue shown.

The bond “yield curve” remains steep

- The “cost” of fixed rate debt (the spread between SIFMA and 30-year MMD) near historic highs of 3.00%
- Compares to:
  - low of 0.43% on November 30, 2006, and
  - more “normal” pre-crisis spread of 1.59% on October 31, 2005
For the Past 20 Years

<table>
<thead>
<tr>
<th></th>
<th>RBI (%)</th>
<th>SIFMA (%)</th>
<th>Spread (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Oct-14</td>
<td>4.72</td>
<td>0.03</td>
<td>4.69</td>
</tr>
<tr>
<td>Average</td>
<td>5.32</td>
<td>2.09</td>
<td>3.23</td>
</tr>
<tr>
<td>Minimum</td>
<td>4.36</td>
<td>0.03</td>
<td>(2.40)</td>
</tr>
<tr>
<td>Maximum</td>
<td>7.37</td>
<td>7.96</td>
<td>5.54</td>
</tr>
</tbody>
</table>

Min Max spread represent the minimum/maximum spread between actual weekly SIFMA and RBI from 1994 to present.

Over the last 20 years, fixed rates have been lower than current levels approximately 10.64% of the time.

1) Market data through October 2, 2014.
2) The Bond Buyer Revenue Bond Index (“RBI”) is an estimate of the yield for long-term fixed rate bonds compiled by the Bond Buyer using an index of tax-exempt, fixed rate revenue bonds maturing in 30 years, with a rating equivalent to Moody’s “A1” and Standard and Poor’s “A+”.
3) The Securities Industry and Financial Markets Association (SIFMA) Index is calculated by taking the weighted average of the clearing rates for a pool of high-grade tax-exempt short-term issues with weekly resets. The SIFMA Index is a widely used proxy for high-grade weekly bonds.

Healthcare Industry Creditworthiness

Healthcare Not-For-Profit Sector Overview

- Credit analysts have a negative view on the sector due to numerous pressures facing healthcare providers
- Downgrades accounted for 58% of hospital rating actions in 2013

Source: Moody’s
Evolution of Healthcare Bond Issuance

- Healthcare bond issuance peaked in 2008 due to collapse of auction rate securities market
- Supply declined steadily since 2008, with a two decade low in 2013
- 2014 YTD is 28% lower than 2013

Private placements have grown since 2010, as banks and investors have purchased bonds directly from issuers/borrowers
- They now make up close to 33% of all healthcare bond issuance
- This decreases the supply in the public market, which partially explains the continued low interest rate and credit spread environment

Direct Purchase Basic Structure

- Direct purchase bonds are comparable to a bank loan
  - Bank loans money directly to the healthcare organization by purchasing entire loan – no bond underwriter required
    - Bank is sole buyer of bond issue
    - Bonds issued by municipality or state authority to make them tax-exempt securities
  - Bond principal and interest payments made monthly to bank at variable or fixed rate
  - Bonds amortize over a period of up to 30 years (maturity date) depending on use of bond proceeds
  - Bonds usually have a ‘put feature’ allowing the bank to accelerate and make all principal due at end of the holding period, unless it extends
    - Generally every five, seven, or ten years – not “committed capital”

Bond $ through Municipal / State Issuer

Variable or Fixed Rate
### Comparison of Public and Bank-bought Bond Issues

<table>
<thead>
<tr>
<th>Financing Product</th>
<th>Public Fixed Rate Bonds</th>
<th>Bank-bought Bonds (Variable and Fixed Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investor(s)</td>
<td>Bond funds, insurance companies, cross-over buyers, individuals</td>
<td>Commercial bank</td>
</tr>
<tr>
<td>Initial Term / Final Maturity</td>
<td>30 years or longer (serial and term bond maturity structure)</td>
<td>2 – 15 year initial term; up to 30 years or longer</td>
</tr>
<tr>
<td>Index / Cost of Funds</td>
<td>MMD plus bond rating credit spread = 3.13% + 1.00% = 4.13% (“BBB”)</td>
<td>67% of one-month LIBOR plus a credit spread (1.20%) = 1.30%, OR Fixed rate = 3.0%</td>
</tr>
<tr>
<td>Interest Rate Reset</td>
<td>Not applicable</td>
<td>Yes, at end of initial “term”</td>
</tr>
<tr>
<td>Factors Affecting Changes in Interest Rate</td>
<td>Interest rate fixed – no variability</td>
<td>Variability of index (LIBOR) for variable rate AND bank “pass throughs” for fixed and variable</td>
</tr>
<tr>
<td>Bond Rating Required?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bond Underwriter Required?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Full Disclosure Documents?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Baptist Health – Direct Purchase Bond Issue - Case Study

**Up to $7,000,000**

- **Purpose:** Refund Stuttgart Regional Medical Center’s (“SRMC”) 2006 Bonds for Baptist Health Hospital, Inc.
- **Bond Issuing Authority:** Public Facilities Authority of Stuttgart, Arkansas
- **Borrower:** Baptist Health Hospital, Inc. (“BHH”)
- **Guarantor:** Baptist Health, Inc.
- **Maturity Date:** 15 years from issue date (11/1/2029)
- **Fixed Interest Rate:** 3.05%
- **Payment Terms:** Annual payments of principal and interest to retire debt over 15 years – same as 2006 Bonds
- **Prepayment:** Non-callable for first 5 years
- **Debt Service Reserve:** None
- **Financial Covenants:** No additional financial covenants (same as for Baptist real estate bank loans)
- **Security / Collateral:** Gross receipts pledge of BHH and first position security interest in sublease agreement with SRMC plus guarantee from Baptist Health, Inc.
- **Bond Rating:** None
- **Bond Offering Document:** None
- **Time to Complete:** 60 – 90 days
Overview of the Municipal Advisor Rules

History of an SEC Rule

Origin 2010
• The Dodd-Frank Act authorized the SEC to adopt rules for the registration of municipal advisors and the MSRB to adopt rules governing municipal advisors.
• The rules are geared towards protecting municipal borrowers by ensuring that municipal advisors act in the best interest of their clients.

Initial Rules 2013
• On September 18, 2013, the SEC approved final municipal advisor registration rules opening a 90-day comment period. (Implementation was expected in January 2014.)
• The definition of “advice” was quite broad and included traditional banking activity (refunding analysis, market advice, etc.), which could snare bankers as municipal advisors and prohibit underwriting.

Market Reaction
• The industry was “caught off guard” and scrambled to set up implementation as quickly as possible, to ensure bank employees, lawyers, etc. don’t inadvertently become advisors.
• Additional guidance was not issued until January 10, 2014, so implementation of the rules was delayed from January until July 1, 2014.

Future 2014+
• Additional guidance was issued May 19th with some clarification but no significant changes. No additional changes in the rules were made.
• SEC/MSRB has indicated through various channels that they expect all borrowers will have a Municipal Advisor in place eventually. For public hospitals, compliance requirements are greater.

What Does This Mean for Hospitals and Municipalities?

Three Blanket “Exemptions” from Becoming a Municipal Advisor Currently Exist for Banks

Underwriter
• An entity can provide advice when serving as an underwriter of municipal securities.
• Limited to a specific plan of finance and only while acting in the scope of the underwriting.
• Does not cover advice on investments, swaps or issues not specific to a particular issuance.
• The underwriter exemption is limited to the period from “engagement” to the closing.
• Inclusion in a pre-approved underwriting pool is not sufficient to qualify for the exemption.

RFP
• Responding to an RFP is not considered providing advice.
• To qualify, an RFP must:
  • State a particular objective;
  • Be open for a reasonable period (no more than six months); and
  • Be competitive (sent to at least three competitors).
• “Mini-RFPs” on selected questions or topics are also permitted but limited.

Municipal Advisor / IRMA
• Having an independent registered municipal advisor (IRMA) in place, allows bank representatives to offer advice without the chance of being deemed a Municipal Advisor.
• To qualify, an IRMA must:
  • provide advice with respect to products or municipal securities issuance;
  • Borrower must represent in writing that it is represented by and will rely on advice of its IRMA;
• Underwriters will likely seek written confirmation of IRMA.

Without one of these exemptions, simply providing an optimized refunding analysis could preclude a bank from acting as an underwriter.
SEC offers issuers / borrowers and underwriters of tax-exempt securities opportunity to “self-report” possible federal securities law violations related to material misstatements in bond issue official statements about the issuer / borrower’s compliance with continuing disclosure undertakings (CDU) required by SEC Rule 15c2-12

Intended to address what the SEC perceives as widespread non-compliance with issuers / borrowers’ CDUs

SEC assures “favorable” settlement terms if SEC chooses to bring an enforcement action

- Self-reporting window for issuers / borrowers ends December 1, 2014
- Underwriters’ self-reporting deadline was September 1, 2014

Many issuers and underwriters are skeptical about participating – SEC does not say what is “material”

SEC Rule 15c2-12 (1995) - Underwriters cannot purchase bonds unless the issuer or obligor of the securities (e.g. hospital borrower) enters into a CDU to file with the EMMA website:

- Annual financial and other information (within 6 months of fiscal year end), and
- Timely notice of certain events (14) (i.e. within 10 days), including:
  - Bond rating changes
  - Merger involving borrower
  - Debt defaults

Issuers / borrowers must disclose in every bond issue official statement any failure during the past 5 years to provide the required annual disclosure and notice of certain events

SEC is convinced that violations are widespread, including:

- Failures to file continuing disclosure documents on a timely basis, and
- False statements (in bond issue official statements) by issuers / borrowers concerning compliance with continuing disclosure obligations

If an issuer / borrower is aware of a potentially “material” misstatement in a bond official statement, it could limit the terms of possible SEC enforcement action by self-reporting under the MCDC initiative
Modified “Prisoner’s Dilemma”

Underwriters and issuers / obligors qualify for this self-reporting program
- Standardized settlement terms will apply if SEC recommends enforcement action

Standardized settlement terms do not include payment of civil penalty by issuers / borrowers

But underwriters are subject to monetary penalties (up to $500,000) – which gives them an incentive to self-report
- Most underwriters have taken advantage of this program
- They have already scrutinized and reported issuer / borrowers’ prior disclosures and possible failures to comply (deadline was September 1, 2014)

SEC may take action against an issuer / borrower based on the underwriter’s filing alone

Underwriters that self-report are not required to reach out to their potentially affected issuer / borrower clients (also, self-reports are not public)

Next Steps for Issuers / Borrowers?

Who should consider self-reporting to the SEC?
- Any issuer / borrower that may have made materially inaccurate statements in final bond issue official statements regarding prior compliance with their CDUs as described in Rule 15c2-12

Initial steps to take to determine whether to self-report?
- Review your bond issue official statements since December 2004 (10 years) to determine what was said about continuing disclosure
- Ask senior managing underwriters (for those bond offerings) whether they have self-reported any CDU violations
- Review CDUs to determine the scope of your continuing disclosure responsibilities
- Review the CDU filings actually made – review (a) timely filing and (b) substance of the reports
  - Make sure information furnished is what was required
  - Don’t forget to look at filing of material event notices (e.g. bond rating changes)
- **If you find a potentially material misstatement in a bond issue official statement consult with bond counsel to determine:**
  - if such misstatement was material (i.e. is it important to a reasonable investor’s buy decision?), and
  - whether to file under the MCDC initiative
Municipal Continuing Disclosure Cooperation Initiative

Is the misstatement material? Factors to consider per the National Association of Bond Lawyers:

- Material otherwise available to the public
- Material available to institutional investors / rating agencies upon request
  - So it was taken into account in any pricing / rating of the bonds
- Did the failures occur prior to the EMMA start date (July 2009)?
- Length of delay in filing
- Reason for the failure
- Significant pattern of noncompliance
- Disclosure of several while failing to disclose a single similar event
- Length of time since failure
- Market acceptance / price impact
- Independent dissemination agent hired
- Training/adoptions of disclosure procedures

Potential Ramifications for Issuers / Borrowers

To report or not to report...that is the question!

No civil penalty from the SEC in connection with self-reporting
- If a issuer / borrower does not self-report and is found in violation, financial penalties could apply

By self-reporting, an issuer / borrower may be admitting to material non-compliance and accepting the SEC’s standardized settlement terms:
- Consent to a cease & desist order
- Disclose the violation and settlement terms in any final official statement for the following five years
- Cooperate with any subsequent investigation by the SEC regarding the false statements
- Establish compliance policies and procedures
- Correct any prior non-compliance
- Provide a compliance certificate to the SEC (on the one-year anniversary date)

Self-reporting effectively gives SEC additional control over issuer / borrower reporting
- After self-reporting, the SEC will likely have the ability to take action for violation of the cease and desist order perhaps with increased penalties

Consult with your bond counsel!
Hospital Merger & Acquisition Activity and Trends

Significant Increase in Hospital Consolidation

Number of Announced Hospital Transactions
Q1 2009 through Q2 2014

- Rolling Quarterly Average for Latest 12 Months

Mergers & Acquisitions Update

Mentality of “everyone is talking to everyone” about various consolidation opportunities

Resurgence of major market, multi-hospital, not-for-profit (“NFP”) deals beginning in 2010

- Detroit Medical Center (six hospitals)
- Caritas Christi (six hospitals)
- Mercy Health Partners (seven hospitals)
- St. Luke’s Episcopal Health System (six hospitals)
- Summa Health (five hospitals)

Percentage of transactions with not-for-profit successors remains stable in 2013

Announced (Synergistic) Joint Venture Partnerships

<table>
<thead>
<tr>
<th>Date JV Announced</th>
<th>For-Profit Partner</th>
<th>Not-For-Profit Partner</th>
<th>Acquisitions/Developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/27/2010</td>
<td>Health Management</td>
<td>Shands HealthCare</td>
<td>JV to operate three rural Shands hospitals</td>
</tr>
<tr>
<td>01/31/2011</td>
<td>LifePoint Hospitals</td>
<td>Duke University</td>
<td>Maria Parham Medical Center (Henderson, NC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health System</td>
<td>Person Memorial Hospital (Roxboro, NC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Twin County Regional Healthcare (Galax, VA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Marquette General Health System (Marquette, MI)</td>
</tr>
<tr>
<td>08/31/2011</td>
<td>Sacred Heart</td>
<td>Bay Medical Center</td>
<td>JV to operate five rural Integris hospitals</td>
</tr>
<tr>
<td>11/02/2011</td>
<td>Health Management</td>
<td>Integris Health</td>
<td>JV to operate four rural Capella hospitals</td>
</tr>
<tr>
<td>12/05/2011</td>
<td>CAPELLA Healthcare</td>
<td>Ascension Health</td>
<td>Mountainside Hospital (Merit Health) (Montclair, NJ)</td>
</tr>
<tr>
<td>02/01/2012</td>
<td>HackensackUMC</td>
<td></td>
<td>JV to pursue M&amp;A and other developments in WI &amp; IL</td>
</tr>
<tr>
<td>05/10/2012</td>
<td>LifePoint Hospitals</td>
<td>Norton Healthcare</td>
<td>Scott Memorial Hospital (Scottsburg, IN)</td>
</tr>
<tr>
<td>08/27/2012</td>
<td>AYIS Healthcare</td>
<td>Aurora Health Care</td>
<td>JV to pursue M&amp;A and other developments in WI &amp; IL</td>
</tr>
<tr>
<td>03/11/2013</td>
<td>Community Health</td>
<td>Cleveland Clinic</td>
<td>Alliance to draw on each other’s vast resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plan for future JV acquisitions</td>
</tr>
<tr>
<td>5/14/2013</td>
<td>RegionalCare</td>
<td>Billings Clinic</td>
<td>JV to pursue M&amp;A and other developments in MT and WY</td>
</tr>
</tbody>
</table>
Other Trends in Hospital Alignments

Structures are highly varied and either and well beyond asset sales, mergers and traditional joint ventures. Below are examples of alternative alignment structures announced in the past year.

- Joint Operating Agreement
- Management Agreement
- Minority Ownership Stakes
- Other Collaborations

Announced Not-For-Profit Divestitures

Despite strong ratings, a number of highly rated NFP systems are divesting assets that are:

- Geographically outside core reach of system
- Financial underperformers or have specific issues
- In markets where NFP has been unable to enhance relative position
- Non-core services (home health, senior living, etc.)

These divestitures strengthen the selling system's financial position and focuses its capital and management on remaining markets.

<table>
<thead>
<tr>
<th>Announced Date</th>
<th>NFP System</th>
<th>Facilities Divested</th>
<th>Acquirer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/14/2014</td>
<td>Mercy Cadillac &amp; Grayling (Cadillac, MI) (Grayling, MI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/17/2013</td>
<td>St. Catherine (Katy, TX) &amp; St. John (Nassau Bay, TX)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/11/2013</td>
<td>Mercy Hot Springs Hospital (Hot Springs, AR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/3/2013</td>
<td>Saint Claire’s Health System (Denville, NJ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/29/2013</td>
<td>Providence Hospital (Kansas City, KS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/16/2012</td>
<td>Carondelet Health (Kansas City, MO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/23/2012</td>
<td>St. Joseph Medical Center (Baltimore, MD)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Divested majority stake
### Announced For-Profit M&A Activity

- **October 22, 2012** – Baptist St. Anthony’s Health System (80% JV), Amarillo, Texas
- **August 28, 2013** – Sharon Regional Health System, Sharon, Pennsylvania
- **July 18, 2013** – Palms of Pasadena Hospital, Memorial Hospital and Town & Country Hospital, Tampa, Florida
- **August 27, 2012** – Development joint venture with Aurora Health Care, Milwaukee Wisconsin
- **February 1, 2012** – Mountainside Hospital (JV with NFP), Montclair, New Jersey
- **March 14, 2014** – Conemaugh Health System, Johnstown, Pennsylvania
- **February 7, 2014** – Garden City Hospital, Garden City, Michigan
- **January 16, 2013** – Sierra Vista Regional Health Center, Sierra Vista, Arizona
- **August 21, 2012** – Mercy Health System of Maine, Portland, Maine (CHE)
- **February 21, 2013** – Emanuel Medical Center, Turlock, California
- **November 30, 2011** – Knapp Medical Center, Weslaco, Texas

### Recently Announced For-Profit-to-For-Profit Consolidation

In the summer of 2013 two of the largest for-profit combination deals were announced

<table>
<thead>
<tr>
<th>Date Announced</th>
<th>Target</th>
<th>Successor/Partner</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| **6/24/2013**  | Vanguard Health Systems | Tenet Health Systems | • Transaction value estimated at $4.3 billion ($1.8 billion in cash and $2.5 billion in assumption of Vanguard’s debt)  
• The 77 combined hospitals results in the third largest for-profit hospital operator in terms of hospitals owned and reach $15 billion in combined annual revenue  
• Tenet will gain entrance into key new markets including Chicago, Detroit and San Antonio  
• In particular, merged company is well positioned to benefit from the Affordable Care Act in Texas, which has nearly 30% of the nation’s uninsured people |
| **8/2/2013**   | Health Management Associates | Community Health Systems | • Proposed transaction value estimated at $7.6 billion  
• Projected combined revenue of $18.9 billion  
• CHS would surpass HCA to become the largest hospital operator in terms of facilities (206 in 26 states)  
• Expected $150 - $180 million of shared savings  
• 63% of the hospitals will be sole community providers |
Publicly traded hospital management companies saw a significant increase in stock prices during 2012 and 2013 after a major decline in 2011. Prices have rebounded above their 2011 levels.

Valuations as a multiple of operating cash flow ("EBITDA")\(^{(1)}\) have increased dramatically from the beginning of 2012.

With Increased Activity, the Number of Failed Transactions Has Increased

Government intervention has picked up steam and does not appear to be slowing down

- State of Connecticut has created a barrier to for-profit acquisitions through restrictions on physician employment
- Ascension – HCA (Kansas City, Kansas)
- Rockford Memorial Hospital (Rockford, IL) – OSF Healthcare
- Capella – Mercy Hot Springs (Hot Springs, AR)
- St. Luke’s Hospital (Maumee, OH) – ProMedica Health System
- Phoebe Putney Memorial Hospital (Albany, GA) – HCA

Agreement on achieving agreeable governance and due diligence can be challenging

- PeaceHealth and CHI were unable to come to terms on merger primarily due to governance matters
- Beaumont Health System – Henry Ford Health System (Detroit, MI): Following lengthy due diligence, BHS medical staff expressed concern about a merger, curtailing further action

Challenges of synergistic partnerships

- After announcing potential acquisitions together, CHS and Cleveland Clinic decided not to pursue such transactions together

It will be interesting to watch the intersection of new healthcare delivery models and anti-trust concerns

---

\(^{(1)}\) EBITDA stands for Earnings Before Interest, Taxes, Depreciation and Amortization.
Drivers of Consolidation

- Historically a primary challenge for standalone hospitals was limited access to capital
- Beginning approximately five years ago, the challenge of physician alignment, employment and integration became an equally important driving factor towards consolidation
- Medicaid and other state level reimbursement challenges further accelerated activity
- Reduction in government funding for academic medicine
- Most recently healthcare reform including the need to address new delivery models and need to address challenges to healthcare reimbursement have become a top driver of consolidation
  - Need for risk contracting experience
  - Need experience in managing health of a population
- As hospitals reach their efficiency plateau they look to consolidation and economies of scale to remain competitive and viable

Indicators of Need to Affiliate

**Ability to meet current or long-term capital needs**
- Is the organization unable to fund key strategic capital plans?
- Is average age of plant well above norms?
- IT expenditures or system upgrades needed in the near future?

**Adequate financial performance and cushion**
- Meaningful operating margin and balance sheet needed to weather projected changes in healthcare?
- If losing money, can profitability be reasonably achieved?
- Is debt burden overwhelming?

**Anticipated trajectory of financial and operating performance over the next several years**
- How significantly different is that from today’s position?
- If these future projected results were happening now, what would be our perspective on need to affiliate?

**Level of preparedness for healthcare reform and new healthcare delivery models**
- ACO’s, medical homes, bundled services
- Population management, health insurance exchanges

**Strength of alignment with physicians**
- Is there a well defined physician strategy?
- Level of clinical integration?
- Recent loss of key physicians?

**Ability and willingness to go after opportunities**
- Are the lack of resources or appropriate mindset making it difficult to pursue new services or initiatives?

**Major challenges or changes in payer landscape**
- Facility has been excluded from certain payer contracts?
- Rapidly changing mix to less profitable payers?

**Aggressive competitor action**
- Merger of other area hospitals or new system to the market?
- Merger of local and regional physician groups?

**Additional opportunities to significantly improve operating and financial performance**
- Add services, physicians, payer strategies that would be game changers?
- Significant expense reduction opportunities that have historically been off limits?

**Specific major challenges that can’t be changed**
- Declining population or challenging payer mix?

**Significant cultural issues**
- Is there a positive environment for physicians and employees that enables the facility to be competitive?
- Strength of board and management?
Select Recent Announced Change of Control Transactions in Arkansas

<table>
<thead>
<tr>
<th>Date Announced</th>
<th>Target</th>
<th>City</th>
<th>Tax Status</th>
<th>Acquirer</th>
<th>Date</th>
<th>Acquirer</th>
<th>Target City</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/02/2009</td>
<td>Siloam Springs Memorial Hospital</td>
<td>Siloam Springs</td>
<td>NFP</td>
<td>Community Health Systems</td>
<td>04/01/2009</td>
<td>Medical Center of South Arkansas (remaining 50% stake)</td>
<td>El Dorado</td>
<td>NFP</td>
</tr>
<tr>
<td>04/14/2009</td>
<td>Sparks Health System</td>
<td>Ft Smith</td>
<td>NFP</td>
<td>Health Management Associates</td>
<td>08/02/2010</td>
<td>HealthPark Hospital</td>
<td>Hot Springs</td>
<td>FP</td>
</tr>
<tr>
<td>08/23/2010</td>
<td>Pine County Memorial Hospital</td>
<td>Murfreesboro</td>
<td>NFP</td>
<td>New Directions Health Systems</td>
<td>05/09/2011</td>
<td>Arkansas Heart Hospital (MedCath)</td>
<td>Little Rock</td>
<td>FP</td>
</tr>
<tr>
<td>08/01/2012</td>
<td>Medical Park Hospital</td>
<td>Hope</td>
<td>NFP</td>
<td>Baptist Healthcare</td>
<td>10/14/2013</td>
<td>St. Joseph’s Mercy Health System (Mercy Health)</td>
<td>Hope</td>
<td>FP</td>
</tr>
<tr>
<td>08/01/2012</td>
<td>Medical Park Hospital</td>
<td>Hope</td>
<td>NFP</td>
<td>Baptist Healthcare</td>
<td>10/13/2013</td>
<td>Hot Springs County Medical Center</td>
<td>Malvern</td>
<td>NFP</td>
</tr>
</tbody>
</table>

Systems Exploring Options – Announced or in the News

<table>
<thead>
<tr>
<th>Date</th>
<th>System</th>
<th>City</th>
<th>Source</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/30/2011</td>
<td>Fulton County Hospital</td>
<td>Salem</td>
<td></td>
<td>Baxter Regional Medical Center plans to make an offer to financially distressed county owned hospital.</td>
</tr>
<tr>
<td>10/31/2013</td>
<td>Conway Regional Health System</td>
<td>Conway</td>
<td>154</td>
<td>Launched formal search to find affiliation partner. May 2014, entered into exclusive talks with CHI</td>
</tr>
</tbody>
</table>

Evolving Health System Strategy

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>Grow by being bigger: Leverage market dominance to secure prime pricing, network status</td>
<td>Grow by being better: Leverage cost, quality, service advantage to attract key decision makers</td>
</tr>
</tbody>
</table>

Key Success Factors

- Expand market share
- Strengthen service lines
- Expand pricing leverage
- Solidify referrals
- Secure physicians
- Increase utilization
- Expand covered lives
- Compete on outcomes
- Minimize total cost

Target of Strategy

- Commercial payers
- Government purchasers
- Physicians
- Employers
- Individuals
- Population health managers

Performance Metrics

- Discharging
- Service line share
- Fee-for-service revenue
- Pricing growth
- Occupancy rate
- Process quality
- Share of lives
- Geographic reach
- Risk-based revenue
- Share of wallet
- Outcomes quality
- Total cost of care

Competitive Dynamics

- Service line competition
- Centers of excellence
- Referral channels
- Physician loyalty
- Comprehensive care
- Patient engagement
- Clinical quality
- Service quality

Critical Infrastructure

- Inpatient capacity
- Outpatient imaging centers
- Clinical technology
- Ambulatory surgery centers
- Primary care capacity
- Care management staff and systems
- IT analysis
- Post-acute care network

Source: Advisory Board