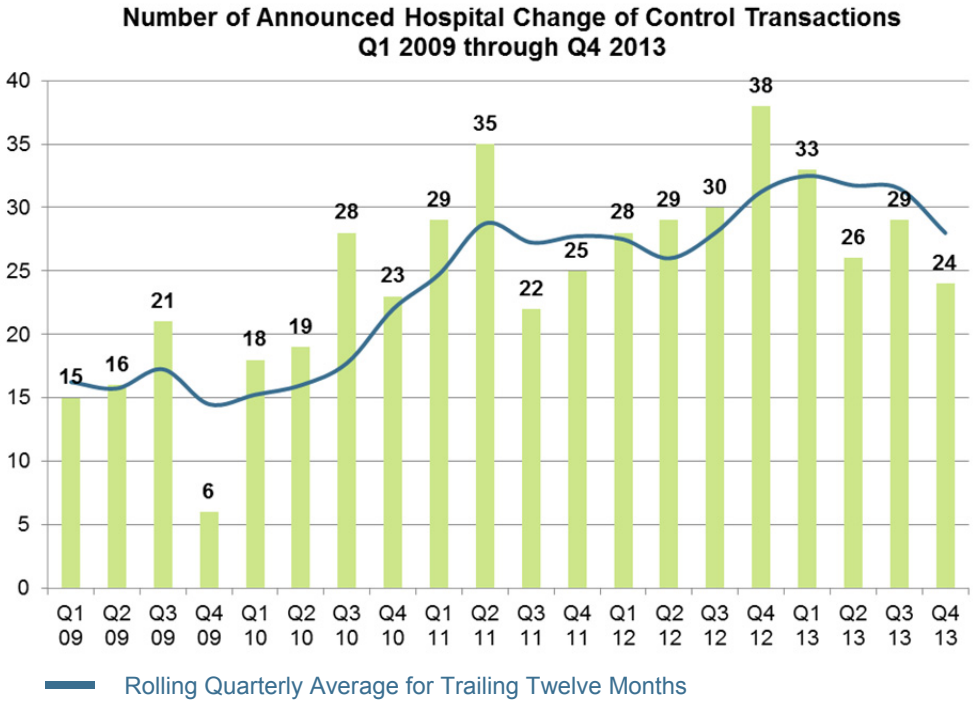
Update on Mergers & Acquisitions Activity in the Hospital Industry

Mergers and acquisitions activity in the acute care sector remained robust in 2013. The number of announced change-of-control transactions was 112 in 2013, similar to deal volume in 2011 and down slightly from the 2012 level. 2013 volume is nearly double the annual rate experienced in the 2007 to 2009 period. Quarterly volume has generally been in the 25 to 33 range since the first quarter of 2011.



The purpose of this report is to provide insights into this robust activity and specifically discuss:

- The drivers of consolidation
- Specific trends in 2013 activity
- The different outlooks from the for-profit and not-for-profit perspectives
- Likely trends in consolidation for 2014

Drivers of Consolidation

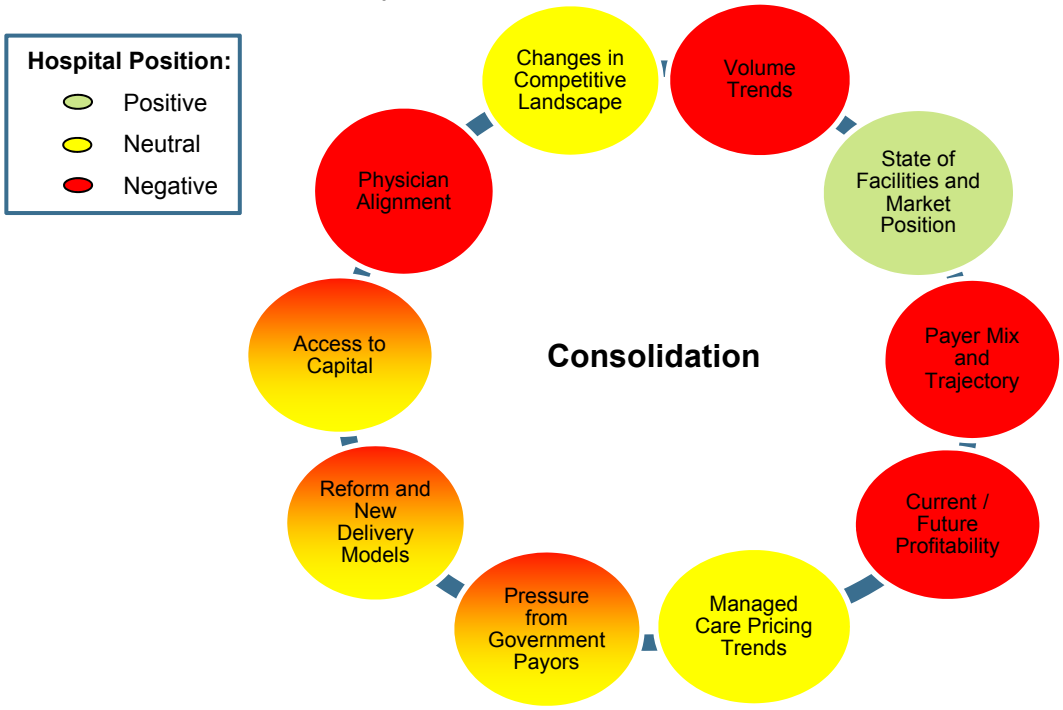
Historically, the number one driver of consolidation has been access to capital. This continues to be a major force in consolidation as community hospitals struggle to maintain facilities, invest in information technology and invest in physicians all while maintaining adequate reserves and on-going balance sheet strength. At the same time, larger, healthy systems continue to rationalize their portfolios thereby reducing their exposure and investment in more challenging markets and concentrating their capital and resources in more productive markets. Although divestiture activity by major systems was down in 2013, there continue to be significant transactions by both for-profit and not-for-profit systems, such as the announced sale of three

hospitals in the Tampa Bay area by IASIS Healthcare to HCA and the transition of St. Joseph's Mercy Health System in Hot Springs, Arkansas, from Mercy Health's sponsorship to Catholic Health Initiatives.

Beginning approximately five years ago, the challenge of physician alignment, employment and integration became an equally important factor driving consolidation. Physician employment increased dramatically forcing hospitals and systems of all sizes to address the trend. More recently, new clinical integration models have become a major force with projects rampant across the country. The Advisory Board estimated that by late 2012 there were more than 500 CI programs, up from a handful just a few years prior. These models require significant investment of management and physician time, as well as financial resources and know-how. It is often challenging for smaller systems and independent hospitals to bring to bear the resources needed to successfully develop these models.

During the past two years, in addition to the pressures of adequate access to capital and the demands of physician alignment, healthcare reform and declining reimbursement are now at the top of the list. Many hospitals and systems have been forced to adjust to dramatic cuts in Medicaid and other state-level reimbursement mechanisms. Projected Medicare payments cuts are being layered into forecasts by healthcare systems as well. At the same time, hospitals and systems are being forced to consider ACO's, medical home models, risk-sharing and a host of other possibilities in light of reform.

The graphic below depicts a typical assessment of the full gamut of drivers of consolidation that Ponder regularly reviews with clients. The coloring of these various forces per the legend included is an example of the representative outcomes for many community hospitals. The graphic depicts challenges from the three big drivers discussed above, as well as declining volume and changes in competitive landscape. Again, this is only an example, but it does reflect the difficulties that many face.



Trends in Consolidation During 2013

In addition to continued strong volume, there were a number of key trends during the year.

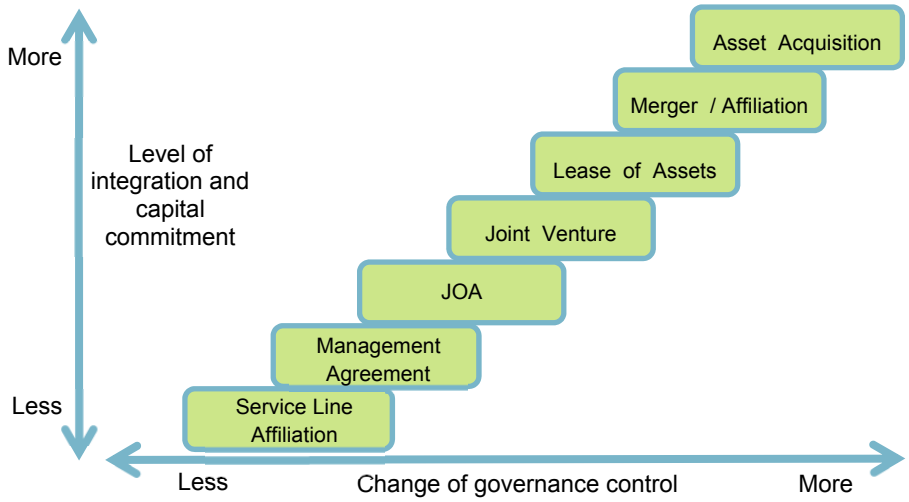
Larger transactions more frequent although median transaction size unchanged. The median transaction size for change-of-control hospital and system transactions was 154 beds, virtually unchanged from 158 in 2012. The result illustrates that the typical transaction continues to be a small to mid-sized community hospital. However, as shown in the chart below, there has been a shift of volume over the past five years from the 50-250 bed range to the 250-500 bed and over 500 bed categories. Therefore, there has been an increase in concentration on larger transactions. Interestingly, in 2013, there were only five transactions announced for hospitals or systems with over 750 beds as compared to 13 in 2012. However, 2013 included two very large for-profit to for-profit transactions in the Tenet Healthcare-Vanguard Health System and Community Health Systems-HMA transactions which heavily skew average transaction size.

Bed Count

Year	Under 50	50 - 250	250 - 500	Over 500
2009	19%	59%	17%	5%
2010	15%	59%	15%	10%
2011	24%	50%	16%	10%
2012	17%	48%	25%	9%
2013	23%	45%	24%	8%

Successor mix shifted further toward transactions with not-for-profit successors. 74% of announced transactions involved a not-for-profit successor in 2013, up from 64% in 2012. However, the mix has been relatively stable over the past four years ranging from 64% to last year's 74%. The large for-profit transactions were highly profiled in 2013, but the overall volume in terms of number of transactions tends to be meaningfully weighted toward not-for-profit driven volume.

The range of structures used in 2013 continued to burgeon. Systems have become more and more creative and diverse in the type of alignments they are considering. In addition to mergers and asset acquisitions that have been most typical historically, joint ventures, joint operating agreements, long-term leases, management agreements, shared services agreements, risk-based alignments and a host of other structures were implemented in 2013.



Many hospitals and systems continued to remain independent through management agreements and shared services arrangements. These transactions are not included in the change-of-control volume numbers, but are equally prominent. For example, a collection of over 20 hospitals and 1,500 physicians in Georgia and Florida have formed Stratus Healthcare, an alliance dedicated to lowering healthcare costs, boosting quality and exploring new payment models, but without a change of control. Systems are working to gain scale and address new healthcare delivery models without fully aligning.

The use of joint ventures gained additional momentum. In 2013, a total of 19 transactions involved new joint ventures ("JVs") or joint operating agreements ("JOAs") or situations where the acquirer was itself a joint venture. Historically, joint venture hospital transactions involved either (i) a joint operating agreement between not-for-profit systems or (ii) a for-profit system acquiring a majority stake in a not-for-profit system with a foundation retaining the remaining stake in a passive way in terms of operations. In addition to the continued use of those alignment types, there has been a significant emergence in the last several years of synergistic JV's where both partners continue to be leading healthcare operators, but the two parties bring different resources and capabilities to the table. The most active synergistic JV has been DLP Healthcare, the joint venture between Duke University Health System and LifePoint Hospitals. The two have announced seven transactions in the past three years. But virtually every for-profit operator has announced similar arrangements although in different stages and to different degrees as reflected in the chart below. It is clear that not-for-profits and academic medical institutions want to leverage their clinical and quality strength, as well as their brand name, without having to provide the capital and operating resources to every opportunity that becomes available.

Date JV Announced	For-Profit Partner	Not-For-Profit Partner	Representative Acquisitions/Developments
01/31/2011	LifePoint Hospitals	Duke University / Duke University Health System	• Maria Parham Medical Center (Henderson, NC) • Marquette General Health System (Marquette, MI)
08/31/2011	LHP Hospital Group, Inc.	Sacred Heart Health System	• Bay Medical Center (Panama City, FL)
11/02/2011	Health Management Associates	Integris Health	• JV to operate five rural Integris hospitals
12/05/2011	Capella Healthcare	Saint Thomas Health / Ascension Health	• JV to operate four rural Capella hospitals
02/01/2012	LHP Hospital Group, Inc.	HackensackUMC	• Mountainside Hospital (Merit Health) (Montclair, NJ)
05/10/2012	LifePoint Hospitals	Norton Healthcare	• Scott Memorial Hospital (Scottsburg, IN)
08/27/2012	IASIS Healthcare	Aurora Health Care	• JV to pursue M&A and other developments in WI & IL
09/18/2012	Vanguard Health Systems	Tufts Medical Center	• JV to pursue M&A in MA, to build ACO infrastructure
03/11/2013	CHS Community Health Systems	Cleveland Clinic	• Alliance to draw on each other's vast resources • Plan for future JV acquisitions
5/14/2013	RegionalCare Hospital Partners	Billings Clinic	• JV to pursue M&A and other developments in MT and WY

JOA's continue to flourish as well with multiple JOA's announced in 2013 and others being explored. Again, systems want to partner and combine efforts, but do not want to always fully contribute operating assets or accept full responsibility for the bottom line and balance sheet in every opportunity. There are also often religious directive reasons for using this structure. The continued use of JOA's is interesting in light of some of the high profile break-ups in the past, including the Health Alliance of Greater Cincinnati and Promina Health System in the Atlanta market. But powerhouse systems such as BayCare Health System in Tampa and Premier Health in Dayton are examples of very successful JOA's that have long term successful track records.

Finally, there has been the emergence of a select number of transactions where a not-for-profit system will acquire a minority stake in a new joint venture with a targeted hospital or system. Catholic Health Partners acquired a 30% stake in Summa Health in 2013 as CHP continues to expand its reach in Ohio. UNC Healthcare announced in April 2013 plans to acquire a 35% stake in 199-bed Johnston Health in Smithfield, North Carolina. Although such arrangements are still infrequent, there has been a willingness of larger systems to take minority ownership positions for strategic reasons.

Meaningful number of transactions involved expanding existing relationship. A significant number of transactions last year involved two systems or hospitals already aligned in a less comprehensive way. Over 30% of the 2013 transactions between not-for-profit entities were between systems or hospitals that already had a clinical affiliation, management agreement or significant other alignment. The shift from management agreement to full ownership was especially prevalent. It is clear that relationships and alignments tend to migrate along the continuum of deal structures over time, and these less integrated arrangements could provide a solid pipeline of future change of control transactions.

Risk and provider-based models continue to converge. Hospitals and managed care providers are more frequently jointly pursuing structures to address new risk-based healthcare models. At the most integrated level, the mergers of West Penn Alleghany, Jefferson Health and St. Vincent Health System in Pennsylvania into Highmark are some of the highest profile examples of this trend. In addition, Catholic Health Partners acquired Kaiser Permanente Ohio's existing health plan covering more than 80,000 lives, as well as its medical group practice and care delivery operations in Northeast Ohio. However, most of the alignments are less integrated and involve the creation of ACO's, narrow networks and exchange-based offerings. As systems continue to try to figure out what healthcare reform means and what solutions need to be provided, the conversion of risk-based strategies and hospitals will continue.

Failed transactions increase with increased volume. In 2013, there continued to be a meaningful number of deals that failed to reach completion. There is no sign that the government is letting up in its defense against potentially anti-competitive transactions. The FTC, state attorneys general and even governors were all active in weighing in on transactions in 2013. Transactions between Ascension Health and HCA, as well as Capella Healthcare and

St. Joseph's Mercy Health System, to name two, were abandoned in 2013 due to resistance from regulators. In Connecticut, the Governor vetoed a bill that would have created a governance structure for for-profit hospitals modeled after a law passed in 2009 allowing healthcare systems to take part in medical foundations as a way to employ doctors. Despite four announced acquisitions by for-profit operators in the past few years, none have closed, and there remains only one for-profit owned hospital in Connecticut.

In addition to regulatory opposition, due diligence issues, significant reimbursement changes during the process, lack of final agreement on governance, opposition from physicians and lack of religious authority support have all played a part in announced transactions not crossing the finish line. Notable examples of other transactions not completed in 2013 include PeaceHealth and Catholic Health Initiatives and Henry Ford Health System and Beaumont Health System.

Valuation and Deal Term Trends

In 2013, valuation levels were generally consistent with 2012 levels. According to Ponder & Co.'s experience in the market, the "trifurcation of valuation" continued. We see the following comparable company transactions based on multiples of net patient revenue:

- Distressed sales: 0.2x to 0.4x
- Average sales: 0.5x to 0.7x
- Highly sought after or highly strategic sales: 0.7x to 1.0x

Valuation as a multiple of operating cash flow or earnings before interest, taxes and depreciation ("EBITDA") varies widely. The core of the range continues to be 7.0x to 10.0x latest twelve months EBITDA although data points at the higher end and beyond are typically characterized by hospitals or systems that are underperforming or in turnaround mode. In terms of the publicly traded hospital operators, stock prices continued their ascent in 2013, exceeding the increase of the overall equity market. Hospital stock prices increased by over 40% as a group in both 2012 and 2013. Valuations for the group as a multiple of trailing 12 month EBITDA increased from approximately 5.5x at the end of 2011 to 7.5x at the end of 2013, a significant move in valuation as the stocks rebounded from historical lows and as additional clarity has been shed on the initial implications of healthcare reform. The increase in overall values in the market was one of the key factors that led to the announcements in 2013 of the acquisition of HMA by CHS and Vanguard by Tenet. The implied multiples for the CHS-HMA and Tenet-Vanguard transactions at the time of announcement were 8.5x and 7.8x trailing 12 month EBITDA, respectively before any projected synergies.

Differences in Outlook: Not-for-Profit Versus For-Profit

It is clear that a significant difference in outlook has developed from the not-for-profit and for-profit vantage points. While for-profit stocks have increased by over 100% in the past two years, not-for-profit systems have grown more bearish, and the top three rating agencies all have negative outlooks on the not-for-profit healthcare sector.

The general outlook from the not-for-profit sector is gloomy. To many not-for-profit healthcare executives, healthcare reform virtually means reduced reimbursement and more complex operating models. The credit rating agencies have a similar vantage point with Moody's, S&P and Fitch all issuing negative outlooks for the not-for-profit healthcare industry in 2014 and expect difficult conditions to remain for at least the next several years. Key contributing factors to the negative outlook include:

- Weaker revenue environment combined with more difficulty identifying incremental cost savings
- Heightened competition for patients from both traditional competitors and new entrants such as urgent care operators
- Mounting capital needs exacerbated by cuts in capital spending in 2012 and 2013
- Reduced government reimbursement in terms of Medicaid, Medicare and specific programs such as disproportionate share funding

At the same time, although the above trends are certainly echoed, the message from Wall Street follows several themes in terms of the for-profit sector outlook:

- For-profit systems have greater access to capital and economies of scale
- For-profit systems are aggressive in cost containment and adjustments needed to address adverse volume and reimbursement trends
- For-profit systems will benefit from the significant consolidation volume enabling these systems to grow topline through acquisitions and leveraging their size and operating efficiency
- Despite headwinds from Medicare and Medicaid cuts, for-profit systems will garner a meaningful benefit from healthcare reform in 2014

The last point is especially interesting in light of the general outlook of not-for-profit healthcare on reform. CHS, Lifepoint and HCA each project a positive impact to EBITDA from healthcare reform of approximately $140MM, $26MM and $100MM, respectively, for 2014. As an example, in early 2014, one of the top for-profit operators reported in its earnings call that it projects a 1.1% decline in 2014 Medicare reimbursement rates and experienced reductions in Medicaid since 2010 of 3.7% in aggregate. However, despite these headwinds and the slow start in terms of exchange enrollment, the outlook related to reform was positive based on the stated opportunities:

- Obtaining close to commercial rates in almost all exchanges
- Participating in an exchange product in virtually all its markets
- Benefitting from expansion of Medicaid in many of its markets
- Assessing opportunity based on 80% of current self-pay clients qualifying for Medicaid under the new rules
- Actively pursuing specific strategies to get healthcare exchange eligible patients enrolled

In summary, converting self-pay or no-pay to Medicaid or exchange plans will produce very significant benefits, and from the perspective of many on Wall Street, when combined with the other potential for-profit advantages, mitigate or outweigh reimbursement and volume declines.

Outlook for 2014

Volume of announced transactions consistent with the levels experienced in the 2011 to 2013 period, but possibly on the lower end of that range. Activity continues to be very high in terms of transactions in the works, and the impetus to be careful about opening discussions with potential partners is virtually gone as "everyone is talking to everyone". The factors driving consolidation show no sign of letting up in terms of volume challenges, declines in reimbursement and healthcare reform pressures. However, there are several factors that may provide offsetting pressure:

- Two of the top for-profit acquirers, HMA and Vanguard, have been acquired by CHS and Tenet, respectively. At the same time, CHS and Tenet will focus on absorbing these large acquisitions and obtaining expected synergies. These acquirers will likely finish the transactions already in process, but then will be less aggressive about new acquisitions in the back half of 2014 and 2015. As a past example, when CHS completed the acquisition of Triad in July 2007, it was nearly two years before CHS completed an acquisition that was not already in process or a conversion of a Triad JV to full ownership. Currently CHS has at least three transactions that it has committed to complete, but acquisitions in new markets may slow thereafter.
- Larger, healthier not-for-profit systems cannot acquire all underperforming hospitals. Many of these systems are currently being approached by numerous hospitals seeking larger partners to be the white knight. Not-for-profit systems do not have unlimited capability for such deals and are often very protective of their bond credit ratings.
- Some states are running out of independent community hospitals to acquire. In Virginia, where there has been significant consolidation over the past decade, only seven independent hospitals with more than 100 beds remain in the state. And there are only three with over 300 beds. Clearly, other states have ample opportunities, but some states are largely consolidated in terms of independent hospitals.
- For many systems the battleground has shifted from inpatient hospitals to risk products, clinical integration and large outpatient centers. Many systems operate inpatient at breakeven levels or losses while outpatient is the money maker. This does not mean inpatient hospitals do not serve an essential role, but the focus in terms of expansion is shifting.

However, in the end, the drivers of consolidation will continue to exert robust consolidation despite these forces. The offsetting forces may result in the lower end of the range in terms of recent years, but the trend continues.

More very large transactions involving not-for-profit targets in 2014. Outside of the two mega-merger for-profit transactions, volume related to very large transactions was low in 2013. This was a downtick in 750+ bed transactions in 2013 from 2012. We believe that trend will be reversed in 2014 as a number of larger systems are pursuing options now, and more will in 2014. For example, with 1,780 beds and over $2 billion in net revenue, Orlando Health publicly announced in February 2014 the hiring of an advisor and its plans to explore options. Likewise, serving Northeast Tennessee and Southwest Virginia with over $800 million in net revenue and 1,250 beds, Wellmont Health System announced similar steps and plans to explore options. These are both large systems and exemplify the pick-up in large transactions in 2014.

More focus on combining regional systems versus absorbing community hospitals. Healthcare systems are thinking beyond adding single community hospitals and are focusing more and more on partnering with other large systems in adjacent markets. These efforts will broaden regional strength, take scale to a new level and prepare for the healthcare changes ahead. Again, the Orlando Health and Wellmont situations are excellent examples, regardless of whether they end up pursuing transactions. These systems are looking to create much larger breadth and reach.

More troubled community hospital situations, more covenant violations than in 2013. The amount of bond covenant violation activity has been relatively low during recent years. But community hospitals, especially smaller hospitals, are very challenged to react to changes in reimbursement and do not have the number of alternatives in terms of offsetting these trends. Further, making the needed changes to address healthcare reform such as strategies to enhance exchange enrollment and develop narrow networks is much more difficult at the community hospital level. This is resulting in meaningful margin compression, operating losses and declining balance sheets and will drive an uptick in covenant violations in 2014.