Ponder & Co – Background

Founded in 1974, Ponder is the nation’s leading capital advisor to the not-for-profit healthcare industry

- The firm has finished #1 or #2 in healthcare capital advisory assignments each year for the last three decades
- Ponder has advised on over 3,000 financing plans and debt issues for health systems, stand-alone hospitals, academic medical centers, health plans and other healthcare providers in Maryland and nationally

Acts only as capital advisor

- Ponder does NOT underwrite or sell bonds or act as counterparty on interest rate swaps
- Remain free of conflicts
- Registered with and audited by the U.S. Securities and Exchange Commission

Employee owned and directed

Specialized expertise

- Ponder is familiar with all types of capital markets solutions, including public market debt, bank private placements, and derivatives (interest rate swaps)
- Ponder does NOT sell or distribute software products
- Ponder does NOT provide strategic business planning or operations consulting services

Client base includes over 250 healthcare institutions in Maryland and across the U.S.

Capital Advisory Group members in 10 locations (30 employees) including Baltimore
Ponder & Co. Advisory Services Lines

**Capital Planning & Advisory Services**
- Capital structure goals and priorities
- Treasury policies and practices
- Credit analysis and capital planning
- Plan of finance development
- Transaction management
- New debt issue structure and pricing

**Capital Markets Advisory Services**
- Market education
- Derivative structuring and analysis
- Derivative product pricing
- Fixed income portfolio management
- Investment policy development
- Debt proceeds investment

**Strategic Advisory Services**
- Strategic partnerships & joint ventures
- Mergers, acquisitions, divestitures
- Strategic option assessments
- Valuation
- Corporate restructuring
- Board & special committee assignments

**Ponder Investment Co.**
An investment adviser and manager of fixed income portfolios for over 40 healthcare system clients
Three Presentation Objectives

1. Provide Update on Current Tax-exempt Bond Market

2. Comment on Rating Agency Outlook on Non-profit Healthcare Industry

3. Discuss Recent Merger & Acquisition Activity in the Healthcare Market
Tax-exempt Bond Market
Alternative Capital Sources for Non-profit Healthcare (in August 2016)

**Tax-exempt debt least expensive – most often used**

Borrowing in the tax-exempt debt markets is cheaper than using cash reserves

<table>
<thead>
<tr>
<th>Source</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax-Exempt Variable Rate Debt</td>
<td>1.08%</td>
</tr>
<tr>
<td>Internal Funds (Riskless Return)</td>
<td>1.45%</td>
</tr>
<tr>
<td>Taxable Variable Rate Debt</td>
<td>1.49%</td>
</tr>
<tr>
<td>10-Year Tax-exempt Bank Loan Variable Rate</td>
<td>2.25%</td>
</tr>
<tr>
<td>10-Year Tax-exempt Fixed Rate</td>
<td>2.75%</td>
</tr>
<tr>
<td>10-Year Taxable Fixed Rate Bonds</td>
<td>7.00%</td>
</tr>
</tbody>
</table>

1. Tax-exempt variable rate bond = 68% of 1M Libor (.49%) + 0.75% = 1.08%
2. Taxable variable rate bond = 1M Libor (.49%) + 1.00%
Tax-exempt bonds make up one of the largest bond markets
$3.7 trillion of tax-exempt bonds

Tax-exempt healthcare bonds account for 10%; their issuance peaked in 2008
Non-profit organizations sell tax-exempt bonds (through conduit issuers, like MHHEFA) if project benefits the public

Aggregate supply and healthcare supply have remained below pre-crisis levels (2008)

Issuance of tax-exempt bonds in 2016 is 1% lower than 2015 (year-to-date)
Long-term tax-exempt interest rates hit all-time lows last month (July)

- In 2016, rates continue their downward path; 30-year Bond “AAA” MMD index is 0.72% lower on the year, hitting all time low July 7
- Investors have added assets to mutual bond funds for 41 straight weeks and on the year $41 billion
- New issue supply was 9.0% higher in June 2016 than in 2015 but 4% below 2015 YTD
- Credit spreads for healthcare borrowers well below average

Bond yield curve is steeper and interest rates 2% to 3% lower than 2007

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.
Healthcare tax-exempt bonds are viewed as riskier investments.

Investors demand higher interest rates due to perceived vulnerability to reimbursement changes and cost pressures in the healthcare industry.

Credit spreads have narrowed since the 2008 financial crisis and continue to grind tighter as investors search for yield in the current low rate environment.

The 10-year average “BBB” healthcare credit spread is 175 bps.
Pricing of Recent “BBB” Rated Tax-exempt Healthcare Bond Issues

Source: Ponder & Co., Thomson Reuters for MMD, Reference MMD is based off of the final maturity of each issue.
The municipal market closely tracks the taxable market, though changes course in times of market dislocation due to muni-specific events and/or demand shifts.

**Future Drivers?**
- FED
- Global Events
- Economy
Emergence of Banks as Direct Purchasers of Tax-exempt Healthcare Bonds

Bank direct placements have grown considerably since 2010

In 2015, direct bank purchases increased due to the absolute low level of rates

Increased bank direct purchases decrease the supply of bonds in the public market

Lowers public bond interest rates and credit spreads

Healthcare Issuance: Public vs. Private as of 12/31/15
(in $ Millions)

Variable or Fixed Rate

Bank direct placements have grown considerably since 2010

In 2015, direct bank purchases increased due to the absolute low level of rates

Increased bank direct purchases decrease the supply of bonds in the public market

Lowers public bond interest rates and credit spreads
# Tax-exempt Bond Issue Options for Maryland Hospitals

## Public Fixed Rate Bonds

<table>
<thead>
<tr>
<th>Key Characteristics</th>
<th>Up to 35 years (2051)</th>
<th><strong>Interest Rate Adjustment Frequency</strong></th>
<th>Fixed for life of bonds (35 years)</th>
<th><strong>Payment Demand Frequency</strong></th>
<th>Bond principal and interest payment dates</th>
<th><strong>Committed Capital</strong></th>
<th>Yes</th>
<th><strong>Interest Rate Risk</strong></th>
<th>No</th>
<th><strong>Bank Renewal Risk</strong></th>
<th>No</th>
<th><strong>Bond Ratings?</strong></th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond Issue Maturity</td>
<td>Up to 35 years (2051)</td>
<td><strong>Interest Rate Adjustment Frequency</strong></td>
<td>Fixed for life of bonds (35 years)</td>
<td><strong>Payment Demand Frequency</strong></td>
<td>Bond principal and interest payment dates</td>
<td><strong>Committed Capital</strong></td>
<td>Yes</td>
<td><strong>Interest Rate Risk</strong></td>
<td>No</td>
<td><strong>Bank Renewal Risk</strong></td>
<td>No</td>
<td><strong>Bond Ratings?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>Interest Rate Risk</td>
<td>No</td>
<td><strong>Payment Demand Frequency</strong></td>
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<td>Yes</td>
<td><strong>Interest Rate Risk</strong></td>
<td>No</td>
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<td>No</td>
<td><strong>Bond Ratings?</strong></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Renewal Risk</td>
<td>No</td>
<td><strong>Interest Rate Risk</strong></td>
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<td>Yes</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bond Ratings?</td>
<td>Yes</td>
<td><strong>Current Indicative Pricing</strong></td>
<td><strong>Fixed Rate</strong></td>
<td><strong>Variable Rate</strong></td>
<td><strong>Fixed Rate</strong></td>
<td><strong>Variable Rate</strong></td>
<td>Yes</td>
<td></td>
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<th><strong>Variable Rate</strong></th>
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<th><strong>Variable Rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax-exempt Interest Rate</td>
<td>4.00%</td>
<td>(average fixed interest rate)</td>
<td>2.25%</td>
<td>(historical average = 2.6%)</td>
<td>1.08%</td>
<td>(historical average = 2.6%)</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>$750,000 for $50 million issue</td>
<td>$300 million for $50 million issue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Bank Purchase Bonds (Fixed or Variable Rate)

<table>
<thead>
<tr>
<th>Key Characteristics</th>
<th>Up to 32 years (2048)</th>
<th><strong>Interest Rate Adjustment Frequency</strong></th>
<th>Fixed or variable for a fixed period (e.g. 10 yrs.); and less than life of bonds</th>
<th><strong>Payment Demand Frequency</strong></th>
<th>Bank may require borrower to purchase bonds at end of initial term</th>
<th><strong>Committed Capital</strong></th>
<th>No</th>
<th><strong>Interest Rate Risk</strong></th>
<th>Yes, at end of initial term for fixed rate and monthly for variable rate bonds</th>
<th><strong>Bank Renewal Risk</strong></th>
<th>Yes, bank may elect <strong>NOT</strong> to extend</th>
<th>No</th>
<th><strong>Bond Ratings?</strong></th>
<th>Yes</th>
</tr>
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<td><strong>Bank Renewal Risk</strong></td>
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<tr>
<td>Interest Rate Risk</td>
<td>No</td>
<td><strong>Payment Demand Frequency</strong></td>
<td>Bank principal and interest payment dates</td>
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</tr>
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<td><strong>Current Indicative Pricing</strong></td>
<td><strong>Fixed Rate</strong></td>
<td><strong>Variable Rate</strong></td>
<td><strong>Fixed Rate</strong></td>
<td><strong>Variable Rate</strong></td>
<td>Yes</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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(1) Assumes Maryland non-profit hospital with “BBB” bond rating and current market conditions (August 2016).
(2) Assumes 10-year initial term
Rating Agency Outlook on Non-Profit Healthcare Industry
Why are Ratings Important?

Rating Agencies supporting Municipal Bond Market
Fitch Ratings -- Moody’s Investors Service -- Standard & Poor’s Corporation

Determine the interest rate on the bonds
Determine who can buy the debt (or lend the money)
Affect bond prices and trading value (for bondholders)
Determine whether you qualify for bank guarantees and derivative products
Determines collateral posting for interest rate swaps
Compliance with bond / lender financial covenants
  Event of Default occurs if rating is less than required minimum

Number of bond ratings required?
  One sufficient for most bond issues
  No need for “3” ratings! (annual cost to maintain)
## Bond Rating Agencies - Top Themes for 2016 in Healthcare Sector

<table>
<thead>
<tr>
<th>Moody’s Investors Service</th>
<th>Standard &amp; Poor’s Corporation</th>
<th>FitchRatings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sector Outlook</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stable</strong></td>
<td><strong>Stable</strong></td>
<td><strong>Negative</strong></td>
</tr>
<tr>
<td>Operating cash flow growth will slow modestly</td>
<td>Upgrades &amp; downgrades will be about even</td>
<td>Stable financial performance and volumes</td>
</tr>
<tr>
<td>Changes to reimbursement remain long-term challenge</td>
<td>Operating margins may have peaked</td>
<td>Continued pressure on reimbursement – low rate increases</td>
</tr>
<tr>
<td>ACA insurance exchanges exhibit stress</td>
<td>Strong credits will remain strong</td>
<td>Increasing consolidation – leveraging size, scale or specialization</td>
</tr>
<tr>
<td>Declines in bad debt slowed considerably</td>
<td>Weak credits (typically smaller) under pressure on margins and liquidity</td>
<td>Divergent management strategies – maintain operating flexibility while assessing partnership opportunities</td>
</tr>
<tr>
<td>More states consider Medicaid expansion while others remained opposed</td>
<td></td>
<td>Challenging operating environment deferred not diminished</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Widening credit gap</td>
</tr>
<tr>
<td>Moody’s Investors Service</td>
<td>Standard &amp; Poor’s Corporation</td>
<td>FitchRatings</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>Unique state-regulated reimbursement – predictable financial performance</td>
<td>All-Payer model provides stability but limited growth potential</td>
<td>Participation in Global Budget Revenue or Total Patient Revenue program is viewed positively and providing financial stability</td>
</tr>
<tr>
<td>Advantages of Medicaid expansion moderated by state’s all-payer model</td>
<td>Maryland Medicare Waiver – intermediate step toward population health – hospitals should perform well in early years</td>
<td>Effective cost management initiatives – labor productivity, supply chain management and reduced clinical variability</td>
</tr>
<tr>
<td>State regulations (CON) provides barrier to entry</td>
<td>Global Budget Revenue program – hospitals at risk to manage utilization</td>
<td>Community hospitals credit is strengthened with tertiary hospital service line partnerships</td>
</tr>
<tr>
<td>Consolidation will continue as hospitals build scale to efficiently operate under Global Budget Revenue program</td>
<td>Unable to negotiate higher rates from commercial payors to offset low or negative margins</td>
<td></td>
</tr>
<tr>
<td>Large government workforce tempers unemployment</td>
<td>Profitability is waning - small rate increases for the last few years</td>
<td></td>
</tr>
<tr>
<td>Health System / Hospital</td>
<td>Moody’s</td>
<td>S&amp;P</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>Number of Ratings</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Johns Hopkins Health System</td>
<td>Aa3</td>
<td>AA-</td>
</tr>
<tr>
<td>LifeBridge Health</td>
<td>A1</td>
<td>A+</td>
</tr>
<tr>
<td>Bon Secours Health System</td>
<td>A2</td>
<td>A-</td>
</tr>
<tr>
<td>Greater Baltimore Medical Center</td>
<td>A2</td>
<td>A</td>
</tr>
<tr>
<td>MedStar Health</td>
<td>A2</td>
<td>A-</td>
</tr>
<tr>
<td>University of Maryland Medical System</td>
<td>A2</td>
<td>A-</td>
</tr>
<tr>
<td>Peninsula Regional Medical Center</td>
<td>A2</td>
<td>A</td>
</tr>
<tr>
<td>Anne Arundel Health System</td>
<td>A3</td>
<td>A</td>
</tr>
<tr>
<td>Calvert Memorial Hospital</td>
<td>A3</td>
<td>NR</td>
</tr>
<tr>
<td>Frederick Memorial Hospital</td>
<td>Baa1</td>
<td>NR</td>
</tr>
<tr>
<td>Adventist HealthCare</td>
<td>Baa2</td>
<td>NR</td>
</tr>
<tr>
<td>Mercy Health Services</td>
<td>Baa2</td>
<td>BBB</td>
</tr>
<tr>
<td>Meritus Health</td>
<td>NR</td>
<td>BBB</td>
</tr>
<tr>
<td>Western Maryland Health System</td>
<td>NR</td>
<td>BBB</td>
</tr>
<tr>
<td>Doctors Community Hospital</td>
<td>Baa3</td>
<td>NR</td>
</tr>
</tbody>
</table>
Maryland has a higher percentage of “A/A/A” and fewer Speculative Grade (S.G.) ratings than the national healthcare market.

### Bond Rating Distribution – National and Maryland

<table>
<thead>
<tr>
<th></th>
<th>NATIONAL</th>
<th></th>
<th>MARYLAND</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moody’s</td>
<td>S&amp;P</td>
<td>Fitch</td>
<td></td>
</tr>
<tr>
<td>S.G., 22, 5%</td>
<td>Baa, 101, 24%</td>
<td>Aa, 102, 24%</td>
<td>A, 202, 47%</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>A, 202, 47%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baa, 101, 24%</td>
<td>Aa, 102, 24%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moody’s</td>
<td>S&amp;P</td>
<td>Fitch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.G., 14, 7%</td>
<td>BBB, 38, 19%</td>
<td>AA, 54, 27%</td>
<td>A, 95, 47%</td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>A, 95, 47%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>BBB, 38, 19%</td>
<td>AA, 54, 27%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moody’s</td>
<td>S&amp;P</td>
<td>Fitch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.G., 15, 6%</td>
<td>BBB, 57, 24%</td>
<td>AA, 62, 27%</td>
<td>A, 101, 43%</td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>A, 101, 43%</td>
<td></td>
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</tr>
<tr>
<td>BBB, 57, 24%</td>
<td>AA, 62, 27%</td>
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<tr>
<td>Moody’s</td>
<td>S&amp;P</td>
<td>Fitch</td>
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</tr>
<tr>
<td>A, 8, 61%</td>
<td>BBB, 3, 27%</td>
<td>AA, 1, 9%</td>
<td>A, 7, 64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>A, 7, 64%</td>
<td>BBB, 3, 27%</td>
<td>AA, 1, 9%</td>
<td>A, 7, 64%</td>
<td></td>
</tr>
<tr>
<td>Moody’s</td>
<td>S&amp;P</td>
<td>Fitch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.G., 1, 11%</td>
<td>BBB, 2, 22%</td>
<td>AA, 1, 11%</td>
<td>A, 5, 56%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A, 5, 56%</td>
<td>BBB, 2, 22%</td>
<td>AA, 1, 11%</td>
<td>A, 5, 56%</td>
<td></td>
</tr>
</tbody>
</table>
Fitch Ratings
Does not publish a rating model or scorecard

Moody's
Factors Moody's considers to be most important when assigning a credit rating
Scorecard is for rating committee discussion
Weighting for each factor - approximate relative importance
Established Ranges … rather than Rating Medians
Three Key Categories (100%):
35% - Operating Performance & Liquidity
20% - Balance Sheet & Capital Plan
45% - Market Position – example for “Total Revenue” the most heavily weighted statistic in the Scorecard:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Sub-Factor Weights</th>
<th>Example Value</th>
<th>Example Score</th>
<th>Implied Rating</th>
<th>Aaa</th>
<th>Aa</th>
<th>A</th>
<th>Baa</th>
<th>SG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenue</td>
<td>25%</td>
<td>$465,000</td>
<td>7.93</td>
<td>Baa1</td>
<td>&gt; $10.0B</td>
<td>&lt; $10.0B</td>
<td>&lt; $1.5B</td>
<td>&lt; $500M</td>
<td>&lt; $250M</td>
</tr>
</tbody>
</table>

S&P - Illustrated on following slides
S&P Analytical Framework - “Enterprise” & “Financial” Profile

Enterprise profile (Score 1-6)

- Industry risk 20%
- Economic fundamentals 20%
- Market position 50%
- Management and governance 10%

Financial profile (Score 1-6)

- Financial policies not weighted
- Financial performance 40%
- Liquidity and financial flexibility 30%
- Debt and contingent liabilities 30%

Initial Indicative Rating

Matrix

1 2 3 4 5 6
1
2
3
4
5
6

Indicative Rating

Positive Overriding Factors (possible adjustment)

Negative Overriding Factors (possible adjustment)

Peer Comparison & Rating Committee

Final Rating

Positive Overriding Factors (possible adjustment)
The combination of the **Financial Profile** (example, “Strong”) and **Enterprise Profile** (example, “Strong”) generates an **INDICATIVE RATING** of “A”.

<table>
<thead>
<tr>
<th>ENTERPRISE PROFILE</th>
<th>Extremely strong</th>
<th>Very strong</th>
<th>Strong</th>
<th>Adequate</th>
<th>Vulnerable</th>
<th>Highly vulnerable</th>
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<td>Extremely strong</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td></td>
<td>aaa</td>
<td>aa+</td>
<td>aa-</td>
<td>a</td>
<td>bbb+/bbb</td>
<td>bb+/bb</td>
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<tr>
<td>Very strong</td>
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<td></td>
<td>a+</td>
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<tr>
<td></td>
<td>aa+</td>
<td>aa/aa-</td>
<td>a+</td>
<td>a-</td>
<td>bbb/bbb-</td>
<td>bb/bb-</td>
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<tr>
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<td>bbb-/bb+</td>
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<td>a</td>
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<td>a-/bbb+</td>
<td>bbb/bbb-</td>
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<tr>
<td>Vulnerable</td>
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<td>bbb+</td>
<td>bbb/bbb-</td>
<td>bbb-/bb+</td>
<td>bb</td>
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<tr>
<td>Highly vulnerable</td>
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<td>bb</td>
<td>bb-</td>
<td>b+</td>
<td>b</td>
</tr>
</tbody>
</table>

Rating overrides and caps are applied to the initial indicative rating to arrive at the indicative rating. *The final rating will be within one notch of the indicative rating with the one-notch difference attributable to peer adjustments.*
Rating evaluation service is a tool to evaluate major strategic options, such as

- Large capital project expenditures funded with cash or additional debt
- Key financing document revisions (e.g., change in security, reserve funds, financial covenants and hospital lease changes)
- Merger & acquisition impact

How does the rating evaluation work?

- Provide rating agency analyst with hypothetical scenarios
- S&P will assess potential credit impact of proposed strategic initiatives
- May be viewed as less favorable or more favorable

Value to Healthcare Organization?

- Confidential assessment (will not affect existing bond ratings)
- Assess how proposed initiatives may affect your creditworthiness ahead of time
- Cost can be credited to bond rating fee (if obtained in 6 to 12 months)
Recent Merger & Acquisition Activity in the Healthcare Market
Overview of Ponder’s M&A Advisory Services

Ponder’s M&A Group was created in 1999, and specializes in mergers, acquisitions and divestitures for not-for-profit healthcare providers.

<table>
<thead>
<tr>
<th>PLANNING</th>
<th>EXECUTION</th>
<th>END OR POST-TRANSACTION</th>
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<tr>
<td>Board Advisory / Education</td>
<td>Mergers, Acquisitions, Divestitures</td>
<td>Fairness Opinions</td>
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<td>Strategic Options</td>
<td>Partnerships and Joint Ventures</td>
<td>Board and Special Committee Assignments</td>
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<td>Assessments</td>
<td>Healthcare Real Estate Transactions</td>
<td></td>
</tr>
<tr>
<td>Valuation Services</td>
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<td></td>
</tr>
</tbody>
</table>
Overview of Ponder’s M&A Advisory Services

Ponder’s Transaction Experience

**Upper Chesapeake Health**

has established a strategic affiliation and formed a joint venture partnership with

**University of Maryland Medical System**

The undersigned acted as the exclusive financial advisor to Upper Chesapeake Health

---

**St. Mary’s Hospital**

has merged with

**MedStar Health**

The undersigned acted as the exclusive financial advisor to St. Mary’s Hospital

---

**Jameson Health System**

has merged with

**UPMC**

The undersigned acted as exclusive financial advisor to Jameson Health System
Number of Announced Hospital Change of Control Transactions 2009 - 2016

- **ACA signed into law March 2010**
- **MACRA proposed rules published**

Source: Ponder & Co. internal database
The slowing over the last three quarters in transactions can be attributed to the following:

- Organizations that survived the last rounds of reimbursement changes are waiting to see what the next wave of reform will look like and how it will affect their organization
- Many larger systems are focused on clinical integration and other non change of control affiliation models
- A number of states, like Maryland have limited opportunities for additional consolidation
- Increased regulatory scrutiny: Advocate-North Shore, Jameson-UPMC, Cabell-St. Mary’s

The recent MACRA rules could potentially accelerate deal velocity over the next several years
ACOs, patient-centered care, capitation, population health management, etc.

Sequestration, future Your Hospital cuts, and other pricing challenges

Top driver of consolidation, historically

In mid-2000’s physician acquisitions and employment began to rival access to capital as top driver

Evolution of the Drivers of Consolidation
Market and Organizational Pressures on the Hospital Industry Remain the Same, but with Increased Urgency

- Declining inpatient volume
- Payer mix continues to shift from managed care/commercial
- Price increases outpaced by expense inflation
- Drive for scale
- Significant focus on shift to valued-based delivery models and need for improvements in quality and lower costs
- Physician losses still major problem
- Access to capital, maintaining facilities and making technology investments remain major obstacles
- Looming cuts in key reimbursement areas
- Emerging healthcare delivery models
- Regulatory compliance costs
- Entry of new competition to traditional healthcare providers
Overview of Affiliation Structures

- Asset Sale
- Merger / Consolidation
- Lease of Assets
- Joint Venture
- Joint Operating Agreement
- Transfer of Minority Interest
- Management Agreement
- ACO
- Collaboration
- Clinical Affiliation (Service Line)

Status Quo

Change of governance control
Increased Challenges to Change of Control Transactions

Regulatory challenges have become more prevalent, often causing significant delays and, in some cases, abandoned efforts. Regulatory issues related to hospital transactions continue to increase due to the following:

Anti-trust challenges have prevented or unraveled a number of major transactions:

- ProMedica and St. Luke’s Hospital in Ohio
- Jameson Health System

Self-disclosures related to poorly structured physician arrangements have regularly come up in due diligence and may extend the timing from announcement of a transaction to closing.
Increase in Non-Change of Control Affiliations

New clinical affiliations, regional collaborations and statewide networks are being announced at an unprecedented pace

- Integration alternative to mergers and acquisitions
- A way to link the clinical expertise and resources of much larger systems with the access and needs of community hospitals and regional systems
- But large regional collaborations and statewide networks have emerged in many states across the country

Types of opportunities delineated in these affiliations include:

- Exchange best practices
- Share resources and business services
- Reduce costs such as supply chain
- Establish ACOs
- Manage population health
- Create clinically integrated networks
Other Strategies Being Pursued

Acquisition of ancillary service companies

- Large health systems continue to look at vertical integration to diversify revenue streams
- Examples include: Ascension Health investment in Accretive Health, Intermountain Healthcare acquired Amerinet, UPMC supply-chain venture with IBM

Ambulatory Strategy

- Invest in freestanding ERs, urgent care centers, ambulatory surgery centers
- Examples include: Tenet Health acquired United Surgical Partners International

Physician Trends

- Physician alignment continues to be central strategy of health systems nationally
- Clinical integration continues to be a major focus of many systems

AMCs

- Many Academic Medical Centers continue to utilize M&A to grow a wide foot print to support their mission and grow tertiary/quaternary capabilities

Collaborations

- Collaborations to date have demonstrated mixed results but still awaiting big payoff
Maryland Mergers and Acquisitions Trends

The level of consolidation activity over the last several years in Maryland has remained slow as compared to national trends, which has experienced the following change-of-control activity:

- 2009 – 3 announced transactions
- 2011 – 1 announced transaction
- 2012 – 2 announced transactions
- 2015 – 1 announced transaction

Large not-for-profit systems are leading the consolidating wave in the state:

- University of Maryland Medical System has completed five affiliations since 2009, including a management agreement with Union Hospital
- Medstar Health has affiliated with three hospitals since 2008, building a system of 10 hospitals

Collaborations

- Advanced Health Collaborative, a collaboration of five Maryland based health systems
- Trivergent Health Alliance, management services organization of three Maryland based health systems
Maryland Hospitals, More than 150 Beds

MedStar Health
- MedStar Franklin Square Medical Center (405 beds)
- MedStar Union Memorial Hospital (370 beds)
- MedStar Southern Maryland Hospital (239 beds)
- Medstar Good Samaritan Hospital (208 beds)

Trinity Health
- Holy Cross Hospital (422 beds)

LifeBridge Health
- Sinai Hospital of Baltimore (1025 beds)
- Northwest Hospital (215 beds)
- Carroll Hospital Center (158 beds)
- Levindale Hebrew Geriatric Center and Hospital (100 beds)

Independent Hospitals
- Peninsula Regional Medical Center (400 beds)
- Anne Arundel Medical Center (317 beds)
- Greater Baltimore Medical Center (303 beds)
- Mercy Medical Center (285 beds)
- Meritus Medical Center (271 beds)
- Frederick Memorial Hospital (245 beds)
- Western Maryland Regional Medical Center (240 beds)
- Doctors Community Hospital (182 beds)
<table>
<thead>
<tr>
<th>Date Announced</th>
<th>Target</th>
<th>City</th>
<th>State</th>
<th>Target Tax Status</th>
<th>Acquirer</th>
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<th>Target Beds</th>
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<td>NFP</td>
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<td>Bel Air</td>
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<td>NFP</td>
<td>LifeBridge Health</td>
<td>NFP</td>
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</table>
What are characteristics of an ideal partner?

- Cultural fit & shared strategic vision
- Complementary clinical assets
- Complementary geography
- Strong brand name
- Scale
- Willingness to share referrals

What can Your Hospital expect to gain through a partnership?

- Increased Scale
- Intellectual capital
- Physician recruitment
- IT support through a common platform
- Expense and cost reduction

What will Your Hospital concede to execute a partnership?

- How important is local control?

What are the implications of first to market vs. last to market?

- Choice ... Act from a position of financial strength
Ponder & Co. Representatives
Mr. Cheney has provided financial advisory services for more than 30 years to non-profit organizations. He specializes in healthcare services, healthcare insurance and life science research. Mr. Cheney joined Ponder & Co. in 2003.

Mr. Cheney has advised many organizations on raising debt capital for major building and equipment projects. During his financing career, he completed approximately 200 debt issues, totaling more than $5 billion. He has extensive experience with both taxable and tax-exempt debt offerings, including all types of fixed and variable rate indebtedness and has also worked with clients to structure more than $2 billion in interest rate swaps and other interest rate hedges.

Prior to Ponder & Co., Mr. Cheney served as an investment banker with Salomon Brothers, Alex. Brown & Sons Incorporated and Banc of America Securities LLC.

Mr. Cheney holds an M.B.A. from Northwestern University’s J. L. Kellogg School of Management and a bachelor’s degree with honors from Northwestern in Evanston, Illinois.

Mr. Cheney is a member of Healthcare Financial Management Association.
Donald Persinski, Managing Director, Capital Advisory Group
412-668-0567
dpersinski@ponderco.com

Mr. Persinski joined Ponder & Co. in 2014. Prior to joining Ponder, Mr. Persinski worked for almost 30 years in the investment banking and banking industries specializing in debt management and capital planning for healthcare organizations. During his tenure with PNC Capital Markets LLC, Mr. Persinski served as the Manager of the Healthcare and Non-Profit Group (included healthcare, higher education and other 501(c)3 organizations).

Mr. Persinski has worked with multi-state health systems, academic medical centers, specialty hospitals, community hospitals and long-term care corporations. He has advised clients and structured fixed rate and multimodal debt plans; tax-exempt and taxable public bond issues and private debt placements. He supported the implementation of various bank credit facilities and derivative strategies.

He has been an invited guest speaker at HFMA meetings and healthcare corporate board retreats. He has guided management teams through the development of credit analyses, debt capacity analyses, and the preparation for rating agency, bank and investor presentations.

Mr. Persinski holds an M.B.A. with an emphasis in finance from the Joseph M. Katz Graduate School of Business, University of Pittsburgh and a B.S. degree in finance from The Ohio State University.

Mr. Persinski is a member of Healthcare Financial Management Association.
Mr. Schoeplein joined Ponder & Co. Mergers and Acquisitions Group in 2014. His responsibilities include evaluating the financial performance of hospitals and healthcare systems, performing market analyses and developing financial models and valuations for clients and prospects. Mr. Schoeplein also focuses on strategic options assessments and assists in transaction development and execution.

Prior to joining Ponder & Co., Mr. Schoeplein was a consultant at Health Care Futures, LP, a strategy and management consulting firm specializing in not-for-profit healthcare systems. He focused on joint venture development, mergers and acquisitions, capital planning and financial feasibility studies concentrating in financial modeling customized to individual client strategy and positioning.

Mr. Schoeplein is a graduate from St. Louis University, with a degree in Finance.

Mr. Schoeplein is a member of the Health Financial Management Association.