I. INTRODUCTION

The healthcare industry is rapidly consolidating to respond and adapt to a number of significant drivers and changes. Over 250 healthcare mergers, acquisitions and affiliations were reported for the second quarter of 2012 alone. Such activity continued at a steady pace through 2012 and we expect this trend to persist well into the future, with continued Medicare and Medicaid reimbursement cuts accompanying demands for expensive information systems and technology, further integration of healthcare delivery, and other new models of care that call for additional funding and capital expenditures.

Hospitals and health systems, in particular, are merging and collaborating in an effort to become stronger and to better prepare for the future. These transactions are complex and require careful navigation through legal hurdles and regulatory approval processes. This paper will briefly explore the forces behind the consolidation trend, provide an overview of common consolidation and collaboration models, and present strategic guidance on handling such hurdles and processes. Finally, this paper will walk through the various steps of a sample change of

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control transaction—a common form of consolidation involving tax-exempt organizations with parallels to several other more complex models.

Attachments include: a Sample Process Overview and Timeline (Exhibit A); a Sample Letter of Intent (Exhibit B); a Checklist of Common Letter of Intent Considerations (Exhibit C); Sample Due Diligence Checklists (both a long and short version) (Exhibit D); a Sample Table of Contents to a Change of Control (Affiliation) Agreement, useful as a checklist in drafting and negotiations (Exhibit E); a Sample Table of Contents to an Asset Purchase Agreement, also useful as a checklist in drafting and negotiations (Exhibit F).

II. CONSOLIDATION DRIVERS: WHAT IS FUELING COLLABORATION, MERGERS & ACQUISITIONS?

A. Healthcare Reform & Reimbursement Changes

The Patient Protection and Affordable Care Act ("PPACA") has changed hospital reimbursement models, cut payments, and incentivized new models of care.\(^2\) PPACA is expected to reduce hospital payment rates by $126 million by 2019.\(^3\) Additionally, Medicaid expansion under PPACA will make it more difficult for hospitals to offset public payors with commercial payors. The payor mix anticipated for 2030 is 60-75% Medicare/Medicaid and 25-40% commercial and other payors.\(^4\) New healthcare models included in PPACA, such as Accountable Care Organizations (ACOs), are expensive to create. Furthermore, ACOs and bundled payment mechanisms require hospitals to rethink care delivery, focusing on episodes of care, which requires greater clinical integration.

\(^3\) Id.
\(^4\) Cain Brothers, "What's the Deal: Focus on Hospital M&A and Thoughts for Not-for-Profit Trustees," *Strategies in Capital Finance* 6 (Fall 2011).
Moreover, the American Taxpayer Relief Act ("ATRA" aka "Fiscal Cliff Law"), signed into law on January 3, 2013, provides for further significant governmental reimbursement cuts. The preliminary estimate of reductions in inpatient hospital payments between 2014 and 2017 is $10.5 billion. Additional cuts include $4.3 billion in disproportionate share hospital ("DSH") payments, $40 million in radiology services payments and $80 million in advanced imaging services payments.\(^5\)

Such dramatic reductions in Medicare and Medicaid payments—included within legislation that also requires restructuring of care models, further integration of health care service delivery components, infrastructures that will support electronic health records and other data systems, and other changes that drive up expenses—have driven consolidation in order to cut overhead, share resources and intellectual capital, and benefit from a stronger market position for managed care contracting and vendor contracting purposes.

Aside from PPACA and ATRA, the healthcare industry faces additional financial challenges driving consolidation efforts. Currently, many states are struggling to fund their portion of Medicaid programs and other state grant initiatives. Payments lag and we are seeing cutbacks in reimbursement under state programs, coupled with an unprecedented initiative in certain states to recoup monies already paid out under such programs and initiatives. On the federal level, the United States Department of Health and Human Services ("HHS") and the United States Department of Justice ("DOJ") continue to prioritize combatting healthcare fraud and abuse.\(^6\) This has resulted in unprecedented recoupment efforts from the federal government.

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as well, which in turn can cost providers significant dollars as they address government audits/recoupment demands and work to ensure compliant practices.

B. Capital Needs & Financing Costs

Operational and other changes that hospitals and health systems are implementing are costly and tax already limited resources in many cases. The industry's move toward electronic health records requires hospitals to invest in technology and modernize their systems. Estimates of the cost of implementation range from $3 million for a small hospital to as much as $200 million for a large hospital.7 Similarly, physician integration comes at a high cost. These projects are not always financeable with tax-exempt debt, leaving tax-exempt hospitals to draw upon current earnings and balance sheet reserves.8 For profits must also find ways to cover these expenses, whether through selling additional shares, borrowing, or cutting other expenses to fund them through current operations.

With respect to tax-exempt organizations seeking to fund projects that do qualify under tax-exempt bond financing, the bond market can be challenging for some systems. Systems with lower credit ratings find it difficult to borrow and borrowing costs have become prohibitive for certain hospitals and health systems.9 In 2010, the issuance of tax-exempt health care sector debt dropped by thirty-two percent.10 For profits have faced similar borrowing constraints as lenders

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8 Id.
9 Id.
10 Edward S. Fishman, supra note 2 at 5.
remain conservative. Access to capital has improved since 2008, but it still remains limited and there is still a wide credit spread between high rated and low rated entities.\footnote{Moody's Investors Service, "For-Profit Investment in Not-for-Profit Hospitals Signals More Consolidation Ahead," 3 April 2010.}

C. Compliance Burdens

Hospitals operate within a heavily regulated industry. They must navigate a myriad of complex regulations, including reimbursement, patient privacy, licensure, quality of care and fraud and abuse laws. These laws require hospitals to establish and operate comprehensive reimbursement, risk management, compliance, utilization review and quality assurance systems which can effectively and efficiently respond to issues which arise both internally and in the industry. Effective compliance systems, for example, require dedicated personnel and technology, with legal support that may place a heavy financial burden on hospitals. Furthermore, as noted above, hospitals are under increased scrutiny and pressure from governmental payors seeking to recoup reimbursement dollars whether based upon fraud or even simple technical errors in many cases.

D. Necessary Economies of Scale

The industry demands placed on a hospital may be easier navigated by larger systems. Systems with greater intellectual capital and shared economies of scale often have more negotiating power with payors and vendors. Also, given the physician shortage in some markets, larger systems often have the ability to attract the best physicians. The healthcare landscape is changing rapidly, and larger systems are likely in a better position to react and adapt financially, administratively, technologically, and intellectually.
III. RANGE OF HOSPITAL COLLABORATION & CONSOLIDATION MODELS

Hospitals or health systems seeking to partner or integrate with one another may wish to fully integrate or may choose a model that allows for greater independence. There are a number of integration models, and organizations must consider which model best fits their needs. The following are some of the more prevalent models utilized in the market.

A. Clinical Affiliations

A clinical affiliation between two hospitals or health systems facilitates an arrangement whereby one or both may benefit from the other's specialty service lines. For example, an acute care hospital wanting to develop a pediatric service line may enter into an affiliation agreement with a leading children's hospital. The clinical affiliation model allows the entities to share best practices, clinical care guidelines, specialists, policy and procedure. They may also work together to coordinate patient care. This model may allow one party to leverage the superior brand name of the other party (generally for a fee).

For example, in 2012, NorthShore University Health System ("NUHS"), located in the northern suburbs of Chicago, entered into an affiliation agreement with the Mayo Clinic located in Rochester, MN. Under this agreement, NUHS pays the Mayo Clinic an annual undisclosed fee in exchange for access to Mayo's specialists and research in the areas of cardiovascular, cancer, and neurological care. The Mayo Clinic explains that the affiliation enhances Mayo's presence in Chicago, and allows Chicago-area patients to gain access to Mayo care without

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13 Id.
having to travel to Minnesota.\textsuperscript{14} NUHS believes that the affiliation will "improve treatment to existing patients, expand its patient base, and enhance its expertise in complex cases."\textsuperscript{15}

As another example, in 2012 the Ann & Robert Lurie Children's Hospital of Chicago entered into a clinical affiliation with the Muscular Dystrophy Association ("MDA") to operate a clinic for children with neuromuscular disorders.\textsuperscript{16} The affiliation allows clinic specialists to collaborate with MDA specialists across the country and to better coordinate the care of existing patients at the Children's Hospital.\textsuperscript{17}

B. Service Line/Department Management Agreements

A hospital may also choose to enter into a service line or department management agreement to outsource parts of its operations management to another provider. Under this model, the hospital would pay a fee to a third party to manage operations, but retain governance and responsibility for its own revenues and expenses. One such model that has become more prevalent lately between hospitals and specialists is the clinical co-management model.

Through this model, a hospital and a medical group create and invest in a clinical co-management company, often a limited liability company, which manages a service line or department within the hospital. Orthopedics and cardiology are two of the more common specialties addressed by hospitals and their specialists through such a model. The clinical co-management company has its own governing board. Often hospitals and physicians choose this model because it allows the hospital to compensate the participating physicians for assisting the

\begin{itemize}
\item \textsuperscript{14} Thomas A. Corfman, "NorthShore inks Alliance with Mayo Clinic," \textit{Crain's Chicago Business} (Sept. 19, 2012).
\item \textsuperscript{15} Frost, \textit{supra} note 12.
\item \textsuperscript{16} Sabrina Rodak, "Lurie Children's Hospital Partners with Muscular Dystrophy Association," \textit{Becker's Hospital Review} (Aug. 31, 2012).
\item \textsuperscript{17} \textit{Id.}
\end{itemize}
hospital in developing, managing, and improving quality of care and efficiency of a hospital department or service line. The physicians receive a base compensation for managing the service line, as well as incentive compensation for meeting certain performance goals. The agreement is usually for a term of one to three years, with the option to renew if both parties choose to do so. Performance goals typically are updated quarterly or annually.

A good example of such an arrangement was the subject of a recent Office of Inspector General ("OIG") Advisory Opinion. In assessing a clinical co-management agreement between a hospital and a cardiology group, the OIG stated that the hospital could offer performance bonuses to the physicians for implementing patient service, quality, and cost-saving measures. The quality measures used by the hospital include reducing costs associated with lab procedures, quality improvement, employee satisfaction, and patient satisfaction. The OIG determined that these benchmarks were in line with national care standards, and therefore were permissible. Additionally, the agreement between the hospital and the cardiology group specifically prohibits cherry picking patients or increasing referrals to the hospital to generate payment.

C. Comprehensive Management

With a comprehensive management model, a hospital and a hospital management company (e.g., another health system) enter into a management services agreement such that the hospital management company assumes control over day-to-day operations and some aspects of finance. However, the hospital retains ultimate authority. One example would be a county or municipality entering into an agreement with a hospital or health system in the region to help

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19 Id.
20 Id.
21 Id.
22 Id.
manage its hospital, seeking expertise beyond the more typical strengths that such entities have, such as taxation. The agreement may include an option for the manager to purchase or assume ownership of the hospital at some point in the future, if permissible under the legal constructs of the municipal/county hospital.

D. Joint Operating Company

A joint operating company allows hospitals that are not jointly owned to jointly operate certain services and business activities. Under this model, hospitals or health systems enter into a joint operating agreement which retains the hospital's/system's separate boards, but turns over management functions to a new separate entity. The joint operating agreement defines the terms of the combined operations. This model is sometimes used to integrate operations without actually transferring assets. Hence it may be referred to as a virtual merger.

A joint operating company is often used by hospitals seeking to retain unique religious character because it accommodates contractual or lease restrictions on the transfer of property. Ultimately, the hospitals retain separate identities, independent boards and some autonomy, while considerable management and financial authority is shifted to the joint operating company's board. The joint operating company is typically a non-profit corporation, a limited liability company, or a partnership. The joint operating agreement, articles of incorporation, bylaws, and management contracts would include details related to powers ceded to the joint operating company and those reserved by the participating hospitals/systems.

A long-standing joint operating agreement exists between Catholic Health Initiatives PorterCare Adventist Health System in which the parties jointly operate Centura Health, a multi-
hospital system in Colorado. A more recent example of a joint operating agreement is that between University of Colorado Hospital and Poudre Valley Health System which will operate the University of Colorado Health under a joint operating agreement. The agreement created a board that has the authority to borrow capital and will operate the hospitals. However, some decisions will require approval from the hospital governing boards.

A joint operating agreement can also present several challenges. First, a non-profit hospital entering into a joint operating agreement with a for-profit hospital must be careful to protect its non-profit characteristics so as to avoid jeopardizing its tax-exempt status. The funds used to operate the joint operating company will not be considered tax exempt, so the non-profit entity must carefully distinguish exempt and not-exempt assets. Additionally, a joint operating agreement must be structured such that the entities are sufficiently independent in order to avoid antitrust concerns, or sufficiently integrated should they desire joint contracting capabilities (this could trigger a Hart Scott Rodino filing, as further discussed below). Finally, if the joint operating company needs capital it will often require capital from each of the parties to the agreement. If one of the entities cannot come up with the requisite capital, then the arrangement could fall apart and need to be unwound. Careful drafting of joint operating agreements is necessary to address potential work-arounds in such situations, and to provide for unwind provisions to facilitate a reasonable disaffiliation.

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25 Id.
E. Long-Term Facility/Operations Leases

A long-term facility or operations lease gives control and responsibility for all operations, revenue, and expenses to the lessee, which makes lease payments to the lessor. These leases are typically for a duration of twenty or more years. Often these leases are between a municipality or governmental entity and a for-profit or non-profit health system. When the lease term ends, the hospital facility control reverts to the lessor. As these entail ceding control of the business, they often implicate regulatory approvals triggered by mergers and acquisitions.

F. Not-for-Profit Mergers & Membership Substitutions

A merger or membership substitution between two or more not-for-profit hospitals or health systems brings together the entities and combines the assets and liabilities. Generally, this type of transaction is cashless. Rather, future capital commitments, other funding requirements, and assumption of liabilities are common consideration components. Entities which choose this model have common goals of strong integration, shared contracting, and economies of scale. This model is usually less complex than an asset deal because the legal entities remain intact. The Sample Letter of Intent and Common Letter of Intent Considerations, attached hereto as Exhibits B and C, respectively, address many key components of such a transaction. A Sample Table of Contents for a Change of Control Agreement is attached hereto as Exhibit E, providing a good outline for the definitive agreement.

Changes to governance or board representation will vary based on the strength and number of facilities that are involved in the transaction. Finally, when a smaller system becomes part of a larger national system, the level of control at the local and national level can vary and sometimes is heavily negotiated. This model is common both regionally and nationally, as not-for-profit systems combine. For example, two or more separate hospitals may agree to merge
through creation of a new parent represented by both boards which will assume control of both/all hospital entities. Similarly, a national parent may assume control of a hospital by becoming the new sole corporate member if the hospital was previously a community hospital with no separate sponsor or membership, or the national parent may be substituted as the new member of a hospital or system which was previously under a different sponsor, such as a religious order.

As an example of two religious sponsored organizations coming together, in January 2012 the Alexian Brothers Health System, a Catholic multi-state system of hospitals, nursing homes, medical clinics and other facilities with corporate offices in Illinois, entered into an affiliation agreement with Ascension Health Alliance, the largest Catholic health system in the nation. This was a change of control transaction changing the system parent from the Alexian Brothers of America to Ascension, a system that continues to expand nationally. On December 21, 2012, Ascension announced that it had signed an affiliation agreement with the Daughters of Charity Health System, a regional health system with 22 sites including six hospitals along the California coast.

As another example under this model, in October 2012, two large non-profit systems in Michigan, Beaumont Health System and Henry Ford Health System, announced merger plans. The merged entity will be governed by a single board and the transaction will also merge Beaumont Foundation and Henry Ford Foundation. However, the medical staffs of the two

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27 Id.
systems will remain independent. The parties expect to close the merger in the first half of 2013.

G. Asset Purchases

When an asset purchase occurs, the buyer assumes responsibility for certain assets and liabilities as well as control of the purchased hospital. When a not-for-profit system acquires a hospital from another not-for-profit entity, it may take responsibility for all assets but that is a point of negotiation. Typically not-for-profit sales to other not-for PROFITS are a result of the acquired facility being owned and operated by a city or county, such that the transfer of ownership cannot be achieved through the more simple change in control of the legal entity over the facility or a merger of both entities (i.e., one may not "buy" a city or county but rather the assets of same). For example, the Illinois Health Facilities and Services Review Board recently approved the sale by Mercer County of both its hospital and nursing home facilities to Genesis Health System, to be effectuated through asset purchase agreements. Such transactions may require public referendum in addition to board approvals.

In asset transfer situations, the asset purchase agreement also may require a cash payment to the seller, capital commitments from the buyer, continued level of service obligations on the buyer for a specified period of time, and a seller right of first refusal on any subsequent sale after a minimum period of operations by the buyer. It is important to keep in mind, however, that when a not-for-profit sells to a for-profit system, the "charitable" assets do not transfer to the purchaser. The purchaser assumes control of the hospital and any physical assets but the value of the charity, if any, remains with seller or is transferred to either an existing foundation or to a

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28 Id.
new conversion foundation set up to hold and oversee the disposition of the exempt proceeds for
the benefit of the community. Conversion foundations are used to further the seller's original
mission. If there is sufficient value such that the acquiring for-profit not only assumes the
ownership and operation of the facility by committing to any negotiated improvements (and
other obligations) but also by paying a purchase price, these funds are transferred to the seller,
existing foundation or new conversion foundation, as applicable. The seller may also negotiate a
continued presence on the purchaser's board.

Common examples of such not-for-profit sales to for-profits include various hospitals
acquired by the Healthcare Corporation of America ("HCA"), the largest health system in the
country. HCA purchases Catholic and other non-profit hospitals, often committing to continuing
the mission and legacy of the seller. For example, in 2011, HCA acquired Colorado Health
Foundation's remaining forty percent interest in a system of hospitals, HCA-Health ONE, which
previously had been co-owned between the foundation and HCA. The agreement included
covenants that required HCA to maintain charity care and other benefits. The Colorado Health
Foundation stated it would use the funds from the sale to expand access to health insurance,
healthier food, and exercise for Colorado residents.

Another example is Vanguard Health System's acquisition of Detroit Medical Center, a
non-profit hospital, in 2010. Detroit Medical Center has a high concentration of Medicaid and

30 Lawrence E. Singer, The Conversion Conundrum: The State and Federal Response to
31 Id.
32 Philanthropy News Digest, "Colorado Health Foundation Receives $1.45 Billion From Stake
33 Id.
34 Id.
35 Moody's Investor Service, supra note 11 at 2.
self-pay patients, and Vanguard agreed to retain its charity care policy.\textsuperscript{36} Vanguard maintained the name and brand in addition to assuming Detroit Medical Center's debt, investing $850 million over five years in capital projects, and addressing a sizeable unfunded pension liability.\textsuperscript{37} As a second example, Cerberus Capital Management, a private equity investment firm, acquired Caritas Christ Health Care in 2011.\textsuperscript{38} Cerberus agreed to invest $400 million in future projects, assume Caritas' debt, and keep all of Caritas' hospitals open for at least three years.\textsuperscript{39} Cerberus also agreed to maintain the Catholic operating procedures and current management.\textsuperscript{40}

H. For-Profit Stock or Asset Deals

When a for-profit hospital or health system purchases another for-profit hospital or system, the purchaser typically acquires the seller's hospital and physical assets through a stock or asset purchase. An asset deal obligates the seller to retain responsibility for any non-assumed debt and liabilities, as described above. With a stock deal, however, the buyer accepts liabilities as well as assets, and essentially steps into the seller's shoes.

The asset purchase agreement or the shareholder's stock purchase agreement will have various terms and conditions, including certain representations and warrantees of the seller that the buyer may rely on, seeking indemnification for damages related to any breach of such representations and warrantees. In a stock deal in particular, the acquiring party will want to engage in significant due diligence so as to be fully informed of actual or potential material risks in assuming the legal entity. For example, a hospital with a mediocre compliance system, poor physician contracting practices, and/or inept coding and billing processes, may be ripe for a

\textsuperscript{36} Id.
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id.
significant whistleblower action or government audit and recoupment initiative. The liabilities associated with such problems can be financially devastating. This would be true in mergers and change of control transactions as well, where parties essentially combine within a system.

Even asset deals are risky in this regard since it is common for the buyer to take on the Medicare provider number of the seller through a CHOW (change of ownership filing) with Medicare that allows participation in Medicare to continue without the buyer having to apply for a new number and face the delays associated with such process. In assuming the number, however, the buyer also assumes any liabilities related thereto as a matter of law. It is not unusual, therefore, for a buyer to delay closing to allow the seller to self-disclose and settle out certain liabilities discovered in due diligence for either a stock or asset deal, whether they are under the federal Anti-Kickback Statute, the Physician Self-Referral Law ("Stark") or both. This is true for the not-for-profit world of mergers and changes of control transactions as well.

From the examples in the preceding section, before Detroit Medical Center ("DMC") was acquired by Vanguard Health Systems, it entered into a Settlement Agreement with the DOJ and the OIG to resolve potential violations of federal law as a result of entering into improper financial relationships with referring physicians. DMC agreed to pay $30 million in exchange for a release from liability under the False Claims Act, the Civil Monetary Penalties Law (which authorizes civil penalties for violations of the anti-kickback statute), the Program Fraud Civil Remedies Act, and the civil money penalties under Stark.41

DMC discovered the improper relationships through the due diligence process. The improper relationships included so-called "technical violations" of Stark, such as the failure to

have a written agreement in place that met the requirements of a Stark exception. It also included more substantive violations that may have raised a colorable allegation of an anti-kickback violation, such as providing business courtesies to physicians and paying higher than fair market value compensation. Although DMC attempted to use the then fairly new Voluntary Self-Referral Disclosure Protocol from the Centers for Medicare and Medicaid Services ("CMS"), CMS encouraged the hospital to work through the DOJ's office after DMC advised that they wanted to settle the matter within four to six weeks so they could close on the acquisition.

IV. **LEGAL HURDLES & REGULATORY APPROVALS**

Consolidations and collaborations implicate a number of legal hurdles and regulatory approvals that must be addressed before closing a transaction. The following are several key areas of concern for parties entering into one of the more complex models noted above.

A. **Financing**

Financing documents often include contractual/legal obligations with which the borrower must comply, including when entering into a transaction with another system or hospital. For example, bond documents include covenant restrictions that may impede a transaction or require significant debt restructuring. Accordingly, early on in any proposed transaction, the parties should complete a thorough assessment of financing implications. Financing matters may actually drive the determination of which model best works for the parties.

B. **Certificates of Need or Certificates of Exemption**

Many states have certificate of need ("CON") or certificate of exemption ("COE") laws which require hospitals to obtain state approval before a change in ownership or control of a

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42 *Id.*
hospital and/or other health care facilities.\textsuperscript{43} The purposes of CON and COE laws are generally to improve and protect cost efficiencies and access to healthcare. Accordingly, not-for-profit transfers to a for-profit owner may trigger particular scrutiny as the transaction could implicate access to care and charity care matters. In fact, some states may require the for-profit to continue certain financial aid programs offered by the not-for-profit seller, as a condition to close. Similarly, when a community or non-religious system transfers facilities to a Catholic system, the state may have access concerns related to the Ethical and Religious Directives for Catholic Health Care Services ("ERDs"). This may slow down or impede the CON/COE process, as further discussed below.

In order to effectively handle CON/COE matters, the parties should assess the need for such approvals early in the process. CON/COE laws can be fairly complicated and apply to different types of facilities impacted by a transaction. For example, in some states both nursing home and hospital transfers will require a CON or COE. Moreover, if a transaction entails significant capital improvements, those may be subject to separate CON approval, as the state considers whether the expenditure is prudent and in line with CON regulations governing health care spending. The parties will then need to work any approval processes into the timing of the transaction, in order to keep this aspect on track. Many states require a significant review lead time.

The parties should also gauge the potential level of scrutiny to expect from the state board or agency, and anticipate and prepare for questions regarding access to care, charity care,

scope of services, staff reduction and any other matter that seems to be the current hot button for
the board or agency. Moreover, it is not uncommon for regulators to want a valuation and/or
fairness opinion depending on the nature of the transaction. Finally, the parties should start
working on building both internal and external constituency support for the proposed transaction.
For example, once public, the parties will want to issue press releases and reach out to
community leaders to gain support since it is not uncommon for state CON/COE boards and
agencies to allow community input into a particular matter up before the board or agency.

C. Attorney General Review

In many states, the Attorney General regulates the use, control, and disposition of
charitable assets. Therefore, the Attorney General may oversee any significant non-profit
corporate changes including the sale to a for-profit or other disposition of assets. The Attorney
General may require that the entities submit a "merger plan," or proposal to sell, to the Attorney
General for approval. It is vital to understand the Attorney General's position and level of
involvement in the state(s) at issue for a proposed transaction, because they very well may have a
track record of impeding proposed transactions based on access to care and charitable trust
concerns, as further discussed below. Moreover, if a community or non-religious facility is
transferring to a Catholic system, the merger plan may face greater scrutiny from the Attorney
General.

To most effectively handle AG review and approval processes, the parties should assess
the need for AG involvement early on in the process, working this into the transaction timeline
as well. They should understand the AG's involvement in these matters, study its history and
recent trends and prepare accordingly. In a not-for-profit sale to a for-profit buyer, the seller
should have a valuation that supports the purchase price and, possibly, a fairness opinion that
assesses the reasonableness of the overall deal for the seller. It should also be able to
demonstrate the need for the sale, since the charitable organization's primary mission is to
continue the business enterprise as a tax-exempt, charitable organization initiative. For example,
if the organization is facing bankruptcy, has gone through the process of finding another
charitable partner to no avail and must either close the hospital or sell, the case can usually be
made that it is in the best interests of the community to sell in order to keep this provider
accessible. The AG often will want to see board minutes, financial assessments and other
documentation in support of this position. Therefore, careful recordkeeping and thoughtful
processes are important from the very beginning of this process.

This is true not only in cases where a for-profit comes into the picture, but also where a
secular hospital is transferring ownership to a Catholic sponsored hospital or health system. AGs
concerned about ERD implications will look not only for documentation that the board started its
process by seeking a suitor more closely aligned with the charitable organization's mission (i.e.,
more community based in nature than religious), it may expect certain pre-closing actions geared
towards maintaining services in the community, as further discussed below.

D. Catholic Issues

The Catholic Church plays a significant role in healthcare in the United States and it is
not atypical to face unique Catholic-related issues when one party to the transaction is Catholic
and the other is not. There are approximately 625 Catholic hospitals and 56 Catholic systems in
the United States, and four of the ten largest healthcare systems in 2010 were Catholic.\footnote{44}
The number of sisters and brothers able and willing to run a healthcare system is diminishing. This

\footnote{44} Jordan Rau, "In Quest to Grow, Catholic Hospital System Pares Religious Ties," \textit{Kaiser Health News} \textit{2} (Jan. 23, 2010).
does not mean, however, that Catholic healthcare is therefore declining in the United States. Rather, Catholic systems are moving towards a Public Juridic Person ("PJP") model that facilitates layperson involvement in governance. Through this model, the Catholic sponsors are able to appoint a layperson board of directors to assume responsibility for Catholic healthcare ministries (such board may, of course, include nuns and brothers). Parties concerned about a Catholic sponsor's ability to provide sufficient leadership into the future may want to consider whether a PJP model should be implemented as part of the overall transaction or planned for in the future.

The delivery of healthcare in a Catholic system also must comply with the ERDs. The Ethical and Religious Directives offer moral guidance and are drawn from the Catholic Church's theological and moral teachings on various aspects of health care delivery. Of particular relevance to healthcare delivery, Catholic healthcare institutions may not promote or condone contraceptive practices, other than natural family planning. Additionally, Catholic health providers may not perform abortions, elective sterilization, or in vitro fertilization. Regulators in some states are concerned about the potential implications such restrictions have on healthcare services for women and such concern may actually impede a proposed merger or consolidation.

Moreover, when Catholic systems acquire secular hospitals, some public interest groups will monitor and lobby against such transactions, attempting to influence CON/COE and AG review and approval processes. Medical staffs may also voice concerns about transitioning into a Catholic healthcare model. In order to avoid or lessen the impact of complications from public

interest groups and state agencies, preparation and due diligence are critical. The same holds true for working with medical staffs. It is important not only to properly educate individuals as to the true scope and implications of the ERDs but also to document alternative healthcare options and the locations of available reproductive services in the community. A secular seller may need to provide funding pre closing to such other providers in order to facilitate access to such services by indigent patients post closing (e.g., through a grant agreement). Moreover, the secular entity should carefully document the reason for the Catholic system's involvement, and work with the providers whose practices would be affected by the ERDs to relocate practices as necessary and simply to better understand the ERDs. ERD compliance education, however, generally is best left to the Catholic suitor.

As an example of AG scrutiny, in Kentucky in 2011, a proposed merger between Catholic Health Initiatives, Jewish Hospital Healthcare Services, Inc., and University of Louisville hospitals gained approval from the Federal Trade Commission ("FTC") and the Catholic Church, but the Attorney General and the Governor refused to approve the planned merger.\(^46\) The Attorney General and Governor stated that they feared that the state would lose control over the university hospital, including the hospital's ability to offer reproductive services post-closing.\(^47\) Additionally, they voiced concern over the conflict between the state Constitution and the ERDs, because the state is prohibited from endorsing religious beliefs under the Constitution.\(^48\) Therefore, the University of Louisville Hospital dropped out of the proposed three-way merger, and Catholic Health Initiatives and Jewish Hospital moved ahead with a

\(^{47}\) Id.
\(^{48}\) Id.
merger of their two remaining hospitals. On the issue of their particular religious affiliations, the two remaining hospitals assured the public that "historically Jewish facilities will remain Jewish and historically Catholic facilities will remain Catholic." Recently, the Governor approved a joint operating agreement between University of Louisville Hospital and KentuckyOne Health, the new entity created by the merger of Jewish Hospital and Catholic Health Initiatives. University of Louisville Hospital will cede day-to-day operation of the hospital to KentuckyOne, but the Center for Women and Infants will remain with University of Louisville Hospital. Such example demonstrates the need to be proactive and flexible in consolidation efforts.

As another example, several years ago a Catholic health system was selected by the board of a Chicago-area community hospital to become the sole corporate member of the hospital's not-for-profit corporation, which was no longer financially viable. The proposed transaction allowed the community hospital to remain not for profit and honor its exempt purpose and mission, including treating its large Medicaid population. The proposed transaction included significant capital improvements and the assumption of pension funding obligations. However, prior to the change of control from the community board to a religious sponsor, the community hospital provided tubal ligations, vasectomies, fertility treatments, and other birth control, all of which would be prohibited by the ERDs under Catholic sponsorship. During its review of the transaction, the Attorney General raised concerns that access to birth control and sexual assault victim treatment protocols, including the morning after pill, would be adversely impacted by the

49 Id.
50 Id. at 56.
52 Id.
proposed transaction. The Health Facilities and Services Review Board refused to act on the application until the Attorney General was comfortable with the community hospital's plan to address these concerns.

Ultimately, the transaction was approved as the parties worked through additional deal components that addressed regulator's concerns. A pre-closing grant support agreement between the community hospital and a community Federally Qualified Health Center funded birth control and other implicated services. Obstetricians and gynecologist practices were relocated to new office space prior to closing, allowing them to practice without the ERD restrictions placed upon tenants of a Catholic healthcare provider landlord. Additionally, the hospital entered into a relationship post closing with a third party to address the counseling and treatment of victims of sexual assault in a manner acceptable to the state and compliant with the ERDs.

Catholic systems which have merged with secular systems have worked through other strategies to effectuate growth and consolidation. For example, Catholic Healthcare West recently became Dignity Health and now has a non-denominational board. The Catholic hospitals in the Dignity Health system will continue to adhere to the ERDs, and the order of nuns that formerly governed the system will continue to be involved. The secular hospitals in the Dignity Health system will adhere to a "Statement of Common Values" that allows for tubal ligations but prohibits elective abortions and in vitro fertilization.53

Also, in New York, following a three-way merger, a secular system and a Catholic system combined maternity wards, but created a stand-alone birthing and reproductive services

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53 Rau, supra note 44 at 3.
clinic, which operates independently. The separate birthing center, Burdett Care Center, allows the distinct Center to operate without complying with the ERDs. Additionally, the New York State Department of Health required that the midwifery philosophy at one of the hospitals be kept following the merger.

E. Antitrust Considerations

This section provides only a brief overview of antitrust considerations, as Part Two of the Presentation Consolidation in a Rapidly Changing Industry: Navigating Options, Antitrust and Other Obstacles focuses on antitrust matters and is supplemented by materials provided by co-presenter David Ettinger.

When affiliating through lesser models such as clinical affiliations, the parties must be careful not to engage in joint contracting or illegal tying (i.e., require that a third party contract with both). They also should not share competitive information that could be used to support a claim of price fixing or other anticompetitive behavior in violation of antitrust laws.

When handling mergers, consolidations and other transactions that result in a combined entity, the parties will need to first determine whether a Hart-Scott-Rodino ("HSR") filing is necessary. If a transaction meets three tests, then the parties must notify the FTC of the transaction. The first test is the "commerce test" which requires that either party to the transaction is engaged in commerce or any activity affecting commerce. The second test is the "size of the transaction test," which is met if, as a result of the transaction, the acquirer entity will hold securities, voting rights, and assets of the acquired entity in excess of $68.2 million. The

56 Id.
third test is the "size of the person test," which is met if the acquirer entity's assets equal $136.4 million or more and the acquired entity's assets equal $13.6 million or more. However, if the size of the transaction is greater than $272.8 million then the "size of the person test" is not applicable, and the parties must report the transaction to the DOJ and FTC and seek approval.\textsuperscript{57} While the FTC reviews the merger, the deal cannot close.\textsuperscript{58} The review period is typically thirty days, but the FTC can extend the waiting period by requesting additional information.\textsuperscript{59}

The FTC has recently intervened in several health care transactions and impeded the ability for the mergers to close. For example, two not-for-profit hospitals in Rockford, IL, Rockford Health System and OSF Health System, sought to merge and become the OSF Northern Region in 2012.\textsuperscript{60} This merger attempt was the most recent of five previous merger attempts in the Rockford area, and would have resulted in a combined entity with over 5,000 employees.\textsuperscript{61} The parties cited reimbursement cuts and increased numbers of uninsured patients as the reasons for the merger.\textsuperscript{62} They also stated that the merger would achieve operational efficiencies, cost savings, clinical integration, and enhanced level, scope, and quality of health care services.\textsuperscript{63}

\textsuperscript{58} \textit{Id.}
\textsuperscript{59} \textit{Id.}
\textsuperscript{60} Melissa Westphal, "Rockford Health System, OSF Saint Anthony deal moves ahead," \textit{Rockford Register Star} (Feb. 1, 2011).
\textsuperscript{61} \textit{Id.}
\textsuperscript{63} \textit{Id.}
After reviewing information on the proposed transaction, the FTC filed a complaint to halt the merger. The FTC stated concerns that the merger would reduce Rockford-area hospital systems to two, and that the two systems, Swedish American and OSF, would control 99% of the acute-care market in Rockford. Further, it noted that OSF alone would control 64% of the acute-care market. The FTC also stated that health plans would have to offer access only to Swedish American or negotiate with OSF, who would have the ability post-merger to demand higher reimbursement rates. The FTC feared that these increased costs would be passed on to consumers. In April 2012, a federal court granted the FTC's injunction to delay the deal. Following the injunction, the two health systems amicably ended their efforts to merge because the costs of fighting the FTC were prohibitive, per the parties.

V. SAMPLE TRANSACTION

The legal hurdles, regulatory approvals, and numerous requisite steps can make a consolidation or collaboration initiative incredibly complex. A sample timeline is attached hereto as Exhibit A, which provides an overall view of the process. The following is a general step-by-step overview of the process involved in completing a change of control agreement transaction, with many parallels to mergers, stock deals and asset purchases, as noted.

66 Id.
67 Id.
68 Id.
70 Id.
A. Assess Need

The first step with any transaction is to assess the need for a partnership through change of control, merger, affiliation, or sale. This step often includes seeking the advice of a financial advisor who can explain and assess the financial considerations. The governing board should also consider the competition in the community and any mission-driven concerns. The discussions that occur at this level should be carefully documented as to establish a thoughtful record in the event the board is ever questioned as to meeting its fiduciary obligations to act in the best interests of the organization.

B. Special Committee

The board should appoint a special committee that can focus on assessing the various options. This committee will review all options and interview potential partners. It may be necessary for the special committee to engage consultants to provide advice. The committee may also seek valuation opinions. Ultimately, this committee should report to the board and make recommendations for next steps. The special committee's process should also be carefully documented.

C. Selection Process & General Due Diligence

This step involves assessing potential partners for compatibility and flagging any issues. The mission of potential partners should be compatible. Mission compatibility is always important, but is especially true in the case of partnerships with religiously-sponsored systems. This step should also include an operations assessment and a financial review. Preliminary due diligence should include an assessment of a potential partner's regulatory compliance and history with previous transactions in order to make sure that the party seeking an affiliation or other change is aware of any major issues. Also, the strategic vision for the applicable region and the
potential partner's model of control (i.e. whether it is top down or regional) should be assessed for compatibility.

D. Financing/Valuation Matters

Another very early step is to review all relevant financing documents to determine how they might impact structuring the deal. For example, the Master Indenture for any tax-exempt bond financed hospital must be reviewed for any covenants or restrictions. During this step, a capital needs assessment should be conducted and fair market value should be established. The scope of the fair market value assessment will vary depending on the state and the type of transaction. Asset deals may require an independent valuation whereas in the case of a change of control between exempt organizations, the facility book value may sufficiently establish fair market value for state approval processes as long as the governing board is assured as to the overall transaction providing reasonable consideration for its organization, taking into account all material facts and circumstances.

E. Letter of Intent

The letter of intent should incorporate all items that the organization views as critical to the transaction. It is important to include information related to the type of transaction, the continued role of the board or other governing bodies, and consideration or capital commitments. Consideration and capital commitments may include completion of certain capital projects, new capital projects, sale of assets, and the purchase price as applicable. Other items that may be included in a letter of intent include other assumed or excluded assets and liabilities; employee matters including continued employment, retention agreements for key employees, and pension funding; charity care commitment and mission; use of names; and physician recruitment commitments.
Furthermore, a system may wish to include information in the letter of intent related to continuation of community services or entities, continuation of operations for a specified period of time, the due diligence process and access to information, indemnification and enforcement, and, possibly, a break-up fee. The break-up fee is a penalty amount that one party pays to the other in the event such party determines not to proceed with the transaction and its determination is not based upon good cause (e.g., troubling due diligence findings).

Finally, the letter of intent should also state that it is subject to confidentiality, a definitive agreement, and exclusive dealing or a no-shop clause. An exclusive dealing clause prohibits the parties from participating in discussions or negotiations for competing proposals. A sample letter of intent is included as Exhibit B, and a sample checklist of common considerations for the letter of intent is included as Exhibit C.

F. Due Diligence

The due diligence process includes extensive review of financial, organization, operation, and compliance information related to the parties. The due diligence process occurs prior to and with some overlap of the review and negotiation of the definitive agreement stage. The first due diligence request will likely be followed by several supplemental requests. The parties and their financial and legal advisors, as applicable, will need to review all the information provided in order to refine and negotiate representations and warranties in the definitive agreement, address operational issues, etc. Two sample due diligence checklists are included as Exhibit D hereto. The first checklist is a comprehensive list of requests. The second checklist is a shorter form. Either may be adapted for use based on the type and complexity of the transaction.

One of the most important parts of due diligence is the compliance due diligence. If a party has potential Stark, Anti-kickback, or other material liabilities, this could impede closing.
As discussed above, one party may require the other to self-disclose and settle any apparent violations of the law before consummating the transaction so as to avoid exposure to the nondisclosing party.

The operational due diligence should establish a checklist of licenses, permits, registrations, accreditations, and whether any notice, or pre or post-closing approvals are required. The operational due diligence should also be used to establish a plan of integration.

G. Definitive Agreement

The definitive agreement should include any letter of intent terms as well as references and schedules. The schedules detail information required in the representations and warranties and lists of any exceptions to the representations and warranties. It is important to note that schedules directly impact representations, warrantees, indemnifications and other key provisions. A sample table of contents for a change of control agreement is attached as Exhibit F, and a sample table of contents for an asset purchase agreement between a for-profit health system and a not-for-profit hospital is attached as Exhibit F. These should serve as good checklists for document inclusions.

H. Approval & Notifications

As the definitive agreement is negotiated, the process of seeking regulatory approvals should begin. The timeline for these approvals should be set early on in the process and take into consideration the amount of time required to complete notifications and approvals. State regulatory agencies may require a certificate of need or certificate of exemption approval. The parties will also need to comply with Hart-Scott-Rodino notifications to the Federal Trade Commission for anti-trust purposes, as applicable. The federal government requires employee termination notifications under the WARN Act in the event of a closing or mass layoff (as
defined therein), and many states have similar requirements that may be implicated by a particular transaction.

A State's Attorney General may also require notification and the chance to review the merger or consolidation plan, if one or both of the entities is a charitable organization. If one of the parties is a Catholic institution then certain religious consents and approvals are required, which may include indults or approvals from Rome. Additionally, the governing bylaws may require certain approvals.

In the case of a change of ownership, the prior owner's Medicare provider number and provider agreement typically will need to be transferred to the new owner. As previously discussed, this transfer will include any liabilities related to the Medicare provider number. In the case of a member substitution, the parties typically do not need to do a CHOW but rather more simple notices to Medicare.

At this point in the process, the parties should refer to the checklist of license, permits, and accreditations created during due diligence to ensure that any other notifications or actions are completed prior to closing. Notifications may include notices to bondholders or other third party contractors. If third party consents are required under any material contracts, the parties will need to make sure the timing is sufficient (e.g., a requirement that prior written consent of assignment of a contract be obtained 90 days in advance of closing would need to be worked into the timeline for certain transactions). The parties should also address employee benefits and pension plan matters as well as employee transition matters.

I. Closing

Closing typically occurs on a mutually agreed upon date, provided that all contingencies are met such as planning board approval, FTC clearance, and board approvals. Prior to closing,
an internal announcement should be made to management and employees. The parties should mutually agree on the contents of this announcement. They should also agree on a jointly issued statement and designate a contact for the press.

J. System Integration

System integration will likely begin prior to closing and much of the integration plan may be agreed upon in mutual due diligence. Post-closing system integration should include press releases, financial systems, employee benefits, technology systems, and integration of mission, contracting, and policy. While it may seem like a lot of work moving through all of the steps necessary to effectuate the transaction, much of the work for managers and operational personnel begins at closing. Integration can take a fair amount of time and requires patience and diligence. A successful consolidation effort is more likely when the parties have worked diligently in the pre-closing stages to outline implementation tasks and appointed team members from both sides of the transaction to collaborate to the extent feasible.
Exhibit A

Sample Process Overview and Timeline

Potential Change of Control Transaction – General Projected Timeline

- Preliminary Legal Input
- Preliminary Site Visits to Potential Partners
- Reverse Due Diligence Process
- Selection of Partner
- Target Letter of Intent Signing
- HSR Review and Filing
- Target Agreement Signing
- System Integration
- Projected Closing
- Prepare Amended Articles & Bylaws
- Submit Contract and License Notices/Requests for Consent
- Regulatory Approvals / COE / CDN / AG / Licensure
- Definitive Document Negotiation / Drafting
- Bond Financing Review
- Due Diligence Process

Exhibit B

Sample Letter of Intent

NOTE: THIS IS A SAMPLE LETTER OF INTENT IN THE FORM THAT THE SPONSOR MAY PRESENT. IT IS PRESENTED FOR YOUR REVIEW AND CAREFUL CONSIDERATION OF EACH ISSUE. OTHER KEY ISSUES SHOULD BE ADDRESSED.

STRATEGIC PARTNER/SPONSOR

__________________________

_________________, __  _____-____

Date

The Board of Directors
Health System
1234 Main Street
Maintown, USA 01234

Ladies and Gentlemen:

This letter of intent sets forth a non-binding agreement in principle between Health System, a ____________ on behalf of itself and its affiliates and ____________ ("Sponsor"), outlining the principal terms and conditions of the proposed change of control (the "Proposed Transaction") pursuant to which Sponsor shall become the sole member (the "Member") of Health System, which owns and operates such Facilities as delineated in Exhibit A attached hereto (the "Facilities") and owns or controls certain other related businesses (the "Related Businesses") as delineated in Exhibit B attached hereto. Health System and Sponsor may be referred to individually as a "Party" and collectively as the "Parties."

Structure of Transaction.

(a) Assumption of Membership. The Proposed Transaction shall be structured and concluded in form and substance mutually agreeable to Health System and Sponsor and shall result in Sponsor becoming the sole Member of Health System (the "Member Assumption"), and, if appropriate to accomplish the transfer of interests, Sponsor replacing Health System as a member or shareholder of any entities that own or operate any Facilities or Related Businesses.

(b) Reserved Powers. Upon the closing, Sponsor shall hold such reserved powers with respect to the governance and operations of Health System, the Facilities and
entities that own or operate Related Businesses (together, the "Health System Entities"),
as determined appropriate by the Parties, including, but not limited to, the powers to
amend the Articles of Incorporation and Bylaws of Health System Entities and to appoint
and remove members of Health System Entities' Board of Directors (the "Board"). The
Parties agree that as of the closing Health System Entities' Bylaws shall contain the
minimum changes necessary to effect the Member Assumption, and that after the closing
Sponsor shall put into place its standard form Bylaws.

(c) **Covenant Enforcement.** Prior to closing, the Board of Health System will
organize an entity or select an existing entity to, among other things, enforce certain
commitments and covenants of Sponsor under the Definitive Agreement. It is intended
that _________'s ("Oversight Entity") oversight role will discontinue after the [eighth
(8th)] anniversary of the closing date. At closing, (i) Oversight Entity will be capitalized,
in the amount of [$1,000,000], to allow Oversight Entity to perform its oversight function
(any such funds remaining at Oversight Entity at the expiration of its oversight function
will be conveyed to Sponsor), and (ii) Sponsor will agree to indemnify Oversight Entity
for its costs and expenses in any action by Oversight Entity to enforce Sponsor's
covenants under the Definitive Agreement.

(d) **Board Member Representation.** The composition of the governing Board
of the Health System Entities shall be determined by the Board of Directors of Sponsor,
which shall consider the individuals' background, qualifications and commitment to the
community served by Health System. [Address any continuing representation of current
directors.]

(e) **Sponsor Board.** For a period of [eight (8)] years after the closing date,
[one] designee of Oversight Entity shall serve as a member of the Board of Directors of
Sponsor. Such member shall be selected by the Board of Directors of Sponsor from a
slate of [four (4)] nominees submitted by the Board of Directors of Oversight Entity.

**Capital Commitments.** Subject to the terms and conditions of the Definitive Agreement,
following the closing, Sponsor shall complete certain capital projects as set forth on Exhibit C
and pledge to make certain capital improvement expenditures in the minimum amount of
$_____________ over a period of __ years.

**Retained Assets.** Health System shall retain all existing cash, investments and all other
assets which exist as of the closing, subject to additions or reductions in the ordinary course of
business or any transfers contemplated by or in furtherance of the objectives of the Definitive
Agreement ("Assets"), other than excluded assets listed on Exhibit D which shall be transferred
to an affiliate prior to closing.

**Retained Liabilities.** Health System will retain all liabilities for its long-term and short-
term debt, and all other liabilities of Health System which exist prior to or on the closing date,
including bonds, medical malpractice liability and self-insurance and pension plan liability, other
than excluded liabilities listed on Exhibit D which shall be assigned to and assumed by an
affiliate prior to closing.
Coverage of Malpractice Claims. On or prior to the closing, Sponsor shall designate sufficient cash and investments to ensure that funds are available to pay any malpractice liabilities of Health System arising prior to the closing.

Donor Restricted Funds. Following the closing, bequests, gifts and endowments of Health System entities that are restricted as to use or manner of investment shall continue to be so restricted and Sponsor shall honor donative intent with respect thereto.

Retention Agreements. Health System will provide retention agreements for key employees to incentivize them to remain employed by Health System through the closing.

Indemnification and Enforcement. As stated above, from and after the closing, Oversight Entity shall have the power to enforce Health System's rights under the Definitive Agreement, including the right to enforce Sponsor's commitments and covenants and to bring indemnification claims. Indemnification claims brought against Health System will not require cash payment, but rather will result in a reduction of Sponsor's capital commitments, up to a maximum amount of $_____________________ (the "Cap"). Sponsor's indemnification obligation liability shall not exceed the Cap.

Additional Terms and Conditions.

Employees. Sponsor will hire all of the active employees of Health System employed in the operation of the Facilities in positions and at compensation levels consistent with those then being provided by Health System.

Benefits. From and for at least ___ years following the closing, Sponsor shall provide benefits and establish terms and conditions of employment, which shall be generally consistent with those offered by Health System in its other affiliations as of the closing. Sponsor shall honor prior service credit under current Health System welfare plans for purposes of satisfying any eligibility waiting periods and will waive any pre-existing condition exclusions in Sponsor's welfare benefit plans. Where Health System has prior qualified retirement programs, Sponsor shall honor prior length of service for purposes of eligibility and vesting in Sponsor's retirement benefit plans, but shall not make contributions to such plans with respect to prior service and shall not assume Health System's retirement plans. Sponsor shall honor prior service credit for purposes of severance, vacation and PTO. Sponsor will assume the accrued liability as recorded in the financial statements at closing for vacation and holiday benefits related to such employees.

Pension Protection. On or prior to the closing, Sponsor shall designate sufficient cash and investments to be set aside or make other reasonable provisions to ensure that all of the benefits due to employees under the Health System's employee pension plan(s) as of the closing are available to be paid when due under the terms of such plan(s). [Address other key pension issues.]
Indigent and Charity Care. Subject to changes in legal requirements, Sponsor will maintain and adhere to Health System's current policy on charity and indigent care and shall continue to provide care to indigent and low-income patients at levels similar to those historically provided by Health System.

Continuation of Services. For a period of at least ___ (__) years following the closing, Sponsor will continue to operate the Facilities they are currently operating. [Address Related Businesses as necessary.]

Physician Recruitment. Sponsor will commit to a physician recruitment plan based upon community, physician and hospital board input and needs.

Medical Staff. The closing shall not affect or change the medical staff privileges held by members of the medical staffs of the Facilities on the closing date, the medical staff bylaws, rules and regulations or credentialing procedures of the Facilities in effect on the closing date, or any agreements with members of the medical staffs.

Healthcare Education and Community Service. Sponsor will commit to the continuation of healthcare education and other community services currently offered at or by the Facilities.

Healthcare Quality Indicators. Sponsor will commit to adopt and implement healthcare quality indicators as mutually determined by Health System and Sponsor.

Break-Up Fee. If either Sponsor or Health System fails to close the Definitive Agreement in breach of the closing requirements, then the Party in breach shall pay the other Party a break-up fee of $_________________.

Access to Information. Pending the execution of the Definitive Agreement, Health System will permit Sponsor and its representatives full and complete access, during normal business hours, to inspect and appraise the Facilities, and will disclose and make available to representatives of Sponsor all books, agreements, papers and records relating to the ownership and operation of the Facilities. In this regard, Sponsor agrees that such inspection shall not interfere with the operations of the Facilities.

No Violation. Sponsor has entered into this letter of intent in reliance on Health System's representation that it is not currently bound under any binding or enforceable contract or agreement with any third party which would materially interfere with the transactions contemplated hereby. This letter of intent, and the transactions contemplated hereby, will not violate any contract, agreement or commitment currently binding on Health System or the Facilities.

Confidentiality; Disclosure; Expenses.

Except as otherwise required by law or as otherwise agreed by the Parties, Health System and Sponsor agree to keep this letter of intent and all information provided by
either Party pursuant to this letter of intent and its contents confidential and not disclose
the same to any third party (except attorneys or accountants hired by them and except to
the applicable governmental agencies in connection with any required notification or
application for approval or exemption therefrom) without the written consent of the other
Party.

Except as required by law, any release to the public of information with respect to
the matters set forth herein will be made only in the form and manner approved by the
Parties and their respective counsel.

Each Party shall bear its own expenses in connection with the implementation of
this letter of intent, regardless of whether the Definitive Agreement is executed.

Definitive Agreement. Except for the provisions of Sections 12, 13, 14 and 15 hereof,
this letter of intent is not intended to be a binding agreement and shall not give rise to any
obligations between the Parties. Further, due to the complexity of the proposed transaction, it is
the expressed intention of the Parties that except for the provisions of Sections 12, 13, 14 and 15
hereof, no binding contractual agreement shall exist between them unless and until Sponsor and
Health System shall have executed the Definitive Agreement, which shall contain the provisions
outlined above and the representations, warranties, and other terms and conditions customary in
this type of transaction, all of which must be acceptable to both Parties in their sole discretion
(including, without limitation, contingencies for all necessary regulatory approvals). Either Party
may for whatever reason terminate this letter of intent and further negotiations by written notice
to the other Party. In such event, there shall be no liability between us as a result of the
execution of this letter of intent, any action taken in reliance on this letter of intent, or such
termination, except with respect to the provisions of Sections 12, 13, 14 and 15 hereof.

No-Shop Provision. From the date of execution of this letter of intent until the earlier of
(i) termination of negotiations by Sponsor or (ii) a date which is ninety (90) days from the date
hereof (unless a Definitive Agreement proposed by Sponsor contains terms and conditions
materially different from the terms and conditions as outlined in this letter of intent, in which
case the provisions of this Section 15 shall not be applicable), Health System will not, without
the approval of Sponsor (a) offer for sale the Facilities (or any material portion thereof) or
Related Businesses or any ownership interest in any entity owning any of the Assets, (b) solicit
offers to buy all or any material portion of the Facilities or Related Businesses or any ownership
interest in any entity owning any of the Assets, (c) hold discussions with any party (other than
Sponsor) looking toward such an offer or solicitation or looking toward a merger or
consolidation or change of control of any entity owning any of the Facilities or Related
Businesses or (d) enter into any agreement with any party (other than Sponsor) with respect to
the sale or other disposition of the Facilities or Related Businesses (or any material portion
thereof) or any ownership interest or change of control in any entity owning any of the Facilities
or Related Businesses or with respect to any merger, consolidation, change or control or similar
transaction involving any entity owning any of the Facilities or Related Businesses.

*   *   *

5
Please indicate your approval of the terms and conditions of this proposal and your intention to enter into these negotiations by executing two copies of this letter in the space provided below and returning one executed copy to Sponsor, whereupon we shall proceed promptly with our evaluation and review of the Facilities and Related Businesses and business prospects and with the preparation and negotiation of the Definitive Agreement. Please be advised that this proposal shall expire unless there has been delivered to Sponsor a fully executed copy of this letter no later than 5:00 p.m. on __________ __, 201__.

We look forward to a successful and mutually rewarding relationship in respect of the transactions set forth herein.

Sincerely,

____________________________________
By: ______________________________________

THE FOREGOING IS APPROVED:

THIS ____ DAY OF ______________, 201__

HEALTH SYSTEM

By:___________________________________
Exhibit C

Checklist of Common LOI Considerations

1. Assumption of Membership (Change of Control) and Reserved Powers
2. Continued Governance Role (Board Member Representation)
3. Consideration and/or Capital Commitments Examples
   a. Completion of Medical Center Expansion
   b. Replacement Facility in ______________
   c. Facility Modernization
4. Assumed Liabilities
5. Excluded Liabilities, if any
6. Excluded Assets, if any / Charitable Asset Restrictions
7. Employee Matters – Continued Employment
8. Retention Agreements for Key Employees
9. Pension funding / Other pension commitments
10. Charity Care Commitment and Mission
11. Use of Names
12. Physician Recruitment
13. Medical Staff Membership
14. Continuation of Community Services / Mission / Certain Entities
15. Continuation of Operations for a Period of Years
16. Due Diligence Process / Access to Information
17. Confidentiality
18. Subject to Definitive Agreement
19. Indemnification and Enforcement
20. Exclusive Dealing (No-Shop Clause)
21. Break-Up Fee
Exhibit D

For a copy of Exhibit D material, please contact the author.
Exhibit E

Sample Table of Contents for Change of Control Agreement

CHANGE OF CONTROL AGREEMENT
(aka Affiliation Agreement)

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