

**Bidder 3**      **Response to**  
**Community Medical Center's**  
**Request for Proposal**  
**September 26, 2013**



From day one.

September 26, 2013

Mr. James M. Moloney  
Managing Director  
Cain Brothers & Company, LLC  
601 California Street, Suite 1505  
San Francisco, CA 94108

Dear Mr. Moloney:

Thank you for providing Bidder 3 ( ) with the opportunity to respond to Community Medical Center's ("CMC") Request for Proposal ("RFP"). Included with this cover letter is our response to CMC's RFP.

We envision CMC and Bidder 3 in developing clinical and collaborative relationships. Together as a network, we believe we could enhance CMC's clinical services, improve CMC's cost structure, better position CMC to serve western Montana and northern Idaho, and build upon CMC's reputation for delivering high quality services and success in achieving operational excellence.

Working with CMC's board of trustees and medical staff leadership, we would facilitate the development of a strategic growth plan for CMC. We envision core elements of the strategic plan would include:

- Build a continuum of care network around CMC with other wellness, outpatient, post-acute care, physician, employer, and payer relationships.
- Develop CMC's provider network. We would evaluate opportunities to form clinical collaborations with Bidder 3 to support the development and coverage of CMC's provider network. We would also recruit physicians in coordination with CMC's existing medical staff, and pursue acquisition of physician practices when/where necessary.
- Invest in and grow CMC's clinical programs and services, focusing on service lines such as Heart & Vascular, Oncology, Orthopedics, and Women's Services (to name a few). We would seek to involve Bidder 3 in the development and expansion of CMC's clinical programs and services.

- Develop new ambulatory access points in CMC's services areas.
- Invest capital to continuously replenish and upgrade CMC's facilities, medical technologies and equipment, and IS/IT platform.
- Use the name "Community Medical Center" for identification and marketing purposes.
- Continue to build upon CMC's physician relationships that continuously advance CMC's commitments to quality, safety, and access to services.
- Provide CMC with access to Bidder 3 contracts, programs and tools in order to help CMC achieve immediate economies of scale.
- Continue CMC's focus on improving operations, quality outcomes, patient safety, physician relations, and customer satisfaction.

As you review our response to CMC's RFP, I hope you will keep the following in mind about us.

- We are one of the leading hospital operators in the United States.
- We have the infrastructure and operating expertise to help CMC thrive in a risk-based and value-based payment environment.
- We have the tools, resources, and processes that can help CMC achieve operational efficiencies, while continuing to deliver high quality patient care, in a safe environment, with high patient and physician satisfaction results.
- We have strong culture of collaboration with our physician partners.
- We believe we share similar philosophies and values with CMC in the sense that we both want to create better places for our 1.) patients to receive care; 2.) physician partners to practice medicine; and 3.) employees to work.

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Again, thank you for considering Bidder 3 and giving us the opportunity to respond to CMC's RFP. We look forward to learning the results of CMC's review of our response to its RFP.

Sincerely,

Senior Vice President  
Acquisitions and Development

**SECTION 1 – ABOUT**

Bidder 3 is one of the largest operators of general acute care hospital systems in the United States. From our founding in , we have grown to hospitals in states with approximately 20,000 licensed beds. Our hospitals provide a broad range of general and specialized healthcare services, including: general acute care, emergency, general surgery, specialty surgery, critical care, internal medicine, obstetric and diagnostic services. We also own physician practices, imaging centers, ambulatory surgery centers, reference labs, home care and hospice agencies, long term care and skilled nursing facilities. Consider the following statistical and financial information for our owned hospitals:

- 17,000+ medical staff members (over 3,000 physicians employed);
- 96,000+ employees;
- 900,000+ surgery cases;
- 1.4+ million adjusted admissions;
- 3.1+ million emergency room visits;
- 17.5+ million outpatient registrations; and
- \$13+ billion in net operating revenue.

**Recognitions**

Each Bidder 3 hospital has its own list of quality and service awards which would be too numerous to list. The following is a list of quality and service awards at a corporate level:

- 50 hospitals recognized by Joint Commission as “Top Performers” on core measures;
- 9 hospitals recognized on Truven Analytics “100 Top Hospitals” list in the last 7 years;
- 6 hospitals received Healthgrades® Outstanding Patient Experience Award;
- 2 hospitals are on Becker’s Hospital Review – 100 Great Community Hospitals list;
- 1 hospital made Modern Healthcare’s 100 Best Places to Work list two years in-a-row;

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<sup>1</sup> Bidder 3 is a company whose common stock trades on the New York Stock Exchange under the symbol “ ”. References in this response to “we,” “our,” “us,” “Bidder 3” or “Bidder 3” refer to any of several affiliates of Bidder 3 in particular Bidder 3 Professional Services Corporation, that provide operational support and/or management services to operating entities.

Bidder 3

We own and operate Bidder 3 in Bidder 3. Bidder 3 is an integrated healthcare delivery system that works to increase access to health services, improve coordination of patient care among providers, and focus on quality and customer relationships. Bidder 3 is comprised of Bidder 3 and Bidder 3. Bidder 3 provides a broad range of general and specialized healthcare services, including: general acute care, emergency, general surgery, specialty surgery, critical care, internal medicine, obstetric, diagnostic, and outpatient services. Rockwood Health System also owns physician practices, imaging centers, ambulatory surgery centers, reference labs, home health, etc. Consider the following statistical and financial information for Bidder 3:

- 1,200+ medical staff members;
- 20,000+ surgeries;
- 30,000+ adjusted admissions;
- 70,000+ emergency room visits;
- 890,000+ million outpatient registrations; and
- \$500+ million in net operating revenue.

Bidder 3 is a key component of Bidder 3. Bidder 3 is a multi-specialty clinic with 300+ physicians and providers, representing 40+ specialties, servicing patients from 58 clinical locations, including Bidder 3 and Bidder 3.

Bidder 3 sees 110,000+ patients per year and employs 1,100+ employees. Bidder 3 is the largest freestanding outpatient diagnostic and treatment center between Bidder 3 and Minneapolis. Bidder 3 is also the largest regional referral center, and home to the region's most comprehensive and skilled medical and health care experts.

Announcement

On July 30, 2013, Bidder 3 and Bidder 3 ("Bidder 3") announced that they entered into a definitive merger agreement pursuant to which Bidder 3 will acquire Bidder 3. When completed, Bidder 3 would own or operate approximately Bidder 3 hospitals in 29 states with a total bed count of over 31,000, and net operating revenue over \$19 billion.

**Strategic Alliance Partner –**

On March 11, 2013, we announced a strategic alliance with [REDACTED]. The objective of the strategic alliance is to enhance the quality of patient care, improve access to healthcare services, reduce costs and drive operational excellence at our hospitals and health systems. The initial focus of the strategic alliance is in three areas:

- **Quality Alliance:** [REDACTED] is helping us establish clinical integration programs at our affiliated hospitals. [REDACTED] Quality Alliance is a framework that enables physicians to share best practices and capture, report and compare data in a standardized format. Clinical integration is a prerequisite for sharing data that drives better quality and value.
- **Cardiovascular Services:** [REDACTED] Heart and Vascular Institute will engage with certain [REDACTED] hospitals for the opportunity to apply the Institute's expertise in cardiovascular services to enhance the quality and data infrastructure of programs at our hospitals.
- **Clinical and Operational Services:** Jointly, we will explore a broad array of other engagements to share best practices and produce synergies. These may include tele-medicine initiatives, second opinion services for physicians and patients, complex care coordination, and other practices in care and cost containment.

[REDACTED] is a nonprofit multispecialty academic medical center that integrates clinical and hospital care with research and education. [REDACTED] has approximately 2,800 full-time salaried physicians and scientists who represent 120 medical specialties. [REDACTED] has pioneered many medical breakthroughs, including coronary artery bypass surgery. For the 19th consecutive year, [REDACTED] heart program has ranked as the best in the nation, earning the No. 1 ranking in U.S. News & World Report's "2013-14 Best Hospitals."

**SECTION 2 – TRANSACTION AND GOVERNANCE SUMMARY**

We propose to acquire substantially all of the assets of CMC in an Asset Purchase transaction. We propose to purchase CMC's assets for [REDACTED]. In addition we would purchase net working capital defined as supplies and inventories, and deposits and prepaid expenses that have continuing value to CMC, less accrued paid time off (e.g. holiday, sick, vacation pay). Assumed capital leases would be deducted from the purchase price. We would pay the purchase price, plus the amount for net working capital, by wire transfer of immediately available funds on the transaction close date.

CMC Foundation would retain the net proceeds from the transaction. CMC Foundation would retain all of its cash, investments, board designated assets, and any other "Excluded Assets". From the transaction proceeds and retained assets, CMC would defease its bonds, pay its debts, and satisfy any other liabilities that are part of "Excluded Liabilities".

Upon completion of the transaction, CMC Foundation would become independent of CMC, with its own separate governing board, charter, and bylaws. The only restriction we would place on CMC Foundation is that it not use the net proceeds from the transaction to compete against CMC with respect to the operation of the facilities for the term of the non-compete period.

The following table presents sources and uses of funds to CMC (dollars in millions).

Purchase Price	[REDACTED]
Plus: Purchase of Net Working Capital <sup>(1)</sup>	[REDACTED]
Total Proceeds	[REDACTED]
Plus: Retained Cash and cash equivalents, Investments <sup>(2)</sup>	[REDACTED]
Plus: Retained Assets (Net Accounts Receivables, Other Receivables/) <sup>(2)</sup>	[REDACTED]
Less: Retained Liabilities that Must Be Paid-Off or Otherwise Satisfied <sup>(2)</sup>	[REDACTED]
Estimated Net Proceeds to CMC Foundation	[REDACTED]

(1) Estimated

(2) Based on the June 30, 2013 unaudited balance sheet

The following lists the proposed included and excluded assets and liabilities in the transaction.

**Included Assets**

- All assets of the CMC, including the hospital, medical office buildings, physician clinics, joint venture interests, land, buildings, furniture, and equipment.
- All real property used in connection with, or acquired for the benefit of, CMC, including buildings, leaseholds, improvements or fixtures, free and clear of all liens and

encumbrances, except those we choose to assume.

- Supplies and inventories.
- Deposits and prepaid expenses that have continuing value to CMC.
- All patient, medical, personnel and other records.
- All licenses, permits and trade names.
- Certain assumable contracts and leases related to the operations of CMC.
- All interests in all property arising or acquired in the ordinary course of the operation of the business between the date hereof and the closing.
- All other property, whether tangible or intangible, of every kind, character or description owned by CMC and used or held for use in the operation of the entities, unless specifically excluded.

#### **Assumed Liabilities**

- Accrued paid time off (e.g. holiday, sick and vacation pay); and
- Capital leases.

#### **Excluded Assets (to be retained by CMC Foundation)**

- Cash and cash equivalents, marketable securities and other investment assets;
- Assets limited to use and other restricted assets, including Foundation assets;
- Patient accounts receivables<sup>2</sup> and non-patient accounts receivables;
- Due from third party payer settlements;
- Deposits/prepaid expenses that do not have continuing value to CMC; and
- Other assets, including, but not limited to, (i) self-insurance recoveries, (ii) pension and post-retirement plan assets, (iii) charitable remainder and perpetual trusts, (iv) long term bequest receivables and (v) cash value life insurance policy proceeds.

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<sup>2</sup> We would be willing to collect patient accounts receivables for a reasonable fee.

### **Excluded Liabilities**

- Accounts payable;
- Accrued salaries, wages and benefits and other accrued expenses;
- Due to third party payer settlements;
- Accrued pension and post-retirement obligations;
- Notes payable, including accrued interest payable;
- Bonds and other long-term debt, including accrued interest payable; and
- All other liabilities (other than assumed liabilities), either known or unknown.

### **Governance**

Each of our hospitals has a local board of trustees (the "board"), which includes members of the hospital's medical staff. The board is typically comprised of 9 to 12 members, who are local community residents and leaders, including the hospital's CEO and Chief of Medical Staff. Typically, we seek to have 3 to 5 members of the medical staff on the local board.

The initial board is appointed based on the recommendation of the current board of directors. In making a governing board transition, we focus on obtaining representation from key businesses and industries in the community as well as local government organizations and medical leadership. It is very likely (and desirable) that some members of the "current" board carry over to the "new" board to maintain governance continuity.

A board member's tenure is typically two to three years, and can be renewed in two to three year increments indefinitely. The board would form a board selection committee comprised of members of the existing board and the local CEO. When a board member retires from the board, the board selection committee identifies candidates to replace the retiring board member. Candidate selections would be decided upon by the entire board.

The "new" board would function similarly to the existing board of directors with similar fiduciary roles and responsibilities, with the exception that we would own the financial fiduciary responsibility for CMC. Specific responsibilities of the board would include:

- Developing a local strategic plan;
- Participating in development and review of operating and capital budgets;

- Adopting vision, mission and values statements, developing policies, and monitoring progress toward achievement of strategic goals;
- Conducting periodic evaluations of the CEO and making recommendations regarding that individual's employment;
- Reviewing and having input into substantive additions/changes in hospital services;
- Granting medical staff membership and clinical privileges and, when necessary, taking action consistent with credentialing processes, bylaws and strategic plans;
- Assuring compliance with Joint Commission accreditation and criteria;
- Supporting physician recruitment efforts; and
- Fostering community relationships and identifying community service opportunities.

The local board of trustees would serve as the eyes, ears, and mouth of the local community to ensure that CMC is providing an appropriate mix of health care services in order to meet the local community's health care needs. The local board is involved in developing and/or reviewing the following plans and reports:

- Strategic Growth Plan;
- Medical Staff Development and Physician Recruitment Plan;
- Annual Operating and Capital Budgets;
- Community Health Needs Assessments;
- Patient, Physician, and Employee Satisfaction Surveys;
- The Joint Commission Accreditation Survey Results; and
- Quality and Patient Safety Reports.

#### **Post Transaction Capital Commitment**

We would execute a long-term capital plan for CMC that aligns with CMC's capital needs, and would be jointly agreed to in the Definitive Agreements.

**SECTION 3**

- 1. Ensure the delivery of high-quality, cost effective health care services with measurable outcomes to the community through a commitment to expanding both the quality and scope of clinical services provided by CMC;**

**Delivering quality care and ensuring our patients' safety are among our highest priorities.**

- All of our hospitals have a Chief Quality Officer ("CQO") who reports to the CEO and is a member of senior management. This person has authority and responsibility to assure quality processes are operational and the organization is "survey ready" every day. At the corporate level, the Senior Vice President of Quality and Clinical Transformation reports directly to our CEO, and is a point of connection for local CQOs to ensure access to corporate resources and support for quality and patient safety.
- A Regional Quality Director and a Regional Case Management Director are assigned to each hospital. This person connects the local hospital to our corporate resources, including best practices and quality toolkits, and assists with issues related to patient safety, performance improvement, case management, and medical staff processes.
- We provide training and education on patient safety, quality improvement, The Joint Commission standards, and other topics through periodic conference calls.
- We utilize The Joint Commission's accreditation processes and provide extensive assistance to our hospitals to meet and exceed accreditation standards, including participation in comprehensive mock surveys.
- There are several Advisory Councils that include physicians and other clinicians that meet periodically. These councils develop and share best practices, give advice on policies and create opportunities for communication and collaboration throughout our affiliated hospitals. Examples of Advisory Councils include, CNO Council, ER Department, OB, Infection Control, Cardiology/Cath Lab, and Bariatric Surgery.
- All of our hospitals share quality and performance data for benchmarking and annually develop a Performance Improvement Plan with the assistance of our Quality and Clinical Transformation department. The following are a few examples:
  - Contract with HealthStream® for comparative patient satisfaction data;
  - Compare all of our hospitals to national and regional quality benchmarks;

- Analyze and report comparative data for every medical staff member; and
- Developed our own data repository to expand measured indicators and increase ability to monitor and share performance and quality data.
- We offer quality management tools to our hospitals, including:
  - Standardized Order Sets – partnering with Zynx Health, these are physician reviewed and approved order sets enable improved care delivery;
  - Senti-7-Electronic Infection Control Surveillance System;
  - SurgiCount technology-Bar coded surgical sponges to ensure patient safety;
  - “MD Staff” Medical Staff Credentialing Software System;
  - On-line resources including Dynamed, Micromedex, American Heart Association Courses for Basic and Advanced Life Support, and Mosby’s Nursing Skills.
- We contracted with Healthcare Performance Improvement to implement methods derived from high-risk industries (e.g. aviation and nuclear power) to enhance safety. All of our hospitals participate in education and training on the error prevention techniques/methodologies that are proven to reduce serious safety events by 70-80%.
- Our latest composite core measure score for all 135 hospitals is 99%.
- In September 2012, The Joint Commission recognized the “Top Performing Hospitals” that attained and sustained excellence in accountability core measure performance. According to The Joint Commission, the hospitals on this list represent the Top 18% of Joint Commission accredited hospitals that report core measure performance data. Of the 620 hospitals that made the list, we had 50 hospitals on the list, representing 8% of the total number of hospitals on the list.

### **Accreditations and Certifications**

The following are the number of our hospitals that have accredited and/or certified clinical programs and services:

- Over 70 of our hospitals offer specialty cardiac services, including:
  - 44 hospitals have accredited Chest Pain Centers

- 37 hospitals have open heart programs
- 38 hospitals have trauma centers status;
- 24 hospitals have Accredited Cancer Center status;
- 19 hospitals have Primary Stroke Center status;
- 12 hospitals have Bariatrics Center of Excellence status; and
- 12 hospitals are Total Joint Replacement certified.

### **Patient Satisfaction**

All of our hospitals participate in "Community Cares", which is a philosophy based on proven design principles. Community Cares is about improving the service experience for patients, physicians and employees. Community Cares is based on StuderGroup principles. Examples of initiatives undertaken through Community Cares include:

- Patient Hourly Rounding
- Emergency Department Discharge Callbacks (1+ million calls made in 2012)
- Patient Falls Prevention Programs
- Reduction in Hospital Acquired Urinary Catheter Infections Program

We have three corporate nurses who have trained with the StuderGroup and visit our hospitals to assist with HCAHPS ("Hospital Consumer Assessment of Healthcare Providers and Systems"). All of our hospitals have "Community Cares Champions" that are responsible locally to train staff on concepts like rounding for outcomes.

- a. **Provide your organization's Mission Statement; identify how it is implemented and how it aligns with CMC's commitment to provide a patient experience that is of high quality, safe and service-oriented to the patients, families and communities who seek health care services at CMC.**

Our mission is simple; we want to create better places for our patients to receive care, physicians to practice medicine, and employees to work. Our goal is simple as well; we want our hospitals to be the provider of choice in the communities they serve. We accomplish our mission and goal through our beliefs, which are our commitments to patients, physicians, employees, and the communities we serve. Our beliefs include:

- dedicating oneself to providing personalized, caring and efficient service to patients with patients' total satisfaction as a top priority;
  - recognizing the value of each employee in providing high quality, personalized care to our patients;
  - encouraging employee involvement in quality improvement on an ongoing basis;
  - advocating employee participation in community activities;
  - involving physicians in partnership, both as consumers of service and as providers of care, in order to ensure the delivery of high quality care;
  - devoting oneself through services, quality, and innovation to providing continued healthcare leadership in the communities served; and
  - dedicating oneself to compliance with all federal, state, and local laws, rules, and regulations, including privacy and security of patient health information, coding, billing, and documentation guidelines, and financial arrangements.
- b. Summarize your organization's overall strategy and specifically indicate how you envision CMC to fit into the strategy including any enhancement or realignment of services at CMC. It is CMC's goal to improve its cost position by 3 – 6% through service realignment with a new regional partner.

#### Overall Strategy

In general, our strategy is to develop integrated delivery networks ("IDN") in markets where we operate. We do *not* operate hub-and-spoke networks, where community hospitals funnel all high-end clinical services to a central medical center. Rather, we operate collaborative networks whereby hospitals within the network support each other for things like best practice sharing, managed care contracting, group purchasing, physician recruiting, resource sharing, risk management, and/or centralization of certain support functions, while at the same time allowing each entity to maintain its own separate identity and pursue its own growth strategies. We attempt to grow each of our hospitals to its maximum capability, and retain as much services at the local hospital level as clinically feasible. To the extent there are clinical services that cannot be provided at the local hospital, we would want to pursue the opportunity to provide these services at one of our other network hospitals (e.g. Bidder 3 ).

**Strategic Plan for CMC**

Working with CMC's board of trustees and medical staff leadership, we would facilitate the development of a strategic growth plan that positions CMC to become an even stronger regional hospital serving western Montana and northern Idaho. As part of the strategic planning process, we would develop specific action plans, with timetables, for growing market share in CMC's services areas, and for enhancing CMC's clinical programs and services. We envision core elements of the strategic plan would include:

- Build a continuum of care network around CMC with other wellness, outpatient/ancillary, post-acute care, physician, employer, and payer relationships.
- Develop CMC's provider network. We would evaluate opportunities to form clinical collaborations with Bidder 3 to support the development and coverage of CMC's provider network. We would also recruit physicians in coordination with CMC's existing medical staff, and pursue acquisition of physician practices when/where necessary.
- Invest in and grow CMC's clinical programs and services, focusing on service lines such as Heart & Vascular, Oncology, Orthopedics, and Women's Services (to name a few). We would seek to involve Bidder 3 in the development and expansion of CMC's clinical programs and services.
- Develop new ambulatory access points in CMC's services areas.
- Invest capital to continuously replenish and upgrade CMC's facilities, medical technologies and equipment, and IS/IT platform.
- Use the name "Community Medical Center" for identification and marketing purposes.
- Continue to build upon CMC's physician relationships that continuously advance CMC's commitments to quality, safety, and access to services.
- Provide CMC with access to Bidder 3 contracts, programs and tools in order to help CMC achieve immediate economies of scale.
- Continue CMC's focus on improving operations, quality outcomes, patient safety, physician relations, and customer satisfaction.

By working together, we believe we could advance CMC's position as the preferred provider in Western Montana and Northern Idaho.

- c. Define how you will lead the adoption of best practices and the elimination of unnecessary practice variation (clinical transformation) at CMC. It is CMC's goal to improve its cost position by 6-14% through this initiative.

We have many ways in which we disseminate clinical best practices, including:

- We employ a group of clinical consultants who assist our hospitals in developing clinical specialties and centers of excellence, including Cardiac Care, Cancer Care, Orthopedics, Surgery, Emergency Medicine, Critical Care, Hospitalists, etc.
- Physician Advisory Boards ("PABs") consists of physicians who meet periodically to discuss and promote clinical best practices. Physicians on PABs share information and provide advice and recommendations in the following areas:
  - Clinical guidelines, protocols and expertise;
  - Quality improvement and patient safety
  - Evaluation of new medical technologies; and
  - Improving physician relations and communications.
- Every year, we have a Chief of Staff meeting where strategy, operations, clinical best practices, quality, safety, and customer satisfaction are discussed.
- We offer a variety of other Physician Leadership Conferences and education seminars, which provide the latest in clinical guidelines and protocols.
- Our Chief Medical Officer and Chief Quality Officer periodically attend local medical staff meetings in order to facilitate best practice idea sharing.
- Physician Leadership Groups ("PLGs") are in place at many of our hospitals. Among other things, PLGs discuss clinical best practices.
- Physician/Nurse Excellence Committees are in place in many of our hospitals. Physician/Nurse Excellence Committees develop recommendations that contribute to improved patient care and satisfaction.

- With our strategic partner, Bidder 3 , we are developing additional access to clinical expertise, education, and leadership programs.
  - Rockwood Health System was selected as one of the initial "Quality Alliance" clinical integration pilots.
- d. Define your plan to centralize "back office" services. It is CMC's goal to improve its cost position by 4-8% by securing scale and the integration of administrative services with a regional partner.

If there is an opportunity to achieve synergies by consolidating back-office services or support functions through Bidder 3 , we would want to explore this.

- e. Define your competencies and goals to advance Lean or process improvement at CMC. It is CMC's goal to secure savings of 8-12% through its Lean initiative.

In general, our approach to innovation and process improvement includes:

- utilizing different methods of process improvement depending on the project size and scope. We have several experts trained in Lean and Six Sigma (Black Belts) who can be utilized at any of our hospitals for projects such as ED throughput improvement, OR turn-around time improvements, and similar type projects;
  - employing nationally recognized programs that focus on improving quality, reducing costs, and enhancing customer satisfaction;
  - analyzing and reporting comparative data for every hospital, and every medical staff members. Data is compared to regional and national benchmarks.
  - sharing data among our hospitals in order to identify and implement best practices, and to assist in complying with regulatory requirements; and
  - providing education and training programs for all senior management, quality directors, nurses, physicians and other professional staff.
- f. Describe your organization's plans to increase the scope of services provided at CMC.

Working with CMC's board of trustees and medical staff leadership, we would identify opportunities to develop and/or grow CMC's portfolio of clinical programs and service offerings. The plan would include consideration for CMC and

Bidder 3 to enter into clinical collaborations. Areas that might be

considered for clinical collaboration include: Heart and Vascular, Oncology, Neurosciences, Orthopedics, Urology, and Women's Services.

- g. Identify the systems and structures utilized to drive, implement, measure, report and improve quality of patient care, and how these systems and structures would be implemented and/or integrated in the CMC environment to achieve measurable improvements in clinical quality (as defined by current CMS standards) at CMC.**

The following are just a few examples of systems and structures that we utilize to drive, implement, measure, report and improve quality of patient care:

- Electronic health record ("EHR") and Ambulatory Medical Record ("AMR") systems;
- Case management modeling systems;
- Outcomes measurement systems;
- Continuous quality improvement measurement systems
- Patient satisfaction measurement programs
- Care coordination systems
- Disease management programs
- Case management, risk management, pharmacy and credentialing systems;
- Computer based training systems;
- Standardize benchmarking and reporting systems
- Emergency Room management system with outcomes data;
- Integrated clinical solutions (PACS, RIS, Lab, Pharmacy, fetal monitoring, etc.);
- Tele-pharmacy systems;
- Physician portals;
- Clinical Physician Order Entry;
- Mosby Nursing Procedures on clinical computers;
- Other on-line resources including Dynamed, Micromedex, and HeartCode-American Heart Association Courses for Basic/Advanced Life Support
- Infection Control Surveillance Systems;
- Bar coded supplies to ensure patient safety; and
- "MD Staff" Medical Staff Credentialing Software System (to name a few)

**2. Enhance and expand CMC's medical staff by recruiting, training and retaining physicians while providing competitive compensation and benefits;**

**We are committed to developing CMC's provider network.**

Upon transaction close, we would begin working on a provider network plan. The provider network plan would be developed by local leadership, with the input from the medical staff. The provider network development plan would contemplate and evaluate opportunities to form clinical collaborations with Bidder 3 where it makes sense. The physician network plan would be reviewed by CMC's board of trustees.

We envision developing and enhancing CMC's provider network through a combination of:

- Provider recruitment and employment;
  - Clinical collaborations with Bidder 3 to support development and coverage of CMC's provider network;
  - Strategic alignment with regional physician organizations, including the possibility of acquiring certain clinical practices; and
  - Strategic placement of providers at ambulatory care clinics and locations.
- a. Describe your primary care and specialty networks and your strategy for achieving Community's goal of hiring approximately 60+ providers over the next three years and building Community Physician Group and developing a virtual, multi-specialty clinic with select specialty groups.**

We recognize the unique opportunity to enhance CMC's market penetration through medical staff development and alignment. Our goal for medical staff development and alignment would be to grow existing clinical service lines and initiate new clinical programs and services not currently offered.

**Physician Recruiting**

In 2012, we successfully recruited over 2,100 physicians to our hospitals. Our physician recruitment department consists of 32 people with 175+ years of experience. We have the ability to source and screen physicians nationwide. We attend over 25 recruitment conferences each year. We have three individuals dedicated to visiting medical and surgical residency programs to establish relationships with first, second, and third year residents. We are actively involved in several job board sites. We do journal

advertising, direct mail campaigns, recruitment seminars, and have a recruitment website. We have over 25,000 physicians in our recruitment database.

Newly recruited physicians receive significant support and resources to help them assimilate into the local health system, including, but not limited to: practice management support, advertising and marketing support, new service development, education and training opportunities, and newsletters and other resources that address physician issues of global interest. All newly recruited physicians attend a 3-day introductory seminar that covers issues involved in starting up a practice.

We would assign a member from our Medical Staff Development department to work with CMC to source physician recruitment candidates. It will still be the job of local leadership to select and recruit physician candidates who represent the best fit for CMC, so that those physician recruitment candidates want to become part of the Missoula community and CMC's medical staff.

**Physician Employment**

Physician employment has become one of the most prevalent mechanisms for integrating hospitals and physicians. We are open to using physician employment models; in fact, we employ over 3,000 physicians company-wide. Deciding on whether to use physician employment models depends on the unique circumstances of the local market. We would be prepared to utilize a physician employment model at CMC.

We have significant resources to support employed physicians and owned physician practices. We have over 300 human resources in the field working with physicians daily. CMC would have access to an extraordinary level of resources to help better support its employed physicians. These resources include, but are not limited to:

▪ Accounting/AR/AP/Payroll	▪ HR Management	▪ Quality Management
▪ Clinical/Financial Reporting	▪ IT Systems & Support	▪ Risk Management
▪ Medical Record/EMR/EHR	▪ Legal Services	▪ Strategic Planning
▪ Billing and Collections	▪ Managed Care	▪ Business Development
▪ Continuing Education	▪ Mgmt. Info. Systems	▪ Marketing/Advertising
▪ Coding Compliance	▪ Physician Recruitment	▪ Customer Relationship Mgmt.

**Physician Satisfaction**

We conduct periodic formal surveys of all medical staff members throughout the system that measures physician satisfaction with our affiliated hospitals. In 2013,

approximately 50% of our medical staff members responded to our physician survey. The following is a brief synopsis of the 2013 survey results:

- 89% were satisfied with the hospital, its care, services and support of physicians;
- 92% were satisfied with nursing care; and
- 92% would recommend the hospital for family who needed care.

**b. Identify the electronic health record system your organization uses that integrates between physicians and other outpatient and inpatient facilities, and how CMC's physicians and facilities would be integrated into that system.**

We support a variety of Electronic Health Record ("EHR") platforms (e.g. Cerner, HMS, McKesson, Meditech, Siemens). We utilize a couple of different Health Information Exchange platforms to support patient data access across all providers, including our physician partners. In our employed physician practices, we use primarily Allscripts or AthenaHealth for the Ambulatory Medical Record ("AMR"). We use a variety of vendors for PACS, RIS, Lab, Pharmacy, etc. systems. Our primary infrastructure vendors are Cisco, Microsoft, IBM, and HP.

**c. Describe the formal organizational structures for physician leadership and how they will have input into regional/organizational strategic and operational care delivery planning and decision making.**

We use a variety of mechanisms and models to engage our physician partners. The following are some examples of formal and informal mechanisms and models.

- Each hospital's board of trustees includes representatives from the medical staff, including both employed and independent physicians.
- Physician Leadership Groups ("PLGs") are in place in many of our hospitals. PLGs are advisory groups to the local CEO. PLGs meet regularly with senior hospital management to discuss strategic issues, such as physician alignment, clinical integration, operations, quality, and patient safety.
- Physician/Nurse Excellence Committees are in place in many of our hospitals. Physician/Nurse Excellence Committees develop recommendations that contribute to improved patient care and satisfaction.

- Every year, we have a Chief of Staff meeting where strategy, clinical integration, operations, best practices, quality, safety, and customer satisfaction are discussed.
- Our Division President, Chief Medical Officer, Chief Quality Officer and other leadership members periodically attend medical staff meetings in order to facilitate open lines of communication with the medical staff.
- We participate in a variety of joint ventures with our physicians partners.
- We use a variety of constructs (PHOs, MSOs, etc.) to share resources such as IS/IT, practice management, group purchasing, and managed care contracting.

### **3. Committed to charitable care delivery and funding;**

**We are committed to providing services to patients with limited incomes through our charity care and self-pay discount policies.**

#### **a. Summarize your organization's charitable care policy and the average percentage of charity care provided relative to net patient revenue over the past three years.**

In 2012, our annual uncompensated care (i.e. bad debt, charity care, and self-pay discounts) exceeded \$3.5 billion of net revenue. During the past three years, our uncompensated care (i.e. bad debt, charity care, and self-pay discounts) has ranged from 21.0% to 23.5% of net patient revenue. Charity care in specific has averaged approximately 4% of net patient revenue for each of the past three years.

#### **Community Benefit Programs**

CMC would have access to education and community health programs that we have developed, including:

- **Healthy Woman:** empowers women with the knowledge and confidence to make informed healthcare decisions for themselves and their loved ones.
- **Tiny Toes:** provides comprehensive healthcare resources for women who are pregnant, all the way up through the baby's first birthday. The program brings together the many resources that expectant and new mothers need.
- **Senior Circle:** encourages healthy and active lifestyles for seniors by providing programs that encourage learning, wellness, health, and volunteering, coupled with social activities.

In addition to participating in blood drives, United Way initiatives, national relief efforts, and philanthropic endeavors, we would encourage CMC's employees to be actively involved in local civic and community programs.

**4. Offer employees a friendly work environment and maintain existing employment practices;**

**We have the infrastructure, resources, and national presence to be able to recruit and retain the very best employees.**

We have a relatively flat organizational structure. All employees at the local hospital level report up through the local CEO who reports to a Division President. The Division Presidents report to the President and CEO of Bidder 3 Mr. '.

There are many opportunities for employees to advance within our company and family of hospitals. We maintain a job bank on our intranet with all available job openings. We have a practice of promoting from within the company.

We have significant employee development and training infrastructure to foster an environment where employees have the resources and support they need to provide quality care to patients.

- *Leadership University*- professional development curriculum presents online courses aimed at helping managers attain leadership skills for professional growth.
- *Online Training Courses* – over 200 self-paced, interactive courses focused on specific subjects; this is a quick way to gain valuable expertise and be more productive.
- *Nursing Scholarship Program* - The Scholarship Committee awards full or partial scholarships for attendance at LPN or RN schools. Scholarship funds are awarded up to \$5,000 per student, per year. LPN to RN progression scholarships are available.
- *Educational Assistance* - employees looking to maintain or improve job related skills may be eligible for tuition reimbursement for courses at accredited institutions.
- *Proprietary Nurse Training* - A variety of sponsored courses, training opportunities and conferences are offered to develop all levels of employees:
- *Physician Office Operations Training* - A three-day course held at our corporate office is conducted once a month for new physicians and their office managers.

- *Continuing Medical Education Courses* - CME courses are regularly offered to medical staffs by local hospitals and periodically by the corporate office.
- *Chief Nursing Officer Training Program* – we assists CNOs in advancing their skills through a formal program. All CNOs are required to complete the program.
- *Computer-based training* - employees are provided access to computer-based training programs that provide opportunities to meet continuing education requirements.
- *Ongoing Educational Conferences* - we support inter-hospital peer networking and continuing education for hospital managers through a wide range of conferences.

We utilize a variety of recognition and incentive programs to reward employees and volunteers who excel in their daily work. Special awards and special recognition include:

- *Employee of the year*—nominations are submitted by hospital peers who recognize co-worker productivity, dependability and dedication.
- *Local Nursing Incentive Awards Programs*—a career ladder program for nurses.
- *Patient Choice Awards*—former and current patients nominate nurses who go above and beyond the call of duty. Awards are presented during Nurse's Week.
- *Caught in the Act of Caring*—a recognition program that allows physicians, patients and visitors to nominate employees who demonstrate caring attitudes.
- *Shining Star Recognition Program*—employees nominate fellow employees who exceed the Community Cares standards of performance.
- *Focus Program*—an incentive-based program that rewards employees for ideas that will save money or increase productivity.
- *CEO of the Year*—one outstanding CEO is selected and an additional 20 CEO awards are given in such areas as quality and patient satisfaction.
- *CFO and CNO Awards*—presented for financial, quality and patient satisfaction.
- *Annual Volunteer Awards*—based on hours served and other criteria.

- a. Provide your organization's nurse staffing levels, nurse-to-patient ratios, and overall turnover and vacancy rates for the past three years.**

The Chief Nursing Officer ("CNO"), under the direction of the CEO, is responsible for nursing care at each of our facilities, including establishing staffing levels. Our affiliated hospitals utilize a primary care nursing model. Hours per patient day are based on an approximate 6-to-1 patient to staff nursing ratio in the medical/surgical units. All of our hospitals use dashboards and benchmarks, and share best practices both intra-hospital and inter-hospital. We also utilize an hourly rounding model with bedside shift report on the medical/surgical floors, and nurse rounding with physicians on the floors in order to increase communication with the total team and patient. In general, staff turnover and vacancy rates at our hospitals are in line with national and regional benchmarks.

- b. Provide the job categories and percentage of your organization's employees that are subject to collective bargaining agreements.**

Out of 96,000 employees, approximately 8,000 employees are unionized.

- c. Define your overall employee satisfaction or employee engagement scores and define how they compare (percentile) with other like providers.**

Our culture is reflected through our Community Cares program. Since implementing Community Cares, we have witnessed tangible results in the way our employees treat each other; treat our patients and our patients' family members; and treat our physicians. The Community Cares emphasis is on providing respectful, professional, and caring interactions among employees, patients and physicians alike.

In 2013, approximately 90% of our employees participated in our annual employee satisfaction survey. The following is a synopsis of what our employees had to say.

- 93% agree with the statement that patients are treated as valued customers;
- 93% believe their hospital provides a safe and secure environment for patients;
- 92% said they are highly motivated to contribute to the success of this organization;
- 94% reported a strong sense of accomplishment in their work;
- 92% said their hospital leadership is committed to the Community Cares culture; and
- 90% said they plan to stay with this organization for the next several years.

**5. Be well-positioned for health care reform and population management in the greater Missoula market;**

CMC would benefit from both our infrastructure and operating expertise required to thrive in a risk-based and value-based payment environment.

**a. Describe the extent to which your organization has entered into shared savings programs/contracts, ACOs, bundled payment programs, or risk bearing contracts with government health care programs or commercial payers.**

For the past several years, we have been positioning ourselves for health care reform. We are developing network integration models that prepare us for bundled payments and risk based contracting. We are developing collaborative relationships with payers. We are focusing on quality, such as core measures, complication rates, re-admission rates, infection prevention, outcome measures, HCAHPS scores, all of which will likely factor into future reimbursements. We are assuming managed care contracts that incentivize quality and lower re-admission rates. We are implementing population health management programs. We are also exploring Accountable Care Organizations ("ACO") frameworks and relationships and experimenting with Medical Home Models.

In **Bidder 3** recently completed the assessment phase of its clinical integration initiative through **Quality Alliance** clinical integration platform. Preliminary planning has begun to develop the infrastructure necessary to support this physician-driven initiative, including the development of a dedicated PHO (or something similar) to manage the program. The PHO would contract with payers for shared savings programs resulting from successful clinical integration and quality outcomes.

**b. Describe your organization's IT infrastructure and its ability to support an ACO/ population health-type model including meaningful use compliance status, integration across the continuum of care, total cost of care management, etc.**

From a core services perspective, we provide:

- clinical operations IS/IT support;
- business office IS/IT support;
- general accounting and financial reporting support; and
- enterprise infrastructure, service desk, and security support.

Specific IS/IT services that we provide include:

- company-wide intranet;
- hospital intranet and internet sites;
- data warehousing;
- case management, risk management, pharmacy and credentialing systems;
- computer based training systems;
- standardize benchmarking and reporting systems;
- technical support from the corporate office;
- Emergency Room management system with outcomes data;
- Integrated clinical solutions (PACS, RIS, Lab, Pharmacy, fetal monitoring, etc.);
- Tele-pharmacy systems;
- Physician portals; and
- Clinical Physician Order Entry.

We have a proven method and skills with regards to EHR implementation and Meaningful Use compliance. We have made, and continue to make, significant capital investments in both infrastructure and information systems technology in order to become meaningful users of EHR. Our Meaningful Use efforts are ongoing in our facilities, and our facilities are at various stages of attestation. We are meeting all goals and are on track to attest all of our hospitals under the HITECH Act. We are making good progress with regards to our employed physicians' adoption of AMR's.

Over the past two years, capital spending on IT, including upgrading our hospitals and health systems to become meaningful users of EHR, has averaged approximately 30% of our overall capital spending. In 2012, we spent over \$250 million in capital expenditures on IT, including implementation of EHRs. We incurred an additional \$50 million in operating expenses related to the implementation/upgrade of our hospitals IT systems.

- c. Describe your organization's ability to provide the continuum of care (including owning/ partnering with SNFs, ALFs, home health agencies, behavioral health, medical homes, etc.) and the level of coordination across all settings.

In addition to the 135 hospitals that we own, we also own physician practices, imaging centers, ambulatory surgery centers, reference labs, behavioral health, home care agencies, hospice agencies, long term care facilities and skilled nursing facilities. In situations where we do not own one of the above services (e.g. SNF, ALF, home health agency, behavioral health, medical home, etc.), we have been able to successfully partner with organizations that can provide the continuum of care service.

- d. Describe the care management models deployed or planned for your organization.

The primary goal of our case management program is to ensure the delivery of safe, high quality patient care in an efficient and cost effective manner. Our case and resource management focuses on:

- management of length of stay consistent with national standards and benchmarks;
- reducing unnecessary utilization;
- discharge planning;
- developing and implementing operational best practices; and
- compliance with all regulatory standards.

Our case management program integrates the functions of utilization review, discharge planning, assessment of medical necessity and resource management. Each hospital has a physician advisor who is a liaison to the medical staff and assists with case management program activities.

- e. Describe the expertise/competency that your organization offers in regards to population health management, shared savings programs and risk-bearing contracts including your organization's ability to spread financial risk under risk-based reimbursement models.

CMC would have access to our contracting expertise. We are exploring value-based and risk-based contracts in markets where clinical integration is more advanced. We have been contracting with payers to tie a component of our reimbursement to achieving certain targets, both quality and financial. We have several contracts, currently being

renewed or negotiated, that have shared savings and risk after certain thresholds are achieved. In addition to implementing Quality Alliance clinical integration platform, Bidder 3 has also entered into narrow network contracts with selected payers. By carefully considering and executing strategies with regards to value-based and risk-based contracts, we believe we can continue to demonstrate consistent operational and financial performance, and continue to achieve high quality outcomes.

We were net positive for the first round of Value-Based Purchasing. Our core measure performance remains strong; our HCAHPS scores continually improve; we have several initiatives in place to reduce mortality rates for AMI, Heart Failure and Pneumonia.

We are implementing population health management programs. We are also exploring ACO frameworks and relationships and experimenting with Medical Home Models.

**f. Describe your organization's strategy to build and expand a regional provider network and how Community would fit into that plan.**

We are committed to developing CMC's physician network. Upon transaction close, we would begin working on a provider network development plan. The provider network development plan would be developed by local leadership, with the input from the medical staff. The provider network development plan would contemplate and evaluate opportunities to form a strategic affiliation/alliance between CMC and Bidder 3 where it makes sense. The provider network development plan would be reviewed by CMC's board of trustees.

We envision achieving the goal of developing and enhancing CMC's provider network through a combination of the following:

- Physician recruitment and employment;
- Strategic affiliation/alliance with Bidder 3 to support development and coverage of CMC's provider network;
- Strategic alignment with other regional physician organizations, including the possibility of acquiring physician practices; and
- Strategic placement of physicians at ambulatory care clinics and locations.

**g. Describe your organization's strategy to position CMC for population health management and/or other new care models under health care reform.**

is the second largest clinically integrated physician network in the United States with over 5,000 physician members. Our strategic alliance with provides our hospitals and physicians the opportunity to clinically integrate through "Quality Alliance" platform. The Quality Alliance has been designed to further the goals of clinical integration, which is a key component for population health management. Along with Bidder 3 we envision CMC participating in Quality Alliance clinical integration platform.

**6. Describe your organization's experience in the merger integration of hospitals, outpatient facilities and physician practices.**

**We have more experience acquiring and integrating hospitals, outpatient facilities and physician practices than any other organization in the health care industry.**

Since 1997, we have acquired and integrated over 110 hospitals (the transaction in 2007 involved 54 hospitals). We are adept at integrating hospitals, outpatient facilities and physician practices. With over 3,000 corporate human resources to assist with acquisition integration, we are able to integrate acquisitions seamlessly and effectively.

**7. Provides a well-integrated health system;**

**With new acquisitions, we typically achieve a 2% to 5% improvement in operating margin performance within the first year as a result of leveraging our programs and services.**

We are able to achieve this level of efficiency because we implement programs and adhere to operating philosophies that include:

- standardizing and centralizing our methods of operation and management;
- improving patient safety and optimizing resource allocation through case and resource management programs, which assists in improving clinical care and containing costs;
- monitoring and enhancing the productivity of our human resources;
- capitalizing on purchasing efficiencies through the use of company-wide standardized purchasing contracts and terminating or renegotiating specified vendor contracts; and
- installing standardized management information systems, resulting in more streamlined clinical operations and more efficient billing and collections procedures.

**Standardization and Centralization**

Standardization and centralization encompass nearly every aspect of our business, from standard policies and procedures with respect to patient accounting and physician practice management to standard processes to initiate, evaluate and complete construction projects. Our standardization and centralization initiatives are a key element that has helped us improve our operating results and reduce costs.

- Revenue Cycle. We have adopted standard policies and procedures with respect to the revenue cycle process.
- Procurement and Materials Management. We have standardized and centralized our operations with respect to medical supplies, equipment and pharmaceuticals used in our hospitals. We participate in HealthTrust Purchasing Group ("HPG"), a group purchasing organization ("GPO"). In fact, we are a 17.6% equity owner in HPG which better aligns our respective financial interests. HPG contracts with certain vendors who supply a substantial portion of our medical supplies, equipment and pharmaceuticals. Clinical Advisory Boards endorse the product quality of supplies purchased by our hospitals. GPO compliance enables us to obtain some of the industry's lowest product costs, and also allows us to share supplies during times of shortage or disaster.
- Benefits. We purchase benefits for 96,000+ employees. Thus, we are able to leverage our purchasing power in order to reduce benefit costs per employee.
- Facilities Management. We have standardized interiors, lighting and furniture programs. We have also implemented a standard process to initiate, evaluate and complete construction projects. Our corporate staff monitors all construction projects, and reviews and pays all construction project invoices. Our initiatives in this area have reduced our construction costs while maintaining the same level of quality and have shortened the time it takes us to complete these projects.
- Other Initiatives. We have also improved margins by implementing standard programs with respect to ancillary services in areas, including emergency rooms, pharmacy, laboratory, imaging, home care, skilled nursing, centralized outpatient scheduling and health information management. We have improved quality and reduced costs associated with these services by improving contract terms and standardizing information systems. We work to identify and communicate best practices and monitor these improvements throughout the Company.

- Financial Reporting Internal Controls. We have centralized many of our significant internal controls over financial reporting and standardized other controls that are performed at our hospital locations. We continuously monitor compliance with and evaluate the effectiveness of our internal controls over financial reporting.
- a. Describe the functions performed at the corporate level versus at the local hospitals

Our corporate resources supplement, not supplant, local resources. The following lists some of our corporate departments (**bold**), with example functions they support.

<b>Accounting</b>	<b>Legal</b>
<b>Acquisitions &amp; Development</b>	- Contracts support
<b>Ancillary Services</b>	- Real estate support
- Pharmacy	- Litigation support
- Laboratory	<b>Managed Care</b>
- Surgery	<b>Marketing</b>
- Imaging	- Community Cares
- ASCs	- Local Hospital Marketing Support
<b>Compliance</b>	- Patient Satisfaction Surveys
<b>Corporate Tax</b>	- Physician Satisfaction Surveys
<b>Eligibility Screening Services</b>	- Public Relations and Communications
<b>Facilities Management</b>	- Affinity Programs (e.g. Healthy Woman, Senior Circle, Tiny Toes)
- Projects/Construction	
<b>Finance/Treasury</b>	<b>Materials Management / Purchasing</b>
<b>Health Information Management</b>	- Group Purchasing
<b>Home Care &amp; Hospice Division</b>	<b>Medical Affairs</b>
<b>Hospitalist Services</b>	<b>Medical Staff Development</b>
<b>Human Resources</b>	- Physician Recruiting
- Employee Relations	<b>Operations Support</b>
- Employee Satisfaction Surveys	<b>Patient Financial Services</b>
- Executive Recruitment	- Billing and Collections
- Benefits Administration	<b>Physician Business Services</b>
<b>Information Systems</b>	- Practice Management Support
- Architecture/strategy	- Billing and collections
- Clinical systems support	<b>Quality &amp; Patient Safety</b>
- Deployment services	- Quality Management
- Application services	- Case Management
- Physician practices	- Joint Commission Survey Preparedness
- Data center operations	- Patient Safety
- Infrastructure implementation	<b>Revenue Management</b>
- Operations support	- Chargemaster Services
- Security	- Specialty Services
<b>Internal Audit</b>	<b>Risk Management</b>

**b. Describe the methodology for allocating capital and corporate overhead**

Working collaboratively with the local board of trustees, we would develop and execute a long-term capital plan for CMC that aligns with the capital commitment jointly agreed to in the Definitive Agreements. Once the capital commitment period ends, we would follow our normal capital expenditure budgeting processes. Each year, our hospitals prepare a Strategic Capital Plan and an Annual Operating Budget. Planning begins in late summer and wraps up by mid-December. The Strategic Capital Plan and Annual Operating Budget are prepared by local management. Local management seeks input from members of their medical staff. The local board of trustees have input into the Strategic Capital Plan and Annual Operating Budget and reviews final versions of both plans. Division leadership provides direction, input and support into both Plans.

We allocate a management fee of approximately 2% of net revenue to cover the costs and expenses of corporate services. However, no funds are exchanged, and the management fee is "eliminated" in the consolidated financial statements.

**8. Provide for CMC's long-term stability and security based on the historic and projected financial performance, long-term vision, and commitment to serve as a stable partner;**

Since 1997, Bidder 3 has demonstrated consistent and stable financial performance.

In 2012, we generated \$13.0 billion in net revenue and \$1.28 billion in cash from operating activities. For 2013, we have issued guidance saying that we expect to generate between \$13.0 and \$13.4 billion in net operating revenue, and between \$1.175 and \$1.250 billion in cash from operating activities.

As of June 30, 2013 (date of last publicly available financial statements), we had approximately \$251 million of cash and cash equivalents on our balance sheet.

We have the ability, under our existing debt covenants, to issue an additional \$1.0 billion of incremental term loans. We also have a \$750 million line of credit.

We are publicly-traded; thus, we have access to public equity markets.

We believe our cash generated from operations, cash on hand, borrowing capacity, and access to equity markets would be sufficient to fund a transaction with CMC, plus fund CMC's future capital requirements.

**a. Provide a summary of your organization's financial position.**

The following table, abstracted from our Securities and Exchange Commission ("SEC") filings, demonstrates our net revenue, EBITDA, Net Income, Cash Flow from Operations, and Capital Expenditures ("CAPEX").

\$'s in Millions	2008	2009	2010	2011	2012	2013 Guidance
Net Revenue	\$9,700	\$10,334	\$11,092	\$11,906	\$13,029	\$13,000-\$13,400
EBITDA <sup>3</sup>	\$1,525	\$1,671	\$1,761	\$1,837	\$1,978	\$1,900 - \$1,950
Cash Flow from Ops.	\$1,057	\$1,076	\$1,189	\$1,262	\$1,280	\$1,175 - \$1,250
CAPEX	\$692	\$577	\$667	\$777	\$769	\$775 - \$825

**i. Three years of audited financial statements.**

Three years of audited financial statements are available in our latest SEC Form 10K filing, which can be found under the Investor Relations section of our website at:

**ii. Interim year-to-date financial statements through the most recent month-end available.**

Year to date financial statements through June 30, 2013 (date of last publicly available financial statements) are in our latest SEC Form 10Q filing, which can be found on our website at:

**iii. Most recent Official Statement, if applicable.**

All public disclosures can be found on our website at:

**iv. Last rating agency updates.**

We can provide copies of the latest equity analyst reports.

**v. Access to third-party capital, including the amount of debt capacity or funds available from equity investors.**

We have the ability, under existing debt covenants, to issue an additional \$1.0 billion of incremental term loans. We also have a \$750 million line of credit. We are publicly-traded; thus, we have access to public equity markets.

<sup>3</sup> EBITDA is defined as net income before interest, income taxes, depreciation and amortization.

- vi. Capital raising plans within the next 12 months, including debt offerings or equity raises including the timing, amount and expected use of proceeds.

As part of our definitive agreement to acquire \_\_\_\_\_, Bank of America and Credit Suisse have pledged to provide financing for other hospital acquisition transactions.

- b. Provide an organizational profile for your organization including (a) not-for-profit/for-profit status, (b) religious affiliation, if any, (c) current listing (including location) of hospitals, (d) number and location of other facilities, (e) founding date of organization, (f) location of headquarters, (g) number of employees, (h) number of physicians on medical staff, (i) number of employed physicians, (j) make-up of board, (k) name and position of senior executives along with their biography, (l) credit rating, (m) top five managed care payers by volume.

(a) Bidder 3 tax status is "For-profit".

(b) Bidder 3 is not affiliated with any religious organizations.

(c) Bidder 3 owns 135 hospitals in 29 states.

(d) Bidder 3 owns a variety of other health care businesses associated with its 135 hospitals.

(e) Bidder 3 was founded in \_\_\_\_\_

(f) Bidder 3 is headquartered in \_\_\_\_\_

(g) Bidder 3 has over 96,000 employees.

(h) Bidder 3 has over 17,000 physicians on its medical staffs.

(i) Bidder 3 employs over 3,000 physicians.

(j) The Bidder 3 board of directors is comprised of eight (8) directors who are actively involved in the leadership and oversight of \_\_\_\_\_

(k) Biographies for all Bidder 3 senior leadership can be found at: \_\_\_\_\_

(l) Credit Rating is B+ (Fitch), B1 (Moody's), B+ (Standard & Poors)

(m) The top managed care payers vary hospital-to-hospital, but would include payers such as: Blue Cross Blue Shield, Aetna, Cigna, Humana, UnitedHealth, and Wellpoint.

- c. **Indicate whether your organization is subject to a corporate integrity agreement and if so, the terms of that agreement(s).**

We are not subject to a corporate integrity agreement.

- d. **Provide a list of any hospitals acquired or sold in the past five years.**

**Hospitals Acquired in Past 5 Years**

Acquisition Date	Name	City, ST	Beds
2012-July	[REDACTED]	[REDACTED]	100
2012-March			330
2012-January			217
			25
2011-October			357
2011-May			198
			48
			67
2010-October			240
2010-October			389
			311
			69
2010-July			124
2009-May			418
2009-February			42
2008-October	388		
	123		

**Hospital Sold in Past 5 Years**

Sold Date	Name	City, ST	Beds
2011-October	[REDACTED]	[REDACTED]	107
2011-September			180
			81

- 9. **Present any financial, regulatory and other non-financial hurdles to closing;**

We would not have any financial contingencies related to this transaction.

- a. **Identify and discuss any and all contingencies to closing, including regulatory (e.g. antitrust) and if applicable, third-party financing.**

We would expect customary conditions precedent to close, including regulatory approvals, accuracy of representations and warranties, receipt of a title policy and required consents from third parties, no material adverse change, no injunction, etc.

The transaction would be subject to a Hart Scott Rodino ("HSR") review.

Upon notice of selection, we could complete the transaction within 150 days, subject to regulatory review and approval processes. This includes time needed for due diligence and to negotiate definitive agreements. We would be prepared to close the transaction at the end of the month following receipt of all regulatory approvals.

- b. Indicate the level at which your response has been approved within your organization and what approvals will be required to sign a definitive agreement and close the transaction.**

Our board of directors would need to approve a transaction. Our board chairman has reviewed the basic terms of this proposal. We do not anticipate any issues in obtaining our board's approval.

- c. Identify any third party consents you will need to obtain for entering into the transaction as contemplated (such as banks, bond insurers, lessors, and landlords).**

We would have no third-party consents that we would need to obtain in order to enter into the proposed transaction with CMC.

[~~BIDDER~~HOSPITAL LETTERHEAD]

~~August 28~~September 26, 2013

[NAME REDACTED]

**LETTER OF INTENT**

Dear Mr. [NAME REDACTED]:

The purpose of this letter of intent (this "Letter") is to set forth certain non-binding understandings and certain binding agreements by and between Community Medical Center ("Hospital") and ~~[BIDDER]~~Bidder 3 ("Bidder") pursuant to which Hospital intends to sell certain assets and operations of Hospital to an affiliate of Bidder, as more particularly described in the attached term sheet (the "Term Sheet"), incorporated herein by reference.

Paragraphs 1 through 24 of the Term Sheet (collectively, the "Non-Binding Provisions") reflect our mutual understanding of the matters described in them, but each party acknowledges that the Non-Binding Provisions are not intended to create or constitute any legally binding obligation between Hospital and Bidder, and neither Hospital nor Bidder shall have any liability to the other party with respect to the Non-Binding Provisions until a definitive agreement and other related documents (collectively, the "Definitive Agreement") are prepared, authorized, executed and delivered by and between the parties. If the Definitive Agreement is not prepared, authorized, executed, and delivered for any reason, neither party to this Letter shall have liability to the other party to this Letter based upon or relating to the Non-Binding Provisions.

Upon execution by the parties to this Letter, Paragraphs 25 to 27 of the Term Sheet (collectively, the "Binding Provisions") will constitute the legally binding and enforceable agreement of the parties in recognition of the significant costs to be borne by the parties in pursuing the transaction and further in consideration of the mutual undertakings as to the matters described herein.

The Binding Provisions may be terminated only by mutual written consent; provided, however, that the termination of the Binding Provisions shall not affect the liability of a party for breach of any of the Binding Provisions prior to the termination. This Letter shall be construed and enforced in accordance with the laws of the State of Montana. No signatory hereto shall assign this Letter to any third party.

Notwithstanding the foregoing, this Letter is intended to evidence the understandings which have been reached regarding the proposed transactions and the mutual intent of the parties to negotiate in good faith a Definitive Agreement in accordance with the terms contained in the Term Sheet.

Each party acknowledges that it is a party to that certain Mutual Confidentiality and Non-Disclosure Agreement, dated ~~December 1~~\_\_\_\_\_, ~~2008~~2013, and that such agreement remains in full force and effect.

If the terms herein are acceptable, please sign and date this Letter in the space provided below to confirm the mutual agreements set forth in the Binding Provisions and return a signed copy to the undersigned.

Sincerely:

[NAME REDACTED]

~~August 28~~ September 26, 2013

Page 2

COMMUNITY MEDICAL CENTER

By: \_\_\_\_\_  
Steve Carlson  
Chief Executive Officer

Date: \_\_\_\_\_

ACKNOWLEDGED AND AGREED:

BIDDER 3

By: \_\_\_\_\_  
~~— [NAME]~~  
~~— [TITLE]~~

Date: \_\_\_\_\_

**Community Medical Center**  
**Term Sheet for a Transaction with ~~{BIDDER}~~**  
Bidder 3  
~~August 28~~ September 26, 2013

Non-Binding Provisions	
<b>1. Parties</b>	<p>a) Community Medical Center, a Montana nonprofit corporation that is exempt from federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and all of its controlled affiliates (collectively, "Hospital"). Hospital is the parent company of an integrated healthcare system providing acute care and general health services to residents of western Montana and <u>northern</u> Idaho (collectively, the "Business").</p> <p>b) <del>{Bidder}</del>, a <span style="background-color: black; color: black;">[REDACTED]</span> <u>Bidder 3</u> (collectively, "Bidder").</p>
<b>2. Form of Transaction</b>	<p>Bidder, through one of its <del>subsidiaries</del> <u>affiliates</u> (the "Subsidiary"), intends to purchase substantially all of the operating assets of the Business (the "Purchased Assets") from Hospital (the "Transaction").</p>
<b>3. Purchased Assets and Assumed Obligations</b>	<p>a) The Purchased Assets shall consist of all of the operating assets of Hospital other than the "Excluded Assets" identified below. The Purchased Assets will include:</p> <ul style="list-style-type: none"> <li>i. Net working capital assets (including inventories, <del>patient accounts receivable, other receivables,</del> and prepaid expenses and advances);</li> <li>ii. owned and leased real property;</li> <li>iii. equipment;</li> <li>iv. patient, medical, personnel and other records of the Business;</li> <li>v. licenses, permits, and trade names (to the extent transferable);</li> <li>vi. operating contracts and leases related to the Business; and</li> <li>vii. interests held by Hospital in joint ventures related to the operation of the Business.</li> </ul> <p>b) The following shall be excluded from the Purchased Assets (the "Excluded Assets"):</p> <ul style="list-style-type: none"> <li>i. Cash, cash equivalent and investments;</li> <li>ii. <u>Patient accounts receivable and other receivables;</u></li> <li>iii. <del>ii-</del> amounts that may result from post-Closing settlements of cost reports, appeals and other risk settlements that relate to pre-Closing periods;</li> <li>iv. <del>iii-</del> amounts earned, accrued or paid with respect to Meaningful Use attested to, or for which the requirements for attestation have been substantially met, prior to the Closing;</li> <li>v. <del>iv-</del> assets whose use is limited or restricted;</li> <li>vi. <del>v-</del> other long term investments;</li> <li>vii. <del>vi-</del> commercially unreasonable contracts or contracts that raise regulatory concerns; and</li> <li>viii. <del>vii-</del> other current and long term assets not related to current operating</li> </ul>

**CONFIDENTIAL**

**Community Medical Center  
Proposed Term Sheet – ~~BIDDER~~ Bidder 3  
Page 2**

	<p>activities.</p> <p>c) Bidder will assume such obligations of Hospital as is usual and customary in transactions similar to the Transaction.</p> <p>d) Exhibit A hereto reflects the estimated allocation of the assets and liabilities between Bidder and Hospital based on the June 30, 2013 balance sheet of Hospital.</p>
<b>4. Treatment of CMC Foundation</b>	<p><del>Prior to executing the Definitive Agreement (as defined in Paragraph 27 hereof), CMC Foundation, at its sole discretion, may request, as a result of the Transaction, Hospital to withdraw or otherwise give up its position as the sole member of CMC Foundation immediately prior to the Closing. In such event, CMC Foundation shall have the right to retain, and exclude from the Transaction, the assets of CMC Foundation at the time of such withdrawal and to continue to operate as an independent tax exempt entity</del> CMC Foundation and its assets will be Excluded Assets.</p>
<b>5. Closing</b>	<p>The closing of the Transaction is referred to herein as the "Closing."</p>
<b>6. Consideration</b>	<p>a) Bidder shall pay a purchase price (the "Cash Purchase Price") of [REDACTED]</p> <p>b) <del>Subsequent to the execution of the Letter of Intent (the "Letter") in which this Term Sheet is incorporated by reference, Bidder shall not propose any reduction of, or other direct or indirect change to, the Cash Purchase Price, except for the determination of Net Working Capital (as defined in Paragraph 7 hereof) or in the event that Bidder discovers, during confirmatory due diligence, a fact or circumstance, of which Bidder was previously unaware, directly related to the operation of the Business that may reasonably result in a Material Adverse Change as defined in Paragraph 24 b) hereof. The Cash Purchase Price will be subject to Bidder's due diligence review of the</del> Business.</p>
<b>7. Net Working Capital</b>	<p>a) The Cash Purchase Price <del>assumes</del> [REDACTED]</p> <p>b) "Net Working Capital" is comprised of inventories, <del>patient accounts receivable, other receivables,</del> prepaid expenses and advances that have continuing value to the operations of the Business, and <del>accounts payable, accrued salaries and expenses,</del> accrued vacation expenses and any PTO whether recorded or unrecorded, with appropriate adjustment for such unrecorded amount.</p>
<b>8. Treatment of Indebtedness</b>	<p>Bidder will not assume, and Hospital will remain liable for all existing indebtedness (including capital leases) with such amounts to be paid out of the Cash Purchase Price.</p>

**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~ Bidder 3**  
**Page 3**

<p><b>9. Capital Commitment</b></p>	<p>For a period of ten (10) years after the Closing, Bidder shall commit to fund annual average capital expenditures <u>(measured over a period of three consecutive years)</u> at not less than 110% of the Business’ annual depreciation to fund the development of projects and services for the benefit of the residents of the Business’ primary service area, subject to deferral based on mutually agreed upon exceptions for exigent financial circumstances and regulatory requirements.</p>
<p><b>10. Subsidiary Governance</b></p>	<p>a) As of the Closing, Bidder will establish a <del>ten (10) member non-fiduciary</del> Board of Trustees for the Subsidiary (the “Local Board”) <u>comprised of ten to twelve members</u>. The Local Board will be comprised of four (4) physicians, five (5) community leaders and the local Chief Executive Officer, <i>ex officio</i>.</p> <p>b) The initial members of the Local Board shall be appointed in consultation with Hospital.</p> <p>c) The Local Board shall be self-perpetuating consistent with the Subsidiary’s governing documents.</p> <p>d) In general, financial, strategic and other decisions of the Local Board will require approval by Bidder.</p> <p>e) The Local Board will provide recommendations to Bidder regarding the establishment of hospital policies, the maintenance of patient care quality and provision of clinical service and community service planning in a manner responsive to local community needs.</p> <p>f) Subject to certain limited exceptions, the duties of the Local Board will include, but not be limited to the following:</p> <ul style="list-style-type: none"> <li>i. Ensure compliance with all accreditation requirements including but not limited to credentialing and other medical staff matters;</li> <li>ii. Provide oversight for institutional planning, make recommendations for new clinical services, participate in an annual review of the Business’ strategic and financial plan and goals;</li> <li>iii. Review and have input into any substantive changes in the services provided by the Business.</li> <li>iv. Review and recommend approval of operating and capital budgets as well as make recommendations with respect to capital expenditures fulfilling commitments made by Bidder in the Definitive Agreement (as defined in Paragraph 27 hereof);</li> <li>v. Make recommendations with respect to quality assessment and improvement programs;</li> <li>vi. Provide oversight of risk management programs relating to patient care and safety;</li> <li>vii. Foster community relationships and identify community service opportunities;</li> <li>viii. Review disaster plans that deal with both internal (e.g., fire) and external disasters; and</li> <li>ix. Evaluate recruitment needs to ensure adequate medical staff capacity to continue to meet community needs.</li> </ul>

**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~ Bidder 3**  
**Page 4**

<p><b>11. Commitment to Quality, Safety, and Patient Satisfaction</b></p>	<p>After the Closing, Bidder shall operate the Business with a commitment to quality, safety and patient satisfaction including maintaining Joint Commission accreditation and participation in the Medicare, Medicaid, and TriCare programs.</p>
<p><b>12. Commitment to Teaching Programs</b></p>	<p><u>For a period of at least five (5) years after the Closing and subject to no significant adverse changes in reimbursement</u>, Bidder shall maintain and continue to support Hospital’s current residency training programs and will seek to expand the training of residents at the Business in a reasonable and appropriate manner in order to support the recruitment and retention of physicians in Hospital’s community.</p>
<p><b>13. Limitations on Change of Control or Sale</b></p>	<p>For a period of <del>ten five (105)</del> years after the Closing (the “Initial <del>Ten Five</del> Year Period”), Bidder will not (i) enter into a merger or other form of a transfer or change of control transaction with a third party with respect to the Business (a “Change of Control Transaction”), or (ii) sell, convey, or otherwise transfer all or substantially all of the assets of the Business to a third party (whether in a single transaction or in a series of transactions) (an “Asset Sale”); provided the foregoing restrictions of this Paragraph 13 shall not apply to a change of control of Bidder.</p>
<p><b>14. Right of First Refusal</b></p>	<p>Following the restrictions set forth in Paragraph 13 hereof, Hospital or its designee will maintain <del>in perpetuity</del> <u>for a period of ten (10) years</u> a right of first refusal to purchase the Business under essentially the same terms and conditions provided to or by Bidder if Bidder agrees to sell or transfer substantially all of the assets and operations of the Business to an unaffiliated third party. Hospital shall have 60 days to exercise its right and 180 days to close, subject to extensions necessary to accommodate any regulatory approvals. The foregoing restriction shall not apply to a change of control of Bidder or a sale of Bidder’s interests in multiple facilities in which the value of the Business represents less than seventy-five percent (75%) of the total value (based upon net revenue) of the transaction.</p>
<p><b>15. Maintenance of Clinical Services</b></p>	<p>Subject to mutually agreed upon exceptions for exigent financial circumstances and regulatory requirements, Bidder shall agree to maintain essential clinical services and departments <del>at not less than current levels</del> (“Essential Services”) at the Business’ current acute care hospital for a period of <del>ten five (105)</del> years after the Closing. Essential Services shall include the following services lines and departments: ICU/CCU, NICU, med/surg, pediatrics, orthopedic, mother/baby, rehabilitation, labor and delivery, inpatient and outpatient surgery, recovery, laboratory, electrodiagnostics, stress testing, cath lab, CT scan, diagnostic imaging, ECHO, endoscopy, pharmacy, respiratory therapy, emergency, pediatrics specialty clinic, departments of Community Physician Group, Community Care Center (chemotherapy and radiation therapy), IVO – infusion therapy, CMC cardiology and outreach, nuclear medicine, trauma (level III), wound care clinic, childbirth education classes, <u>and MT Pediatric Surgery</u>, <del>sterile supply, and materials management</del>.</p>
<p><b>16. Charity Care and Community Obligations</b></p>	<p>Bidder acknowledges that Hospital has historically provided significant levels of care for indigent and low-income patients and has also provided care through a variety of community-based health programs. Bidder shall adopt, maintain, and adhere to Hospital’s current policies on charity and indigent care or adopt other policies and procedures that are at least as favorable <u>from a financial point of view</u> to the indigent and uninsured as Hospital’s existing policies and procedures. Bidder shall also continue to provide care through community-based health programs, including cooperation with local organizations that sponsor healthcare initiatives to address identified community needs and improve the health status of the elderly, poor, and other at-risk populations in the community. <u>The foregoing</u></p>

Community Medical Center  
Proposed Term Sheet – ~~BIDDER~~ Bidder 3  
Page 5

	<p><u>commitments shall be subject to changes in legal requirements or governmental policies (such as implementation of the Patient Protection and Affordable Care Act or universal healthcare coverage).</u></p>
<p><b>17. Medical Staff Matters</b></p>	<p>a) Bidder intends to involve the Business’ physicians in the strategic and capital planning process for the Business, insuring that the critical needs of the medical staff are met and that strategic initiatives and investments are prioritized to best meet the needs of medical staff physicians and their patients.</p> <p>b) Bidder shall commit to provide the necessary resources to effectively recruit and retain a quality medical staff consistent with a recruitment plan to be mutually agreed to by the parties prior to the Closing, which the parties expect will contemplate the recruitment of an additional 60 FTEs over a three-year period covering a broad range of specialties including, but not limited to, cardiology, emergency medicine, surgery, oncology, obstetrics / gynecology, hospitalists, neurology, neurosurgery, ENT and urology.</p>
<p><b>18. Employee Matters</b></p>	<p>a) Bidder shall <del>maintain wages and benefits, with no downward pay adjustments for at least 12 months after the Closing, to all</del> <u>offer to hire all active employees of the Hospital in good standing as of the Closing in positions and at compensation levels consistent with those provided by the Hospital</u> <del>employees retained by Bidder</del> <u>as of the Closing.</u></p> <p>b) Bidder shall <del>commit to honor all existing severance agreements between Hospital and Hospital’s employees, provide benefits and establish terms and conditions of employment, which shall be generally consistent with those offered at other hospitals affiliated with Bidder.</del></p> <p>c) Hospital employees shall retain their current seniority and vesting in <del>Hospital’s or any successor</del> <u>Bidder’s retirement</u> benefit <del>programs</del> <u>plans.</u></p> <p>d) Hospital employees retained by Bidder shall retain their current seniority for purposes of determining vacation accruals after the Closing.</p> <p>e) As of the Closing, Bidder shall provide Hospital employees with a retirement plan, vacation, sick leave, holidays, health insurance, life insurance, and other employee benefits consistent with <del>the current benefit plans in effect at Hospital</del> <u>or those Bidder benefit plans in effect from time to time with no waiting periods or pre-existing condition limitations for any benefit plan offered by Bidder to current Hospital employees.</u></p> <p><del>f) Bidder agrees to honor any existing collective bargaining agreements.</del></p>
<p><b>19. Treatment of Contracts</b></p>	<p>Bidder shall accept assignment of and assume all obligations arising after the Closing under contracts, operating leases, physician arrangements and other operating obligations of the Business, with no offset against the Cash Purchase Price <u>(other than standard prorations); provided, however,</u> that Bidder shall not be obligated to assume commercially unreasonable contracts or contracts that raise regulatory concerns.</p>
<p><b>20. Indemnification</b></p>	<p>Bidder and Hospital shall agree to indemnification provisions along with certain limitations usual and customary in transactions of this type.</p>
<p><b>21. Medicare Provider Number</b></p>	<p>Bidder will assume Hospital’s Medicare acute-care hospital provider number.</p>
<p><b>22. Tail Policies</b></p>	<p>As of the Closing, <del>Bidder</del> <u>Hospital</u> shall provide and pay for appropriate tail insurance policies to cover Hospital directors’ liabilities, <u>professional liabilities,</u></p>

**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~ Bidder 3**  
**Page 6**

<p><b>23. Transition</b></p>	<p><u>general liabilities</u> and such other risks as applicable.</p> <p>a) Subject to applicable regulatory requirements, Bidder shall have the opportunity to provide limited input to significant business activities of Hospital after execution of the Definitive Agreement and prior to the Closing including, but not limited to:</p> <ul style="list-style-type: none"> <li>i. Capital expenditures in excess of \$1.0 million not included in Hospital’s routine annual capital and operating budgets.</li> <li>ii. Significant new contracts in excess of \$<del>250,000</del><u>25,000</u> in annual expense.</li> <li><u>iii. New or amended contracts with physicians or other referral sources.</u></li> <li><u>iv. <del>iii.</del> Changes in title or assignment of specified senior executives.</u></li> </ul> <p>b) In addition, Hospital shall work with Bidder to perform, or cause to be performed, any act, submission or filing, including the Letter for the purpose of application for a Certificate of Need (“CON”), as is necessary and directed by Bidder including CON’s necessary for Hospital to remain competitive in its marketplace.</p>
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**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~ Bidder 3**  
**Page 7**

<p><b>24. Closing</b></p>	<p>a) The Closing shall take place as soon as practicable after all required regulatory and other approvals for the Transaction have been obtained, unless otherwise mutually agreed by the parties to the Letter. The Closing will be subject to mutually agreed closing conditions, including but not limited to (i) completion of a satisfactory due diligence review of the Purchased Assets and the Business, (ii) receipt of surveys, title insurance commitments and environmental and engineering surveys reasonably satisfactory to Bidder, (iii) receipt of all necessary regulatory approvals and permitted license transfers, (iv) delivery of documents of conveyance and assignment, (v) expiration of the “waiting period” under the HSR Act, and (vi) no “Material Adverse Change” (as defined below) shall have occurred.</p> <p>b) “Material Adverse Change” shall mean an event, change or circumstance which, individually or together with any other event, change or circumstance would be reasonably expected to have a material adverse effect, either individually or in the aggregate, on the business, assets, liabilities, financial condition or results of operations of the Business whether such effect would be realized before or after the Closing; provided, however, that a Material Adverse Change shall not include: (i) changes in the financial or operating performance due to or caused by the announcement of the Transaction or seasonal changes; (ii) changes or proposed changes to any law or regulation, reimbursement rates or policies of governmental agencies or bodies that are generally applicable to hospitals or health care facilities; (iii) requirements, reimbursement rates, policies or procedures of third party payors or accreditation commissions or organizations that are generally applicable to hospitals or health care facilities; (iv) general business, industry or economic conditions, including such conditions related to the Business; (v) local, regional, national or international political or social conditions, including the engagement by the United States in hostilities, whether or not pursuant to the declaration of a national emergency or war, or the occurrence of any military or terrorist attack; (vi) changes in financial, banking or securities markets (including any disruption thereof and any decline in the price of any security or any market index); or (vii) changes in GAAP.</p>
<p><b>Binding Provisions</b></p>	
<p><b>25. Expenses</b></p>	<p>a) Each party shall bear its respective legal, accounting and other expenses and costs in connection with the Transaction; <del>provided, however, if the Transaction is consummated, Bidder will bear all such expenses.</del></p> <p>b) Bidder and Hospital shall split the cost of title insurance upon the real property to be leased and the cost of a survey of such property, as well as all recording taxes and fees payable in respect of the Transaction.</p> <p>c) Bidder shall pay the filing fee, if any, required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (the “HSR Act”) and all expenses of inspecting the Purchased Assets, including the cost of any environmental surveys.</p>
<p><b>26. Press Release</b></p>	<p>Except as otherwise required by law, all press releases or other public</p>

**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~ Bidder 3**  
**Page 8**

	communications of any sort relating to the Transaction, and the method of the release for publication thereof, will be subject to the prior approval of both parties.
<p><b>27. Legal Effect and Diligence</b></p>	<p>a) This Term Sheet is subject to and contingent upon due diligence review and the negotiations, approval, and execution of all necessary definitive agreements and related documents (“Definitive Agreement”). Upon execution of the Letter, Bidder and Hospital will negotiate in good faith the terms and conditions of the Definitive Agreement.</p> <p>b) As part of Hospital’s due diligence on Bidder, Bidder shall in reasonable detail describe its strategy for the Business post-Closing including, but not limited to, steps to reduce expenses at the Business through implementation of best practices and reduction of overhead.</p> <p>c) <del>The Letter and this Term Sheet are not intended, and shall not be construed, to create an obligation that Hospital negotiate exclusively with Bidder regarding the Transaction or any similar strategic transaction; provided that Hospital will neither engage in any due diligence review nor execute a term sheet or similar preliminary document with any other party relating to a change of control transaction or asset sale of all or substantially all of the assets of the Business, unless Hospital first notifies Bidder of Hospital’s intention to do so. Upon execution of the Letter by both parties, Bidder and Hospital will conduct and cooperate in reasonable due diligence regarding the Transaction, including without limitation the Business and parties to the Transaction. Bidder and Hospital intend that the period of diligence not exceed 45 days and that the Definitive Agreement be approved and executed within 30 days thereafter.</del> <u>In consideration of the significant investment by Bidder of time and expense in connection with the transactions contemplated by this Term Sheet, from the date of execution of the Letter until the date of which is 60 days after the written termination of negotiations pursuant to this Term Sheet (unless such negotiations are terminated by Bidder or are terminated by Hospital following a request by Bidder for a material change in the terms embodied in this Term Sheet, in which case the 60 day period shall not be applicable), Hospital will not, without the approval of Bidder (a) offer for sale or lease all or any significant portion of the Purchased Assets or any ownership interest or membership substitution in any entity owning any of the Purchased Assets, (b) solicit offers to buy all or any significant portion of the Purchased Assets or any ownership interest or membership substitution in any entity owning any of the Purchased Assets, (c) initiate, encourage or provide any documents or information to any third party in connection with, discuss or negotiate with any person regarding any inquires, proposals or offers relating to any disposition of all or any significant portion of the Purchased Assets or a merger or consolidation or membership substitution of any entity owning any of the Purchased Assets, or (d) enter into any agreement or discussions with any party (other than Bidder) with respect to the sale, assignment, or other disposition of all or any significant portion of the Purchased Assets or any ownership interest or membership substitution in any entity owning any of the Purchased Assets or with respect to a merger or consolidation or membership substitution of any entity owning any of the Purchased Assets.</u></p>

**Community Medical Center**  
**Proposed Term Sheet – ~~BIDDER~~Bidder 3**  
**Page 9**

<b>Summary Report:</b>	
<b>Litéra® Change-Pro ML 6.5.0.416 Document Comparison done on 9/24/2013 2:55:09 PM</b>	
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<b>Original Filename:</b>	
<b>Original DMS:</b> dm://DOCS/3217429/1	
<b>Modified Filename:</b>	
<b>Modified DMS:</b> dm://DOCS/3217429/2	
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<del>Delete</del>	61
<del>Move From</del>	5
<del>Move To</del>	5
Table Insert	0
<del>Table Delete</del>	0
Embedded Graphics (Visio, ChemDraw, Images etc.)	0
Embedded Excel	0
<b>Total Changes:</b>	<b>139</b>



