Community Health Systems, Inc.'s Acquisition of Triad Hospital, Inc.[1]

On March 19, 2007, Community Health Systems, Inc. ('CHS'), the largest non-urban provider of hospital healthcare services in the US, announced plans to acquire Triad Hospital, Inc. for $6.8 billion. The bid, financed with a new debt issue, consisted of $5.1 billion for Triad's equity (including cash of approximately $200 million), and assumption of $1.7 billion in its debt.

The bid represented a premium of 20% on Triad's stock price one month prior to the date of announcement, and a 40% premium relative to three months prior.

The merged company would retain the acquirer's name and operate 129 hospitals with 19,000 licensed beds in 28 states, to generate 2007 revenue of over $11 billion, becoming the largest publicly-owned hospital services provider in the US.

Larry Cash, SVP and Chief Financial Officer of CHS, said: "We are excited to have this opportunity to significantly increase our company's size and geographical reach. The mid-sized urban markets in which Triad operates create a huge opportunity for growth for us. Triad has excellent physical plant, outstanding medical staff, and strong physician relationships. There are synergy opportunities from bringing more discipline to their capital spending and expense management. The potential for long-run shareholder value creation is great."

On the news, Triad's stock price increased by 5.3%, but CHS's stock price fell 5.8%.

The Acquirer

CHS is the largest provider of non-urban hospital healthcare services in the US. At the end of 2006, CHS owned or leased 77 hospitals in 22 states, primarily in the South of the US. The company had 2006 net operating revenues of $4,365 million and net income of $168 million (see Exhibit 1 for CHS's summary financials and operations). CHS's hospitals are one of three or fewer healthcare providers in 98% of its markets, and sole provider in 85%. The state in which it does most business – Tennessee – accounts for just one-fifth of revenues. The CEO believes that this geographic diversity helps mitigate risks associated with varying state regulations that determine a significant portion of the company's revenues.

CHS's strategy is to focus on markets with strong population growth, those that are underserved by other healthcare providers. Reimbursement rates from government payers such as Medicare and Medicaid are higher in non-urban markets and for sole providers, making this an attractive strategy.

CHS's revenue strategy rests on three legs. It operates a centralized recruiting system for new primary-care physicians and specialists; each additional recruitment expands its capacity to attract new inpatients and outpatients. CHS also focuses on expanding complex medical services, particularly orthopedics, cardiovascular services, and urology where payment profiles are

[1] This case was developed by Anant K. Sundaram (anant.sundaram@dartmouth.edu) as a basis for class discussion. To minimize clutter in the text of the case, all references to sources and databases are shown in an Appendix. (Revised: August 2013).

generally more attractive. Finally, the company invests in technology and physical plant in its emergency rooms, surgery/critical care departments, and diagnostic services: 60% of CHS's hospital admissions come from emergency room visits.

CHS prides itself in having developed significant expertise in focusing on the quality of healthcare throughout its system.[2] Quality improvements not only produce better patient results, but also reduce risk and improve financial performance. CHS implemented numerous initiatives related to quality improvement across the company, including: (i) standardized data and benchmarks across departments and facilities to monitor improvements; (ii) policies and procedures based on scientific and medical research; (iii) an aggressive program of hospital-based training and coaching, including programs for both clinical and management personnel on regulation, reporting requirements, leadership skills, and communication; (iv) sharing of best practices across departments and hospitals; and (v) evidence-based tools for improving patient, physician, and staff satisfaction.

CHS has grown through acquisitions – of primarily non-profit hospitals – completing 23 between 2001 and 2006. During this period, revenues increased 163% from $1,657 million to $4,365 million, while net income grew 273%. The CEO claimed that the rising profit, despite acquisitions, was due to his team's ability to integrate targets quickly (the senior team at CHS has collectively made 55 acquisitions), and their ability to take advantage of scale by bringing targets into its centralized purchasing arrangements, standardized IT systems, and a proprietary 'case and resource management program' for capital budgets and expenses.

CHS's total hospital admissions grew at a compounded annual growth rate (CAGR) of 21% between 2002 and 2006, while 'same store' revenue – a measure of organic growth – grew by 8.2% per year. Although the growth in net income since 2001 looked impressive, a closer look indicates increased cost pressures: earnings before interest, taxes, depreciation and amortization (EBITDA) as a percentage of sales declined from 17.0% in 2002 to 13.1% in 2006 (see Exhibit 1). 'Provision for doubtful accounts' – the uncollectable revenues from 'self-pay', i.e., the revenues from hospital costs that patients must pay themselves – jumped from 8.7% of sales in 2002 to 11.7% in 2006.[3]

From January 1, 2004 to March 1, 2007, CHS's share price went up from $26.80 per share to $35.25, i.e., CAGR of 9.6%: after a relatively modest rise in 2004, the stock shot up by 40% in 2005, followed by a 10% decline in 2006. During the same period, the S&P500 index had a CAGR of 8.1% (although, if the 1.7% in annual dividend yields were included, the return on the S&P500 index would be the same as that of CHS).

Financial, capital market, and operating data for large, publicly traded hospitals in 2006 are shown in Exhibit 2.

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[2] There has been an industry-wide focus on improving the quality of healthcare delivery, propelled by the increasing focus by payers – especially Medicare and Medicaid – on tying payments to outcomes. This focus has led hospitals to address measurement and reporting of indicators related to quality of services delivered, such as timeliness, safety, effectiveness, efficiency, and patient-centeredness of care.

[3] Self-pay revenue comes from two sources: copayments and deductibles that are due from insured patients, and payments due from uninsured patients.

The Target

Triad Hospitals, Inc. is also a provider of hospital healthcare services. Triad operates in mid-sized urban markets in the South, Midwest, and West of US. It owns or leases 50 hospitals in 17 states. Triad also has a facility in Dublin, Ireland, and joint ventures with other hospitals. A subsidiary, QHR, provides management and consulting services to US hospitals.

Triad was previously the Pacific Group business of HCA, Inc. In May 1999, HCA divested Pacific Group via a spin-off of shares to HCA's shareholders and renamed it Triad. Two years later, in a move to expand scale, Triad acquired Quorum Health Group for $1.4 billion. The company acquired 13 more hospitals through 2006. In the first half of 2006 alone, Triad announced four major acquisitions and JVs.

In 2006, Triad had revenues of $5,538 million and earned a profit of $222 million (see Exhibit 3 Triad's summary financials and operations). It was one of three or fewer providers of hospital services in 70% of its markets, and sole provider in 38%. During 2002-06, Triad's total revenues and EBITDA grew at a CAGR of 15.2% and 7.1%, respectively, while its 'same store revenue' grew at 8.8% per year. EBITDA as percentage of sales declined from 10.9% in 2002 to 9.9% in 2006.

The months prior to the CHS announcement were tumultuous. At Triad's third-quarter (3Q06) earnings announcement on October 16, 2006, CEO Denny Shelton surprised markets when he announced that the company had an earnings decline resulting from higher bad debt expenses and deterioration in collection rates. Provision for doubtful accounts increased to 11.1% of revenue (compared to 7.3% in 3Q05 and a previously forecasted 10.4%). Moreover, if collection trends experienced in 3Q06 continued into 4Q07, Triad's earnings per share (EPS) estimate for 2007 would be lowered by about 13%, to $2.50 per share.

Although Triad reported strong growth in admissions and in revenue-per-admission and most analysts covering the company reiterated previous ratings guidance, its stock fell by 10% in the three days surrounding the announcement, from $42 to $38 per share. Mr. Shelton stated that Triad's "management was entertaining all possible avenues to return to shareholder value creation." Analysts interpreted it to mean that Triad would become a candidate for a leveraged buyout (LBO) or put itself up for sale.[4]

Events Leading Up to the CHS Bid

Two days after the earnings announcement, TPG-Axon Capital Management LP, a hedge fund, announced that it had acquired 6.1% of Triad. TPG-Axon said that it had acquired the stock "with a purpose of influencing control" of the company and that Triad "…should act to

[4] In the following weeks, the market was rife with rumors that Triad might be taken private, bidding up stock price. Analysts saw Triad as an 'industry consolidation opportunity' similar to hospital company HCA, which was taken private in an LBO in July 2006 by a coalition consisting of Bain Capital, Kohlberg, Kravis and Roberts (KKR), and Merrill Lynch, for $21.3 billion. Analysts predicted that multiples and premiums similar to those in the HCA deal would put Triad as a $45 - $50 per-share opportunity for a financial or strategic buyer.

increase shareholder value by reducing capital expenditures and acquisitions, and by focusing on margins." TPG-Axon included a warning that if management did not follow its advice, it "...may take actions regarding [Triad's] operations, plans, management, directors, governance or capital structure." In response, Triad announced that it would repurchase up to $250 million in its stock.

The company's stock price barely registered a reaction to either announcement.

Three months later, on January 12, 2007, the company received a takeover proposal from a coalition that included Goldman Sachs (GS) and CCMP Capital Advisors – a private equity fund in which Ms. Nancy-Ann DeParle, one of Triad's board members, was a principal – for $45 per share. Triad revealed that, in the weeks prior, it had executed confidentiality agreements with GS/CCMP, allowed them to undertake due diligence, hired Lehman Brothers as financial advisor and Baker Botts LLP as legal advisor. The Board also had approved 'change of control severance agreements' – golden parachutes – for all of Triad's officers with a rank of VP and above. In the week following these announcements, Triad's stock rose by 7%.

On February 2, 2007, a new potential buyer – identified in filings only as 'Buyer A' – made a formal proposal to buy Triad for slightly below $49 per share, an offer that GS/CCMP immediately countered with an offer of $49 per share. Lehman informed Triad's Board that other buyers had expressed interest, upon news of which, GS/CCMP increased its bid to $50.25 per share. Rumors of this news sent up the stock to $49.75.

A few days later, CHS executed a confidentiality agreement with Triad to conduct due diligence. CHS also gave preliminary indications of its interest in acquiring Triad for a price in excess of GS/CCMP's offer.

Five months to the day after the earnings surprise that precipitated the stock price drop and the corporate control events, on March 16, 2007, CHS made a formal proposal to acquire Triad for $58.50 per share. Triad's Board accepted the bid, and ended its agreement with GS/CCMP by paying them a termination fee of $40 million.

On March 19, Lehman delivered its opinion to the Board that the offer was "…fair to the shareholders from a financial point of view," and Triad issued a press release announcing the CHS transaction. (Capital market-related information on the company are shown in Exhibit 2.)

The US Healthcare Sector and Hospital Services Industry

The healthcare industry is a sprawling sector of the US economy, with $2.12 trillion in expenditure in 2006, i.e., 16% of GDP. Since 1990, the sector has grown at 7% per year. The Center for Medicare and Medicaid Services (CMS) forecasts growth of 6.9% per year to $4.14 trillion by the year 2016, or to over 19% of GDP.

Almost 94% of US healthcare spending is for 'health services and supplies.' Within 'health services', the largest spending categories are hospital care ($652 billion), professional services such as physician, clinical, dental etc., services ($663 billion), and nursing home/home care services (($179 billion). Within 'health supplies,' the largest spending item is prescription

drugs ($214 billion). Data on US healthcare expenditures by major category from 1990 to 2006, and forecasts for 2010 and 2016, are shown in Exhibit 4.

'Health services' includes several types of facilities that address different types of needs. 'Acute care hospitals' – facilities that provide medical and/or surgical services to all individuals that seek care and treatment for most ailments, regardless of ability to pay for such services, through an Emergency department as well as inpatient care – are the largest segment.[5] According to American Hospital Association's *AHA Hospital Statistics*, there are about 5000 acute care hospitals in the US in 2006, 82% of which are in the non-profit or government sector.

Since 2001, hospital revenues have been growing at 7.7% per year. Driven by factors such as increasing life expectancy, increasing obesity, and increased consumer demand for more innovative and sophisticated, i.e., technology-driven, means of delivering healthcare services, spending on the hospital services sector is forecasted to grow slightly faster than overall healthcare spending.

A number of negative trends loom on the cost side.[6] Since 2000, payroll and benefit costs have risen 7.5% per year, and with the forecasted shortage of physicians and nurses, payroll expenses are expected to grow at a faster rate than revenues.[7] The proportion of uncompensated care has been rising, and as a result, bad debt expense is likely to grow. Trends such as more people opting out of insurance coverage,[8] increased cost sharing for those that have coverage because of more employers dropping or constraining health benefits,[9] and payment pressures from Medicare, Medicaid, and managed care organizations (MCOs) are additional sources of cost constraints. Prescription drug costs have risen at 10% per year since 2000, and will continue to grow, albeit at a somewhat reduced rate. Spending on technology – on information technology and healthcare delivery technology – is likely to grow faster compared to the previous decade.

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[5] Most of CHS's and Triad's facilities fall into this category. In addition to acute care hospitals, the healthcare facilities sector includes rehabilitation hospitals (which can be standalone or part of a larger facility), psychiatric hospitals, nursing homes, assisted-living facilities, and home healthcare services.

[6] The main categories of operating expenses for hospitals are salaries & benefits, supplies, provision for doubtful accounts, rent, and malpractice insurance. In 2006, for-profit hospitals spent 41% of revenues on salaries and benefits, 15.6% on supplies, and 9.6% on provision for bad debt.

[7] The US Health Resources and Services Administration (HRSA) predicts a shortage of 800,000 nurses and 150,000 doctors by 2020. The most severe shortages are expected in rural areas, and in certain specialties such as emergency medicine and psychiatry.

[8] The percentage of US population not covered by health insurance went up from 14.2% in 2000 to 15.6% in 2005, to an estimated 47 million individuals.

[9] A study by the non-profit healthcare research firm, Kaiser Family Foundation, found that people not covered by employer-sponsored healthcare plans paid an average of 60% of costs out-of- pocket (compared to 34% for those with such plans), leading many to decline or delay seeking care. They also found that only 60% of firms offered health insurance in 2005, down from 69% in 2000. Even within firms offering coverage, only 80% of employees are eligible (and only 83% of those eligible chose to enroll).

Given these adverse cost trends, EBITDA margins have been declining in the past few years in the US hospital sector. For the hospitals covered by S&P's rating services in the for-profit sector, EBITDA margins declined from 18% of sales in 2003 to 14% in 2006. Analysts forecast that EBITDA margins in the for-profit sector of the hospital industry will continue to decline over time, stabilizing somewhere between 12.0% - 13.0% of sales.

Hospital Revenues: Payers and Payment Systems

Hospital revenues come from five sources: Medicare, Medicaid, private payers (such as insurers or MCOs), patients (self-pay), and 'other' sources (e.g., endowments, charitable donations, non-operating income). Revenues depend on inpatient occupancy levels, volume of outpatient procedures, and charges for services provided, which are based on negotiated rates with key payers. Charges for routine services can vary widely depending on the type of service and geographic location.

In recent years, the proportion of revenue from outpatient services has increased, because of advances in technology (which allow more services to be provided on an outpatient basis) and pressure from payers to reduce hospital stays. Given the resulting overcapacity in beds in many hospitals, the need to drive up patient and surgical procedure volumes has become important.

Medicare and Medicaid dominate the payment system. Medicare (formally, 'Health Insurance for the Aged and Disabled') created as part of the 1965 Social Security Act is a federally-funded health payment program for people over 65, some types of disabled, and people with end-stage renal disease. Medicare consists of three parts: hospital insurance ('Part A'), supplemental insurance ('Part B'), and prescription drug benefit ('Part D'). Medicare is funded via mandatory payroll deductions (Part A), beneficiary premium payments (Parts B and D), and general federal revenues (Part D). In 2006, with payments totaling $404 billion, Medicare was the single largest payer for medical care in the US, accounting for almost 20% of spending on health services and supplies.[10]

Medicaid, also part of the same 1965 Act, is a program designed to provide healthcare to eligible needy persons. It is jointly funded by the federal and state governments, but administered by states. The federal government sets guidelines, but states can set their own eligibility standards. As a result, programs vary from state to state, and over time. States with higher per-

[10] Initially, Medicare reimbursed on cost-plus basis. Based on its determination of the 'reasonable cost' of providing care, Medicare paid for 'reasonable and necessary costs' plus a certain percentage. Given the predictable consequences, starting 1983, the 'prospective payment system' (PPS) was developed, which made fixed payments for a patient based on an assigned 'diagnostic related group' (DRG). DRG rates are set based on a normal distribution of the severity of a medical condition, but allowances are made for 'outliers,' for rural v. urban, by geographical area, for income mix of care recipients, and based on whether the hospital is also a teaching facility. Hospitals keep the extra if costs are less than the DRG rate, but must absorb costs in excess. DRG rates are adjusted based on 'market basket.' Through 2003, adjustments were limited to market basket *minus* 1.1%, but starting 2005, all hospitals that reported 'quality of care data' (as defined by CMS) would receive full adjustment. By the end of 2005, nearly all hospitals were reporting quality data, and were scheduled to receive a full-market basket 3.7% increase by 2006. (See Exhibit 7, Panels 1 and 2, for how CHS compares with the national average, as well as government hospitals, non-profit hospitals, and all for-profit hospitals on key quality and patient experience metrics). Whether such increases could continue into the future was debatable, given the increasingly loud voices in Washington, D.C. that something drastic needed to be done to contain US healthcare costs.

capita income get lower federal reimbursement, a proportion that varies between 50% and 83% of total spending. In 2006, Medicaid made payments of $310 billion (with the federal portion accounting for 56%, on average). Medicaid payments are generally less than the total cost of providing the service, and thus is a drag on a hospital's profit margins.

MCOs are private organizations accountable for paying for the healthcare of a defined population group, through a system of provider networks. They are typically one of two types: health maintenance organizations (HMOs), which offer fixed-fee subscribers access to medical services from a select list of providers, and preferred provider organizations (PPOs), which pay for care as it is received instead of in advance. (PPOs also usually allow for visits to out-of-network providers, at a greater expense to the policyholder.) Currently, about 45% of the US population – and 90% of employer-provided health insurance programs – belong to MCOs. Private insurers and MCOs together accounted for $728 billion in US health spending in 2006.

Self-pay revenue for hospitals comes from copayments and deductibles for insured patients, and from payments for uninsured patients. According to analyst estimates, hospitals collect only 50% - 60% of copayments and deductibles from insured patients, and just 8% - 10% of the payments due from the uninsured. Provision for doubtful debt, as percentage of sales, for all for-profit hospitals, was 9.6% in 2006.

According to Kaiser Family Foundation data, in 2006, Medicare payments covered about 95% of the true cost of providing services. Medicaid covered less, about 90%. Private payers – insurance companies and MCOs – covered approximately 130%.[11] (The 2006 payer mix in the for-profit and non-profit sectors – as well as for CHS and Triad – is shown in Exhibit 5.)

Post-Acquisition Plans and Synergies

Given its history of successfully integrating acquisitions, CHS was confident that Triad would be no exception. CHS put together a dedicated and experienced team to manage the process, with a goal to complete the integration within two years. Synergies were expected from operating costs, capital expenditure, and from revenue-enhancement.

On the cost front, CHS expected to realize $40 - $50 million in (pre-tax) synergies in the first year, from headcount and overhead reductions. In subsequent years, CHS anticipated more savings from using their purchasing contracts, elimination of further overheads, and additional cost-saving initiatives. Analysts estimated that, starting year two, such savings could easily approach $50 - $70 million (pre-tax).[12] On the capital expenditure front, Triad had spent over $1.5 billion, or 8% - 9% of revenues, in capex during the past four years, CHS's management

[11] Although indicative of payment levels by payer type, experts suggest caution in using these numbers to compare across payer types, since service mix and intensity can vary significantly.

[12] However, CHS might be expected to incur restructuring charges of between $200 million and $300 million during the first year of integration.

felt that they could leverage these facilities and increase operating efficiencies, thereby lowering the need for capex relative to prior levels.

CHS expected growth in revenue from three fronts. First, although the combined entity would now be the sole provider in only 65% of its markets (compared to CHS's previous 85%), population over 55 was expected to grow faster in Triad's mid-sized urban markets compared to rural markets. Triad's strong presence in the faster-growing (and warmer) South and West of the US was also a favorable factor in this regard. Second, CHS's revenue strategy was based on the belief that the key method to expand patient volume was by aggressive recruitment and retention of new physicians, in both primary care and in specializations such as general surgery, obstetrics & gynecology, cardiovascular services, orthopedics, and urology.[13] CHS operates a successful centralized physician recruitment program that it expects to implement at Triad.

The third leg of revenue-enhancement is to use the hospitals' emergency rooms as a conduit for inpatient admissions. About 60% of CHS's admissions originate from its emergency rooms. CHS believes that the overall impression of its hospitals is substantially influenced by emergency rooms, since that is often a patient's first experience with the hospital. CHS invests significantly in renovating and expanding emergency rooms, in improving service times, and in aggressively marketing the quality and convenience of its emergency rooms through local media. Triad has not pursued a similar strategy, and CHS expects that to be a major source of future revenue growth.

Although buying a for-profit hospital was a departure for CHS, analysts were bullish. They were in agreement that the combination offered many synergy opportunities. (Enterprise value multiples and price multiples for acquisition transactions in the hospital services sector are shown in Exhibit 6.) Yet, in a government-influenced industry with declining margins from rising costs and revenue constraints that would result in a merged entity with a high level of debt, a few did worry whether the CHS had been too aggressive.

[13] The number and quality of physicians is considered an important determinant of competitive advantage in the hospital industry, since they decide whether a patient should be admitted to the hospital and the types of procedures that should be performed. Net of turnover, CHS recruited 300 physicians in 2006, compared to 290 in 2005 and 240 in 2004, with approximately 60% being specialists. CHS believed that its locations, patient mix, facilities, and lower reliance on MCOs made it a more attractive employer for high-quality physicians.

Appendix: Sources and Databases

Sources:

1. Blue Cross Blue Shield Association, Healthcare Trends in America: A Reference Guide from BCBSA (2009 edition).
2. Buckingham Research Group, Research Note for Triad Hospitals, Inc., October 17, 2006; January 4, 2007.
3. Center for Medicare and Medicaid Services, National Health Expenditure Projections 2006 - 2016, 2006.
4. Center for Medicare and Medicaid Services, National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 – 2008, 2009. (Spreadsheet)
5. Deutsche Bank Securities, Research Notes for Triad Hospital, Inc., October 16, 2006; November 22, 2006; January 19, 2007; February 5, 2007.
6. Henry J. Kaiser Family Foundation, Community Hospital Payment-to-Cost Ratio by Source of Revenue 1980 - 2007, www.slides.kff.org, 2008.
7. Jeffries & Company, Inc., Triad Hospitals (NYSE: TRI) Company Update, October 31, 2006.
8. J. P. Morgan North America Equity Research., Triad Hospitals, October 17, 2006.
9. J. P. Morgan North America Equity Research., Community Health, March 19, 2007.
10. SEC Edgar, Community Health Systems, Inc. Form 10-K, filed February 20, 2007.
11. SEC Edgar, Community Health Systems, Inc. Form DEF 14A (Proxy Statement), filed April 12, 2007.
12. SEC Edgar, Community Health Systems, Inc. Form S-4, filed September 24, 2007.
13. SEC Edgar, Community Health Systems, Inc. Presentation to Investors, filed March 19, 2007.
14. SEC Edgar, Triad Hospitals, Inc. Form 10-K, filed February 15, 2007.
15. SEC Edgar, Triad Hospitals, Inc. Schedule 14A (Preliminary Proxy), filed March 16, 2007.
16. Standard & Poor's Industry Surveys, Healthcare Facilities, December 28, 2006.
17. Standard & Poor's Industry Surveys, Healthcare Facilities, September 27, 2007.
18. Standard & Poor's Industry Surveys, Managed Care Organizations, September 27, 2007.
19. Thomson StreetEvents, CYH - Community Health Systems, Inc. Conference Call: Preliminary Transcript, March 19, 2007.
20. US Census Bureau, Statistical Abstract of the United States, 2009.
21. US Health Resources and Services Administration, What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses? September 2004.
22. US Health Resources and Services Administration, The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand, December 2008.

Databases:

1. American Hospital Association, AHA Hospital Statistics (various years).
2. Bloomberg LLC, Bloomberg Database (electronic).
3. Center for Medicare and Medicaid Services (CMS) Hospital Compare database (electronic).
4. www.finance.yahoo.com
5. www.google.com/finance
6. Thomson Reuters, SDC Mergers and Acquisitions Database (electronic).
7. Thomson Reuters, Datastream Database (electronic).

Exhibit 1: Summary Financials and Operations – Community Health Systems

($ million, unless otherwise noted)

Summary Financials	*2002*	*2003*	*2004*	*2005*	*2006*
Net Operating Revenues	2,039.3	2,676.5	3,203.5	3,738.3	4,365.6
Salaries and Benefits	820.8	1,070.3	1,279.1	1,486.4	1,741.2
Supplies	177.8	255.8	324.6	377.6	547.8
Provision for Doubtful Debt	238.2	314.8	389.6	448.2	510.4
Rent	50.2	65.1	77.0	87.2	97.1
Other Operating Expense	405.8	543.8	641.5	768.8	899.9
Depreciation & Amortization	106.5	132.9	149.2	164.6	188.8
EBIT	240.1	293.8	342.5	405.5	380.5
Net Interest Expense	60.0	68.1	75.3	94.6	102.3
Other Financial Expense	8.6	-	0.8	-	-
Income before Taxes	171.5	225.6	266.4	310.9	278.2
Provision for Income Taxes	70.4	90.2	104.1	120.8	106.7
Net Income	101.1	135.4	162.4	190.1	171.5
Assets, of which:	2,809.5	3,350.2	3,632.6	3,934.2	4,506.8
Cash	132.8	16.3	82.5	104.1	40.6
Net Property, Plant, Equipment	1,029.3	1,395.3	1,484.5	1,611.0	1,986.6
Liabilities, of which:	1,595.2	1,999.6	2,392.6	2,369.6	2,783.1
Total Debt	1,192.5	1,474.7	1,831.7	1,667.6	1,941.2
Other Long-term Obligations	102.8	156.6	225.4	283.7	301.8
Equity	1,214.3	1,350.6	1,240.0	1,564.6	1,723.7
Fully Diluted Number of Shares Outstanding (in millions)			105.8	98.6	96.2
Capital Expenditure			164.3	188.4	224.5
Operating Net Working Capital			453.1	476.8	446.1
Inpatient Revenue/Total Op. Revenue			50.5%	50.9%	50.0%
Outpatient Revenue/Total Op. Revenue			48.1%	47.8%	48.7%

(Continued)

Exhibit 1, Continued: Summary Financials and Operations – Community Health Systems

Operating Data	*2004*	*2005*	*2006*
Consolidated Data:			
Number of Hospitals	66	69	77
Licensed Beds	7,358	7,974	9,117
Beds in Service	5,960	6,476	7,341
Admissions	267,390	291,633	326,235
Adjusted Admissions*	493,776	538,445	605,511
Patient Days	1,091,889	1,204,001	1,344,728
Average Length of Stay (days)	4.1	4.1	4.1
Occupancy Rate (Beds in Service)	51.2%	52.9%	53.0%
Net Operating Revenues ($M)	3,203.5	3,738.3	4,365.6
Depreciation & Amortization ($M)	149.2	164.6	188.8
EBIT ($M)	342.5	405.5	380.5
Same-store Data:			
Admissions		291,633	294,820
Adjusted Admissions		538,445	543,074
Patient Days		1,204,001	1,213,429
Average Length of Stay (days)		4.1	4.1
Occupancy Rate (Beds in Service)		52.9%	53.3%
Net Operating Revenues ($M)		3,738.3	4,000.8
Depreciation & Amortization ($M)		164.6	173.4
EBIT ($M)		405.5	365.2

** 'Adjusted admissions' is often used as a measure of combined inpatient and outpatient volume. It is defined as [Inpatient Volume]×[Inpatient Revenue + Outpatient Revenue]÷[Inpatient Revenue].*

Source: Annual Reports, 10-K filings, Form S-4 filing.

Exhibit 2: Key Operating, Financial and Capital Markets Data – Publicly Traded Hospitals in 2006

	Community Health	*Health Mgmt Assoc*	*LifePoint Hospitals*	*Tenet Healthcare**	*Triad Hospitals*	*Universal Health Svcs*
Operations						
Number of Hospitals	77	58	49	57	52	25
Licensed Beds	7,343	8,340	5,707	14,913	9,614	5,498
Average Stay Length (Days)	4.1	4.3	4.3	5.0	4.7	4.5
Total Admissions:						
% Change	11.9%	1.4%	10.2%	–10.9%	10.2%	8.9%
Same Store Admissions:						
% Change	1.1%	–1.0%	0.4%	–1.7%	1.8%	8.9%
Revenue per Admission	6.1%	2.0%	3.9%	2.0%	6.0%	5.3%
Financials						
Revenue ($M)	4,366	4,052	2,440	8,701	5,538	4,189
EBITDA Margin	13.1%	16.9%	18.5%	8.3%	11.3%	12.4%
EBIT Margin	8.7%	8.9%	10.1%	<0	7.2%	7.0%
Profit Margin	3.9%	4.6%	5.8%	<0	4.2%	6.2%
As % Total Revenues:						
Salaries & Benefits	39.9%	39.8%	38.8%	44.7%	40.3%	42.7%
Supplies	12.5%	13.9%	13.9%	17.9%	17.3%	20.7%
Bad Debt	11.7%	10.6%	11.3%	6.4%	10.4%	8.3%
Outpatient Revenues	48.7%	48.6%	47.9%	29.0%	45.5%	27.5%
Total Debt/Capital (12/06)**	52.9%	50.5%	51.3%	92.8%	34.6%	33.5%
Market/Book Ratio (12/06)	1.98	2.19	1.26	13.97	1.13	3.61
P/E Ratio (12/06)	19.81	28.79	12.56	NM	15.91	19.48
CAPM (Equity) Beta***	0.73	1.24	0.96	0.54	NA	0.42
Fama-French:****						
Beta	0.62	1.06	0.74	0.61	NA	0.43
HML Premium	–0.6%	2.4%	1.4%	–1.7%	NA	–0.7%
SMB Premium	1.2%	2.1%	2.5%	–0.8%	NA	–0.2%
Credit Rating	NA	BBB	B+	CCC+	BB–	BBB
Bond Yield	NA	6.125%	3.250%	9.250%	7.000%	6.125%

* *Tenet's financial data for 2006 should be used with caution for financial comparisons, although its operating data are sound. In June 2006, Tenet was ordered to pay $900 million to resolve claims it defrauded the government for overbilling Medicare claims during the 1990s, as a result of which it posted a loss of $840 million for 2006.*

** *Capital = Total Debt + Book Equity*

*** *Single-factor model; long term US Treasury bonds yield 4.65% at end-2006, and 4.72% in March 2007*

**** *Three-factor model; the beta calculated in Fama-French can differ from the single-factor beta.*

'NM' = Not Meaningful; 'NA' = Not Available; '<0' = Negative.

Sources: Annual Reports, 10-K filings, CHS's Form S-4 filing, Yahoo Finance, Google Finance, S&P500 Industry Reports for 2006 and 2007, Ibbotson Beta Book, Ibbotson Cost of Capital Book, Bloomberg.

Exhibit 3: Summary Financials and Operations – Triad Hospitals, Inc.

($ million, unless otherwise noted)

Summary Financials	*2002*	*2003*	*2004*	*2005*	*2006*
Net Operating Revenues	3,145.3	3,550.6	4,218.0	4,747.3	5,537.9
Salaries and Benefits	1,319.2	1,446.0	1,695.4	1,940.2	2,233.1
Supplies	491.9	556.4	692.4	801.3	957.9
Provision for Doubtful Debt	237.8	360.6	427.2	403.3	576.9
Other Operating Expense (incl. Rent)	627.8	715.1	833.7	936.5	1141.5
Depreciation & Amortization	146.0	158.8	178.6	205.9	229.8
EBIT	320.6	313.7	390.8	460.0	398.7
Net Interest Expense	139.9	131.0	111.1	101.6	95.3
Other Financial Expense	-	39.9	76.0	8.4	-
Equity in Earnings of Affiliates	21.7	25.4	20.5	35.0	43.5
Income before Taxes	202.4	168.2	224.2	385.0	346.9
Provision for Income Taxes	86.0	64.1	81.8	141.9	132.5
Income (Loss) from Discontinued Operations (after-tax)	13.0	(1.8)	59.0	(3.4)	14.4
Net Income	129.4	102.3	201.4	239.7	228.8
Assets, of which:	4,381.6	4,735.4	4,981.4	5,736.9	6,233.8
Cash	67.4	14.2	56.6	310.2	208.6
Net Property, Plant, Equipment	1,767.1	2,023.0	2,264.0	2,584.2	2,940.2
Liabilities, of which:	2,427.1	2,659.1	2,638.1	2,809.2	3,007.4
Total Debt	1,689.1	1,758.0	1,667.0	1,703.5	1,705.4
Other Long-term Obligations	314.7	419.2	501.0	598.1	721.8
Equity	1,954.5	2,076.3	2,343.3	2,927.7	3,226.4
Fully Diluted Number of Shares Outstanding (in millions)			76.6	83.6	87.2
Capital Expenditure			436.0	393.7	461.8
Operating Net Working Capital			593.6	958.6	892.9
Inpatient Revenue/Total Op. Revenue			52.7%	54.6%	54.5%
Outpatient Revenue/Total Op. Revenue			47.3%	45.4%	45.5%

(Continued)

Exhibit 3, Continued: Summary Financials and Operations – Triad Hospitals, Inc.

Operating Data	*2004*	*2005*	*2006*
Consolidated Data:			
Number of Hospitals	45	48	52
Licensed Beds	7,475	8,674	9,614
Beds in Service	6,766	7,773	8,314
Admissions	296,542	316,963	349,491
Adjusted Admissions*	506,334	538,635	596,061
Patient Days	1,380,089	1,484,104	1,643,495
Average Length of Stay (days)	4.7	4.7	4.7
Occupancy Rate (Beds in Service)	52.7%	54.6%	54.5%
Net Operating Revenues ($M)	4,218.0	4,747.3	5,537.9
Depreciation & Amortization ($M)	178.6	205.9	229.8
EBIT ($M)	390.8	460.0	398.7
Same-store Data:			
Admissions		303,783	309,251
Adjusted Admissions		517,695	530,541
Patient Days		1,412,379	1,436,712
Average Length of Stay (days)		4.7	4.7
Occupancy Rate (Beds in Service)		54.9%	55.2%
Net Operating Revenues ($M)		4,575.6	4,996.5
Depreciation & Amortization ($M)		200.6	209.9
EBIT ($M)		475.0	436.0

** 'Adjusted admissions' is often used as a measure of combined inpatient and outpatient volume. It is defined as [Inpatient Volume]×[Inpatient Revenue + Outpatient Revenue]÷[Inpatient Revenue].*

Source: Annual Reports, 10-K filings, CHS's Form S-4 filing.

Exhibit 4: US Healthcare Expenditures by Major Category

Type of Expenditure	*Billions of Dollars*					*% of Total*				
	1990	*2000*	*2006*	*F2011*	*F2016*	*1990*	*2000*	*2006*	*F2011*	*F2016*
Health Services and Supplies	666.7	1264.4	1987.7	2778.1	3869.9	93.4%	93.4%	93.6%	93.7%	93.5%
Personal Health Care	607.5	1139.9	1769.2	2472.6	3449.4	85.1%	84.2%	83.4%	83.4%	83.4%
Hospital Care	251.6	417.0	651.8	922.3	1287.8	35.2%	30.8%	30.7%	31.1%	31.1%
Professional Services	216.8	426.7	662.8	918.9	1253.2	30.4%	31.5%	31.2%	31.0%	30.3%
Nursing Home/Home Health	65.2	125.8	179.4	239.2	322.0	9.1%	9.3%	8.5%	8.1%	7.8%
Retail Sales	74.0	170.3	275.2	392.1	586.4	10.4%	12.6%	13.0%	13.2%	14.2%
Prescription Drugs	40.3	120.8	213.7	317.5	497.5	5.6%	8.9%	10.1%	10.7%	12.0%
Durable Medical Equipment	11.2	19.3	25.2	30.5	37.6	1.6%	1.4%	1.2%	1.0%	0.9%
All Other Products	56.2	79.7	97.8	118.7	140.2	7.9%	5.9%	4.6%	4.0%	3.3%
Gov't Administration & Net Cost of Private Insurance	39.2	81.2	156.8	217.9	295.7	5.5%	6.0%	7.4%	7.3%	7.1%
Gov't Public Health Activities	20.0	43.4	61.7	87.6	124.8	2.8%	3.2%	2.9%	3.0%	3.0%
Investment	47.3	88.8	134.8	188.3	267.0	6.6%	6.6%	6.4%	6.3%	6.5%
Research	5.4	23.4	41.7	55.5	75.0	0.8%	1.7%	2.0%	1.9%	1.8%
Construction	34.7	63.2	93.1	132.8	191.9	4.9%	4.7%	4.4%	4.5%	4.6%
Total National Health Expenditure	714.0	1353.3	2122,5	2966.4	4136.9	100%	100%	100%	100%	100%

Source: Center for Medicare and Medicaid Services

Exhibit 5: Revenue by Payer Source for US Hospitals, CHS, and Triad in 2006

Source of Revenue	*All Hospitals*	*CHS*	*Triad*
Medicare	27.0%	30.7%	29.5%
Medicaid	10.4%	11.0%	5.2%
Private Insurance & MCOs	40.9%	23.9%	46.3%
Patient Self-pay	5.0%	11.9%	9.7%
Other Sources*	16.7%	22.5%	9.3%

**Veterans, National Institutes of Health, Indian Affairs, workers' compensation, nonpatient care revenue, philanthropy, etc*

Source: Annual Reports, 10-K filings, CHS's Form S-4 filing, US Census Bureau.

Exhibit 6: Comparable Acquisition Transactions (January 1997 – January 2007)

Date	Acquirer	Target	Deal Value *($ million)*	EV/Sales*	EV/EBITDA*	P/E**
05/07/97	Vencor Inc.	Transitional	628.0	1.19x	12.62x	NM
02/04/98	Shareholders	Vencor	765.7	1.23x	8.65x	14.70x
07/29/98	Shareholders	LifePoint	292.6	1.25x	11.85x	NM
10/18/00	Triad	Quorum	1,400.0	1.16x	8.11x	NM
08/16/04	LifePoint	Province	1,270.3	2.01x	11.41x	26.75x
07/24/06	KKR/Bain/Merrill	HCA Inc.	32,919.0	1.29x	8.32x	16.64x
01/08/07	UNCN	United Surgical	1,444.1	3.05x	10.83x	36.09x

** EV = Enterprise value of acquisition; ** Price paid for target's equity divided by net income ('NM' = target's net income negative).*

Source: Casewriter analysis based on SDC M&A database (Thomson Reuters).

Exhibit 7, Panel 1: Readmission and Mortality Rates – CHS versus Various Hospital Categories

	30-Day Readmission Rates from:			30-Day Mortality Rates from:		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
CHS	19.94%	24.73%	18.52%	16.98%	11.41%	11.92%
All Hospitals	19.93%	24.53%	18.20%	16.50%	11.17%	11.64%
Government	20.06%	24.71%	18.13%	16.77%	11.40%	12.00%
Non-profit	19.91%	24.39%	18.20%	16.36%	11.11%	11.50%
For-profit	19.89%	24.86%	18.31%	16.77%	11.06%	11.66%

Source: Casewriter analysis based on CMS data. The data covers 4261 hospitals in the US, and excludes approximately 300 hospitals for which sample sizes are too small.

Exhibit 7, Panel 2: Patient Experience Survey – CHS versus Various Hospital Categories

	Communication[1] Nurses	Communication[1] Doctors	Medicines Explained[2]	Room/ Bathroom Clean[3]	Room Quiet[4]	Pain Control[5]	Home Instruc-tions[6]	Would Recom-mend?[7]
CHS	74%	81%	58%	65%	61%	69%	81%	64%
All Hospitals	74%	80%	59%	70%	56%	68%	80%	68%
Government	75%	81%	60%	71%	59%	69%	80%	67%
Non-profit	74%	79%	59%	69%	54%	68%	81%	69%
For-profit	72%	79%	57%	68%	60%	67%	79%	67%

Source: Casewriter analysis based on CMS data. The data covers 4261 hospitals in the US, and excludes approximately 300 hospitals for which sample sizes are too small.

[1] Percent respondents saying nurses or doctors 'always communicated well.'
[2] Percent respondents saying 'always explained medicines before giving to them.'
[3] Percent respondents saying 'the area around their room was always quiet at night.'
[4] Percent respondents saying that their 'rooms and bathrooms were always clean.'
[5] Percent respondents saying that their 'pain was always well-controlled.'
[6] Percent respondents saying 'given instructions on what to do during recovery at home.'
[7] Percent respondents saying 'they would definitely recommend the hospital.'