VMG'S HEALTHCARE M&A REPORT

2017 TRENDS & 2018 EXPECTATIONS

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Healthcare Mergers and Acquisition ("M&A") activity continued its half-decade long growth trend in 2017. When excluding the managed care megadeals in 2015, the dollar value of healthcare transactions has continued to increase annually since 2012. Mega-mergers and disruptive transactions dominated the headlines however, the transacted value of small to midsized organizations also increased in 2017 relative to 2016. The increase in both volume and value of healthcare M&A activity is driven by changing technology, an aging population, an increase in the number of insured people through the Patient Protection and Affordable Care Act ("ACA"), and the implementation of value-based payments and alternative payment models. Taken together, these factors have driven providers to consolidate and coordinate in an effort to take advantage of the economies of scale necessary to meet the goals of the "triple aim", namely, increase service offerings and access to care, decrease cost, and improve the quality of care.

An overarching factor shaping the near-term future of healthcare M&A activity is the uncertain regulatory environment. While buyers tend to proceed cautiously in the face of uncertainty, large regulatory changes affecting healthcare providers have historically been accompanied by an increase in M&A activity. Increased capital budgets as a result of the Tax Cut and Jobs Act of 2017 may result in an increase of M&A activity, despite the near-term uncertainty.

Leveraging VMG's expertise as a leading provider of transaction healthcare valuation services, this annual report examines 2017 trends and 2018 expectations in key areas affecting M&A activity, such as transaction trends, regulatory changes, reimbursement outlook, M&A outlook, and other industry dynamics driving M&A, across several prominent healthcare verticals. Namely:

- Ambulatory Surgery Centers
- Diagnostic Imaging Centers
- Acute Care Hospitals
- Physician Services
- Post-Acute Care
- Behavioral Health Facilities
- Urgent Care Centers
- Dialysis Facilities

AMBULATORY SURGERY CENTERS

SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

Between 2010 and 2016, the total number of Medicare-certified Ambulatory Surgery Centers ("ASCs") in the United States grew at a compound annual growth rate of 1.3%, increasing from 5,105 Medicare-certified ASCs in 2010 to 5,532 Medicare-certified ASCs in 2016 (1). The ASC industry continues to remain highly fragmented with approximately 72% of freestanding ASCs being independently owned and operated. The remaining 28% of the ASC industry is controlled by large players including AmSurg Corp. (merged with Envision Healthcare), United Surgical Partners, Inc. (joint venture with Tenet), Surgical Care Affiliates, Inc. (owned by Optum/UnitedHealth Group, Inc.), HCA Holdings, Inc., Surgery Partners, and other multi-site operators (2).

In 2017 VMG observed an increase in valuation multiples with median total invested capital ("TIC") to trailing twelve month ("TTM") earnings before interest, taxes, depreciation, and amortization ("EBITDA") ("TIC/TTM EBITDA") multiples increasing from approximately 6.6x in 2016 to approximately 6.8x in 2017 (3). We note the median multiples can be used to observe a market trend (increase, decrease, tightening, etc.) and should not be used in isolation to develop a valuation or pricing for an individual center, which may bear unique characteristics and circumstances.

TIC / EBITDA	2015	2016	2017
25th Percentile	5.4x	5.8x	6.0x
Median	6.4x	6.6x	6.8x
75th Percentile	7.0x	7.4x	7.4x

*Note: Chart above represents VMG observed ASC multiples for control level transactions.

"So the pricing ranges, we're still seeing 6x to 8x"

-Teresa Sparks, EVP & CFO
Surgery Partners Q3 Earnings Call

On November 1, 2017 CMS released the CY 2018 Hospital OPPS and ASC payment system policy changes and payment rates final rule. Based on the final ruling, CMS increased the ASC conversion factor by approximately 1.2% in CY 2018, a decline from the CY 2017 final rule which increased ASC payment rates by approximately 1.9%. Beginning January 1, 2017, CMS began implementing its site neutral policy. The goal of the policy is to stop paying hospital off-campus facilities the same reimbursement rates as hospital outpatient departments ("HOPD"). For ASCs which are billed as HOPDs, the change could cut reimbursement rates by up to 50.0%. Facilities affected under this policy include facilities located more than 250 yards from a hospital's campus that began serving patients after November 1, 2015, and were previously billing Medicare as an HOPD (4).

The trend of consolidation and mega-transactions continued in 2017, following the 2015 merger of Tenet Healthcare Corporation and United Surgical Partners, Inc and the 2016 merger of Envision Healthcare Holdings with Amsurg Corp. At the start of 2017 there were two publicly-traded pure-play ASC companies

remaining, and both were involved in megadeals in 2017. Optum (a subsidiary of UnitedHealth Group) announced the acquisition of then publicly-traded Surgical Care Affiliates, Inc. ("SCA") on January 9, 2017 for approximately $2.3 billion consideration paid to shareholders (2). The transaction closed in March of 2017 and resulted in SCA going private. On May 9, 2017, publicly-traded Surgery Partners, Inc. ("Surgery Partners") announced the acquisition of National Surgical Healthcare ("NSH") for approximately $760 million and a TIC/EBITDA multiple of approximately 9.7x (2,5). The transaction closed in August of 2017.

"I want to make sure that we don't leave any misimpression about our desires to want to partner with payers, but that in no way means that we have a lack of a desire to partner with providers and hospitals accordingly"

-Wayne Scott DeVeydt, CEO
Surgery Partners Q4 Earnings Call

Private equity firms were active in the space as well. In addition to partially funding the acquisition of NSH by Surgery Partners in exchange for preferred equity in the latter, Bain Capital Private Equity also acquired a 54% stake in Surgery Partners for approximately $503 million from H.I.G. Capital. Private equity firm KKR & Co. L.P. ("KKR") announced in August of 2017 their acquisition of Nashville-based Covenant Surgical Partners, an operator of ASCs and physician practices across 17 states. The transaction closed in October of 2017 and financial details were not disclosed (2).

VMG expects the consolidation trends to continue in 2018 as ASCs seek to guard themselves from increasing competitive risk; and as health systems and insurers aim to defend market share and diversify operations. Driving these factors is the healthcare industry's continued push to provide services in lower cost outpatient settings. We expect hospitals and health systems to continue direct participation in the ASC industry through either outright acquisitions or indirect participation via a joint venture ("JV") arrangement with ASC management companies and/or local physicians. We also expect to see continued interest from payers in the market with interest in ventures and partnerships that reduce cost in the healthcare system (i.e.,

shifting surgical volume to lower cost outpatient settings). VMG expects ASC multiples to trend neutral to favorable in 2018 due to continued high demand, continued regulatory tailwinds pushing volume to outpatient settings, and favorable economic variables for ASCs.

DIAGNOSTIC IMAGING CENTERS

SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

The diagnostic imaging center market in the United States is estimated to generate over $100 billion in annual revenue. Imaging services are typically differentiated between hospital-based imaging and non-hospital-based imaging, with hospital-based imaging accounting for an estimated 60% of the total imaging market in terms of net revenue (which includes inpatient imaging and HOPD imaging services) (6). The IMC market is highly fragmented with the top twenty operators accounting for approximately 14.9% of the total centers. RadNet, Inc. is the largest single operator, controlling 298 of the approximately 6,740 total IMCs (2).

Physician alignment with hospitals has impacted referral volume to unaffiliated and independent IMCs. Many hospitals are now pursuing transactions of IMCs after having already acquired and aligned with the referring physician groups (for example, large ortho groups). The IMCs are often secondary targets and might be acquired several months later, after referral patterns have shifted. The continued physician alignment trend has tempered actual and anticipated volume growth in unaffiliated IMCs.

Health system imaging services, like many other health system services, are continuing to be affected by regulatory changes aiming to lower industry costs by shifting services to the outpatient setting. Further, patients in high deductible plans are becoming more engaged in deciding where to get their health care services, and price is becoming an increasingly motivating factor. It is estimated that imaging services performed in a health system receive reimbursement rates 2x to 5x higher than the freestanding outpatient rates. Subsequently, IMC operators and health systems are increasingly pursuing JV relationships in an effort to reduce competition and reduce costs.

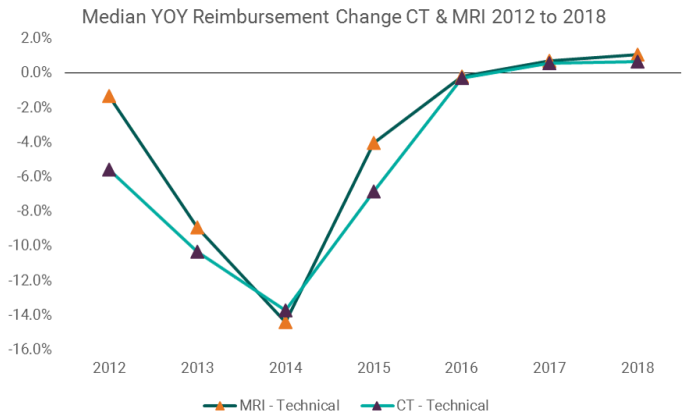
"We expect 2018 will bring new joint venture opportunities as health systems seek affiliations and solutions to manage their radiology delivery and offerings."

- Howard Berger, Chairman and CEO RadNet, Inc. Q4 Earnings Call

Since the passage of the Deficit Reduction Act of 2005, there have been significant reimbursement cuts for IMCs. The reimbursement cuts have targeted perceived over-utilization and cuts have been structured to incentivize upgrading equipment by providing lower reimbursement to older, technologically outdated scanners. For example, in 2018, IMCs not meeting computed tomography ("CT") scanner standards will have technical reimbursement reduced by approximately 15% (4). Estimates to upgrade older CT equipment range from $20,000 to $150,000. Similar cuts are proposed for x-ray machines providing analog (i.e., film-based) or computed (i.e., cassette-based) imaging. The cumulative result is a dampening of cash flow returns to IMC investors as both operating expense and capital expense, as a percentage of revenue, increase.

Since 2010, CMS has made a number of revisions to the methodology utilized to determine relative value units ("RVU") under the MPFS which have resulted in reimbursement cuts for imaging procedures. While the changes have impacted all imaging modalities, advanced imaging modalities have

experienced larger reimbursement cuts due to their higher reimbursements and perceived over-utilization. Presented in the chart below is the median annual MPFS reimbursement change for the technical component of MRI and CT codes from 2012 to 2018. From 2012 to 2015, MRI and CT experienced reimbursement cuts as a result of the RVU changes. The largest reimbursement cuts occurred in 2014 as a result of the increased equipment utilization rate implemented by CMS. Since 2015, reimbursement for CT and MRI has remained relatively flat, increasing slightly (3,7,8).



**Note: Charts presented above represent median change for MRI and CT CPT codes. Actual reimbursement changes will depend on the center's scan mix. Reimbursement cuts presented above do not include reimbursement cuts resulting from MPPR cuts, CPT code bundling, or sequestration.*

Medicare pays for non-hospital-based imaging services under the MPFS and hospital-based imaging services under the OPPS. On November 2, 2017, CMS released the FY 2018 MPFS payment and policy changes final rule and increased the MPFS conversion factor by approximately 0.31% in 2018, an increase from the 2017 MPFS final rule which increased the MPFS conversion factor by approximately 0.25%. In the 2017 final payment ruling for the OPPS and ASC payment system, CMS placed a payment cap on off-campus provider-based departments ("PBDs"), defined as PBDs located more than 250 yards from the main hospital campus. Off-campus PBDs that were not licensed as of November 5, 2015 will be paid under the MPFS or another applicable fee schedule, as opposed to the OPPS, beginning January 1, 2017. During 2018, services provided at non-exempt off-campus PBDs will generally be paid at 40% of the OPPS rate. The payment restrictions do not apply to emergency services (4).

Transaction activity in 2017 resulted in RadNet, Inc. being the only remaining publicly-traded pure-play imaging provider in the U.S. In April 2017, Tahoe Investment Group Co., Ltd. ("Tahoe"),

formerly known as Fujian Thai Hot Investment Co., completed its acquisition of all remaining outstanding common stock of Alliance HealthCare Services, Inc. ("Alliance"). The transaction resulted in implied TEV/Revenue and TEV/EBITDA multiples of 1.6x and 6.2x (9), respectively, and took Alliance off the public markets. In March of 2016, Tahoe acquired a 51.5% majority stake in Alliance for approximately $102.5 million and implied TEV/Revenue and TEV/EBTIDA multiples of 1.7x and 6.5x, respectively (2,9).

While M&A in the IMC market has been muted over the past few years, the recent investor interest in the radiology physician services market could lead to increased M&A volume for IMCs due to the fact that many radiology physician groups have ownership in one or several IMCs. However, acquisitions will be heavily scrutinized by strategic and private equity buyers on a case-by-case basis due to the capital intensity and expertise required to operate an IMC - acquisitions of one or more IMCs in conjunction with a radiology physician group will be the exception, not the norm. VMG expects M&A volume to trend neutral as operators opt to pursue strategic partnerships and JV relationships with health systems in lieu of outright acquisitions.

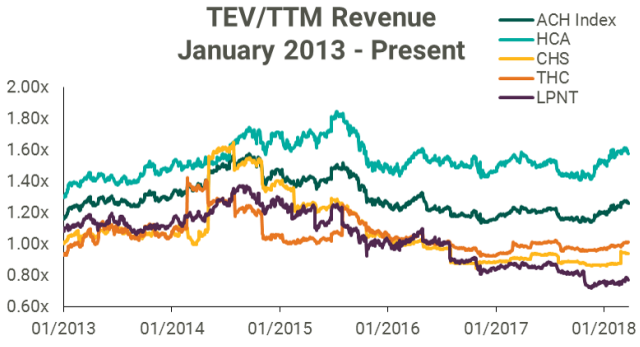
ACUTE CARE HOSPITALS

SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

Between 2010 and 2016, the number of general acute care hospitals ("ACH") has remained relatively flat in the United States at approximately 4,700 (1). In 2016, spending on hospital services accounted for the largest percentage (32.4%) of total personal health expenditures. Total hospital spending has increased 4.7% compounded annually from $902.5 billion in 2012 to $1.083 trillion in 2016 (4). The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years.

The chart below presents TEV/TTM Revenue multiples for the major public ACH operators as well as the VMG ACH Index from January 2013 through March 2018. The VMG ACH Index consists of HCA Holdings, Inc. ("HCA"), Community Health Systems, Inc. ("CHS"), Tenet Healthcare Corporation ("THC"), LifePoint Health, Inc. ("LPNT"), and Quorum Health Corporation ("QHC"). QHC is not included in the 5-year lookback as the company did not start trading on the New York Stock Exchange until April 2016. The VMG ACH Index ended 2017 with a TEV/TTM Revenue multiple of 1.21x (9).



The divesting trend of 2016 continued through 2017 with several public for-profit health systems (CHS, THC, and QHC) divesting a sizable amount of hospital assets in an effort to reduce debt. In 2017 and early 2018, CHS divested approximately 30 hospitals including a total of approximately 5,000 beds. Thanks in large part to the divestitures, CHS was able to reduce its debt load by approximately $800 million from $14.8 billion at 2016 year-end to $13.6 billion at 2017 year-end. During the same time period, THC divested eight hospitals with over 2,100 beds and sold its minority stake in four more hospitals related to its joint venture with Baylor Scott & White Health. Finally, QHC divested eight hospitals with over 600 beds in 2017 and early 2018. Through its divestitures, QHC was able to generate approximately $47 million in net proceeds, reduce secured debt by approximately $45 million, and improve its 2017 Adjusted EBITDA by approximately 14.5%. Buyers for the above-mentioned hospital assets have been primarily for-profit and not-for-profit health systems including HCA, who was involved in several acquisitions of CHS and THC divested hospitals in 2017 and early 2018 (2,5).

"The pipeline is strong, but our strategy remains the same. We are highly selective in our acquisition candidates."

-Steve Filton, CFO & EVP
LifePoint Health, Inc. Q4 Earnings Call

The divesting trend is expected to continue in 2018. In their Q4 2017 earnings call, CHS executives outlined their plan to divest more hospitals in the mid-single digit EBITDA range accounting for approximately $2.0 billion in net revenue. CHS' planned 2018 divestitures are expected to generate approximately $1.3 billion in gross proceeds which will be used to continue to pay down debt. THC outlined in their Q4 2017 earnings call that they are on track to complete their program to improve finances, which is expected to yield over $1.0 billion in proceeds, including approximately $700 million in cash from divestitures of hospitals in non-core markets. In QHC's Q4 2017 earnings call, they estimated they will be able to pay down a total of $203 million to $253 million of secured debt generated from sales proceeds, including the $45 million already paid (2,5).

Large mergers dominated the hospital scene in 2017, particularly in Massachusetts. In April 2017, Boston-based nonprofit Partners HealthCare ("Partners") signed a letter of intent to acquire nonprofit Care New England. The acquisition would add four hospitals to Partners' 15 hospitals as well as a behavioral health platform with multiple locations across Massachusetts. The two companies agreed to enter into a definitive merger agreement on January 25, 2018. In July 2017, five other nonprofit Massachusetts hospitals signed a definitive agreement to merge and create a new 13-hospital system: Beth Israel Deaconess Medical Center; New England Baptist Hospital; Lahey Health; Mount Auburn Hospital; and Anna Jacques Hospital. The proposed merger was approved by the Massachusetts Department of Public Health on March 5, 2018 and the Massachusetts Public Health Council on April 4, 2018. The merger must still be approved by the Massachusetts Attorney General and the Health Policy Commission before it can be finalized. The new combined entity would rival Partner's market share in Massachusetts with the new entity accounting for 24.7% of hospital discharges in Massachusetts, compared to Partners' current market share of 27.0% (sans Care New England merger) (2,10).

In December 2017 three large deals were announced in one week. First, on December 4, nonprofit Advocate Health Care ("Advocate") and nonprofit Aurora Health Care ("Aurora") announced their plans to merge and create a 27-hospital system serving close to 3 million patients per year and generating approximately $11 billion in annual revenues. The news came after Advocate's planned merger with NorthShore University HealthSystem was abandoned after a federal judge halted the merger in May 2017, causing both systems to drop merger plans due to the high cost of appeal. The Advocate/Aurora merger received final regulatory approval on March 22, 2018 and finalized the merger on April 1, 2018. Second, on December 7, 2017, nonprofit Catholic Health Initiatives ("CHI") and nonprofit Dignity Health signed a definitive agreement to merge into a single Catholic health system. The merger would create a 139-hospital system with a combined revenue of

approximately $28.4 billion. On December 11, 2017 it was reported that nonprofit Ascension Health and nonprofit Providence St. Joseph were discussing a potential merger (11). If the merger had taken place, it would have created the largest hospital operator in U.S. with 191 hospitals and annual revenues of approximately $44.8 billion, ahead of HCA's 177 hospitals and approximately $43.6 billion revenue. However, it was announced in March 2018 that the two organizations had tabled merger discussions as they elect to focus on their own individual strategies and patient populations (2,12).

Several other notable deals were announced or closed in 2017 and early 2018. In May 2017, Boston-based for-profit Steward Health Care signed a definitive agreement to acquire Tennessee-based for-profit IASIS Healthcare. The transaction has been valued at approximately $1.9 billion and closed in October 2017. The deal created the largest private for-profit hospital operator in the United States, with Steward Health Care now operating 36 hospitals with projected annual revenue of almost $8 billion. In July 2017, HCA closed its acquisition of four Houston hospitals from THC for an enterprise value of approximately $750 million and implied TEV/Revenue multiple of 1.3x (9). In February 2018, HCA closed its acquisition of Savannah, Georgia-based Memorial University Medical Center for an estimated purchase price of approximately $456.7 million (5). It was announced on March 22, 2018 that HCA signed a letter of intent to acquire nonprofit system Mission Health and its six hospitals throughout North Carolina, a new market for HCA. Financial terms were not disclosed. The two companies stated they would each contribute $25 million to a "healthcare innovation fund" that invests in healthcare companies. Finally, in February 2018, Maryland-based nonprofit Bon Secours Health System and Cincinnati-based nonprofit Mercy Health announced their intent to merge. The merger, if completed, would create a new system of 43 hospitals, generating approximately $8 billion in net revenue and approximately $239 million in operating income (2).

"Our belief is that having a fully integrated network of inpatient facilities, emergency rooms, outpatient facilities, physician clinics is a very synergistic platform for achieving growth."

-Samuel Hazen, President & COO
HCA Healthcare, Inc. Q4 Earnings Call

Specific to rural hospitals, there have been high rates of closures and financial distress in recent years. From 2010 to early 2018, there have been 83 closures of rural hospitals with the majority being in the southern region of the United States. During this time period, Texas had fourteen closures; Tennessee had eight closures; Georgia had six closures; and North Carolina, Mississippi, and Alabama each had five closures. Reasons for the difficulties faced by rural hospitals include high amounts of uninsured patients compared to urban areas, insufficient patient populations due to smaller rural communities, and physician shortages due to the remote location of subject hospitals (13).

On August 2, 2017, CMS released the FY 2018 Inpatient Prospective Payment System ("IPPS") policy changes and payment rates final rule. Based on the final rule, IPPS payment rates will increase by 1.2% in 2018, an increase from the FY 2017 final rule which increased the IPPS payment rates by 1.0%. Additionally, Medicare is making two changes to the calculation for uncompensated care payments to DSH hospitals. First, CMS finalized the proposal to incorporate data from the National Health Expenditure Accounts into its estimate of the percentage change in the rate of uninsurance, which is utilized in calculating the total amount of uncompensated care payments available to be distributed. In addition, CMS will incorporate uncompensated care cost data from the FY 2014 cost reports, in combination with the hostpital's share of Medicare and Medicaid low income days, to determine the distribution of uncompensated care payments to individual hospitals. Based on these changes, CMS estimates that it will distribute roughly $6.8 billion in uncompensated care payments in FY 2018, an increase of approximately $800 million from FY 2017. As required by the ACA and subsequent legislation, this amount is equal to 75% of what otherwise would have been paid as Medicare DSH payments under the original formula, adjusted for the change in uninsured individuals and other factors (4).

For 2018, VMG expects a continued high level of ACH M&A activity including divestitures, as well as other strategic

alignments including JVs and joint operating agreements, as hospitals and health systems emphasize providing coordinated, cost-effective care. VMG expects multiples to trend neutral as large operators continue to divest non-core entities and mid-size operators continue to consolidate.

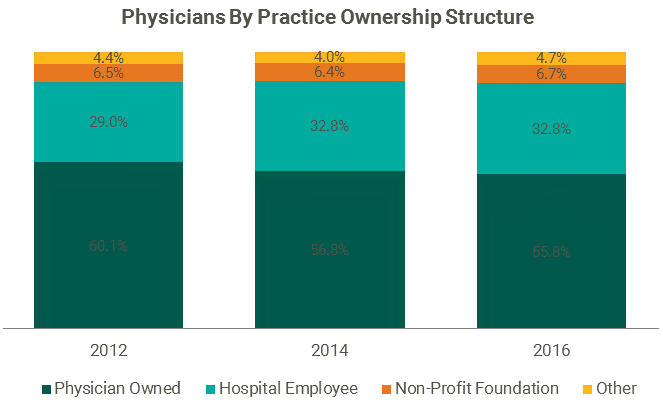
PHYSICIAN SERVICES

SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

The number of physicians in the United States has increased 0.9% compounded annually from approximately 814,000 in 2000 to approximately 951,000 in 2017 (14,15). As of 2016, approximately 88.2% of active physicians primarily focus on providing patient care. The remaining 11.8% of physicians primarily focus on teaching, research, and other professional activities. There are over 150 specialties and subspecialties recognized by the Accreditation Council for Graduate Medical Education. The largest specialties in terms of active physicians during 2015 were internal medicine and family medicine/general practice, accounting for approximately 13.3% and 12.9% of the total number of active physicians during 2015, respectively (16).

Regulatory pressure and reimbursement pressure from government and commercial payors has resulted in a continued decline in the percentage of U.S. physicians in private practice. To avoid declining revenues and increased capital burdens associated with electronic medical records systems, physicians have sold their private practices and subsequently entered into employment agreements with local health systems. As outlined below, the percentage of physicians directly employed by a hospital or in a practice with hospital ownership increased from 29.0% in 2012 to



32.8% in 2016. Likewise, the percentage of physician owned practices decreased from 60.1% to 55.8% from 2012 to 2016 (17).

Historically, the annual volume of physician services transactions has been impacted by large regulatory changes (i.e., the passage of the ACA in 2010 and the passage of MACRA in 2015). Physicians increasingly opt to align into larger groups, adopt the accountable care organization ("ACO") model, or align with health systems rather than face the burden and expense of increased regulatory and data reporting requirements alone. Recently, strategic buyers and private equity buyers alike have taken a particularly strong interest in radiology practices. Additional specialties which have seen high transaction volume include ophthalmology, dermatology, anesthesiology, emergency medicine, hospitalist, neonatology practices, and primary care.

Envision Healthcare Corporation ("Envision") and MEDNAX have been active buyers of large practices. In 2017 and early 2018, Envision acquired Sunshine Radiology, a 35-physician group in Tampa Bay, FL; Emergency Professional Services, a 50-physician group in Phoenix, AZ; Gwinnett Emergency Specialists, P.C., a 40-physician group in Lawrenceville, GA; Infinity Healthcare, Inc., a multi-specialty physician group in Milwaukee, WI with over 340 physicians and mid-level providers; Northside Emergency Associate, P.C., a 40-physician group in Atlanta, GA; and Chandler Radiology Associates, a 15-physician group in Phoenix, AZ. During the same time period, MEDNAX acquired Radiology Alliance, PC, a 64-physician group in Nashville, TN; Newborn Intensive Care Specialists, P.A., a 14-physician group in Spring, TX; Radiology Associates of South Florida, a 70-physician group in Miami, FL; Jefferson Radiology, PC, a 60-physician group in Hartford, CT; and Synergy Radiology Associates, PA, a 92-physician group in Houston, TX. Both companies acquired multiple smaller practices throughout 2017 and 2018 as well (2,5).

"Our preference is always to put our money to work by using our cash to acquire practices."

-Roger Medel, CEO & Director
MEDNAX, Inc.. Q4 Earnings Call

On December 6, 2017, Optum Inc., a subsidiary of UnitedHealth Group, Inc., announced its acquisition of DaVita Medical Group ("DMG"), a subsidiary of dialysis operator DaVita Inc. for approximately $4.9 billion in cash. The transaction has an implied TEV/Revenue multiple of approximately 1.2x (9). Optum also acquired New West Physicians, PC in August 2017, a 72-physician group, and closed its acquisition of Reliant Medical Group in April 2018, a 230-physician group. The Reliant Medical Group transaction was reportedly valued at approximately $28 million. In August 2017, private equity group Ares Management L.P. ("Ares") announced a $1.45 billion capital infusion in DuPage Medical Group ("DuPage") and its 600+ physicians. Under the terms of the transaction, DuPage's physician group will remain 100% physician-owned while Ares acquires Summit Partners' share in DuPage Medical Group Practice Management Solutions, which provides management services to physicians of DuPage (2).

Medicare reimburses physicians and physician practices according to the Medicare Physician Fee Schedule ("MPFS"). On April 14, 2015, the Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") which permanently removed the sustainable growth rate ("SGR") formula from the determination of the conversion factor under the MPFS. The SGR formula has been replaced with fixed 0.5% annual increases through 2019. Therefore, under MACRA the conversion factor will increase 0.5% annually from 2015 to 2019. After 2019, physician payments under the MPFS will remain flat through 2025. During this time period, individual physicians can achieve payment increases through participation in the Merit-based Incentive Payment System ("MIPS"), which will be developed by the Secretary of Health and Human Services, or participation in an alternative payment model ("APM")4. It should be noted that in January 2018 the Medicare Payment Advisory Committee ("MedPAC") recommended to the CMS that it eliminate MIPS and replace it with an alternative program. However, until action is taken by the CMS, the MIPS program remains active.

The MIPS supersedes three legacy CMS programs; Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier. Depending on the provider's participation level, payment adjustments will range from negative 5.0% to positive 5.0% for performance in 2018. The range will increase annually to approximately negative 9.0% to positive 9.0% for performance in 2020. The incentive payments will be made two years following the performance year (i.e., incentive payments earned in 2018 will be paid in 2020). Providers opting into the Advanced APM route will have the potential for a lump sum incentive payment of 5% annually from 2019 to 2024. The following ten models are approved as Advanced APMs by CMS for 2018:

- Bundled Payment for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)
- Comprehensive ESRD Care (CEC) Model – (large dialysis operator arrangement)
- Comprehensive ESRD Care (CEC) Model – (non-large dialysis operator two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Medicare Shared Savings Program ACO Track 2
- Medicare Shared Savings Program ACO Track 3
- Next Generation ACO Model
- Oncology Care Model (OCM) – (two-sided risk arrangement)

The BPCI Advanced Model is a new voluntary episode payment model introduced by the Trump administration in January 2018 with participation starting October 2018. Additionally, the FY 2018 final rule introduced a demo project that would allow Medicare Advantage plans to be classified as Advanced APMs under MACRA. Eligible clinicians will be allowed to become qualifying participants starting in the 2019 reporting period. This is a significant change to both insurers and providers, as the FY 2017 final rule stated that Medicare Advantage plans would not qualify to receive credit under Advanced APMs until 2021. Finally, it should be noted that the Vermont Medicare ACO Initiative model is included as an Advanced APM via participation in a version of the Next Generation ACO Model (4).

On November 2, 2017, CMS released the FY 2018 MPFS payment and policy changes final rule and increased the MPFS conversion factor by approximately 0.3% in 2018, an increase from the 2017 MPFS final rule which increased the MPFS conversion factor by approximately 0.2%.

VMG expects physicians and physician groups to continue to seek alignment in order to avoid penalties from MACRA's data reporting requirements and reduce reimbursement risk related to value-based payments and alternative payment models. We expect private equity buyers to remain focused on acquisitions and roll-ups. We expect transaction volume in 2018 to trend neutral to higher driven by the move to value-based reimbursement and alternative payment models.

POST-ACUTE CARE

SECTOR REPORT

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Post-acute care facility types include inpatient rehabilitation facilities (IRF), long-term acute care hospitals (LTACH), skilled nursing facilities (SNF), home health agencies (HHA), and hospice agencies (HSPA). Of these facilities, SNFs, IRFs, and LTACHs provide post-acute services in an inpatient setting, and HHAs and HSPAs provide post-acute services in an outpatient setting.

INPATIENT REHABILITATION FACILITIES ("IRF")

The number of Medicare-certified IRFs decreased from 1,221 in 2004 to 1,161 in 2013. The decline during this time period is attributable to the reimplementation of the 75% rule in 2004. The 75% rule required that 75% of patients admitted to an IRF have a primary diagnosis that falls within 13 distinct high acuity diagnostic categories. Even though the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") lowered the 75% threshold to 60%, the effects of the rule still resulted in a large decrease in IRF volume, particularly by limiting the number of hip and knee replacement patients that could be treated at an IRF. It should be noted that the number of Medicare-certified IRFs increased 0.8% compounded annually from 1,161 in 2013 to 1,188 in 2016. IRFs can be licensed as a freestanding hospital or as a hospital-based IRF, which is a specialty unit located within an acute care hospital. As of 2016, there were 273 Medicare-certified freestanding IRFs and 915 Medicare-certified hospital-based IRFs (1).

On July 31, 2017, CMS released the FY 2018 final payment rule for the IRF PPS which resulted in a base payment rate increase of approximately 0.8%, a decline from the FY 2017 final payment rule which had previously resulted in a base payment rate increase of approximately 1.5% (4).

"A lot of our free cash will go toward the rehab joint ventures."

--Robert Ortenzio, Executive Chairman Select Medical Holdings Q4 Earnings Call

LONG-TERM ACUTE CARE HOSPITALS ("LTACH")

LTACHs were first approved for Medicare funding with the passage of the Tax Equity and Fiscal Responsibility Act of 1982. By 2002, there were approximately 300 LTACH facilities and total annual Medicare spending of approximately $2.2 billion. Medicare implemented a prospective payment system ("PPS") for LTACH hospitals in 2002 which went into effect January 1, 2003. After the implementation of the LTACH PPS, the number of LTACH facilities and total Medicare spending increased 7.3% and 19.6% compounded annually, respectively, to 398 facilities and approximately $4.5 billion in 2006. As a result, Congress passed the MMSEA, which imposed a moratorium on new LTACHs from 2007 to 2012 unless specific exemptions were met. The moratorium on LTACHs was reinstated by the SGR Reform Act for a three-year period from April 1, 2014 to September 30, 2017. As a result of the moratoriums, the number of LTACH facilities decreased slightly from 426 in 2008 to 407 in 2016. Over the same time period, increases in Medicare spending on LTACH services slowed, increasing just 1.3% compounded annually from approximately $4.6 billion in 2008 to approximately $5.1 billion

in 2016. On September 30, 2017, the moratorium on LTACHs expired (1,18).

In addition to reinstating the moratorium, the SGR Reform Act established a site-neutral payment policy for certain cases performed in an LTACH, which went into effect September 30, 2016. Under the new policy, LTACH PPS rates will only apply to LTACH discharges that had an acute care hospital ("ACH") stay immediately preceding the LTACH admissions and for which the ACH stay included at least three days in the ICU or the discharge is assigned to the MS-LTC-DRG based on the receipt of mechanical ventilation services for at least 96 hours. For all cost reporting periods beginning on or after October 1, 2017, all other discharges, regardless of ICU use, will be paid at the lower of the ACH IPPS rate or the LTACH IPPS rate (4).

On August 2, 2017, CMS released the FY 2018 final payment rule for the LTACH PPS which resulted in a standard federal rate decrease of approximately (2.5%), a decline from the FY 2017 final payment rule which had previously resulted in a standard federal rate increase of approximately 1.7%. Additionally, the FY 2018 final rule adopted a moratorium on the full implementation of the 25% threshold policy, which sets a limit on the percentage of cases that can be admitted from a single referring ACH to 25%. As a result of the moratorium, the 25% rule will only apply to discharges occurring on or after October 1, 2018 (4).

HOME HEALTH AGENCIES ("HHA")

In response to rapid increases in utilization and Medicare spending for home health services in the early 1990s, CMS implemented new coverage eligibility requirements, applied temporary spending caps, and replaced the historical cost-based payment system with a new prospective payment system ("PPS") in 2000. After the implementation of the HHA PPS, the number of Medicare certified HHAs increased 4.2% compounded annually from 7,528 in 2000 to 12,311 in 2012. Effective July 2013, CMS imposed a moratorium on new HHA enrollment on the Chicago, Dallas, Detroit, Houston, Miami-Dade, and Fort Lauderdale areas, determining these areas to have a high risk of fraud. The moratorium was expanded in 2016 to include all of Florida, Illinois, Michigan, and Texas. As a result, the number of HHAs has declined, decreasing (0.2%) compounded annually from 12,311 in 2012 to 12,204 in 2016 (1).

On November 7, 2017, CMS issued the FY 2018 final payment rule for the HHA PPS which resulted in a base payment rate increase of 1.0%, a decline from the FY 2017 final payment rule which had previously resulted in a base payment rate increase of 2.5% (4).

HOSPICE AGENCIES ("HSPA")

The number of Medicare hospice beneficiaries increased 3.8% compounded annually from approximately 1.16 million in 2010 to approximately 1.43 million in 2016. During the same time period, the number of hospices increased 3.5% compounded annually from 3,498 in 2010 to 4,382 in 2016. The increase in HSPA's is primarily attributable to growth in for-profit hospice providers which increased from 1,954 hospices in 2010 to 2,938 hospices in 2016, or approximately 7.0% compounded annually, as compared to the number of nonprofit hospices which decreased (0.6%) compounded annually from 1,319 hospices in 2010 to 1,273 hospices in 2016 and hospices with government or other ownership structures decreased (4.5%) compounded annually from 225 hospices in 2010 to 171 hospices in 2016 (1).

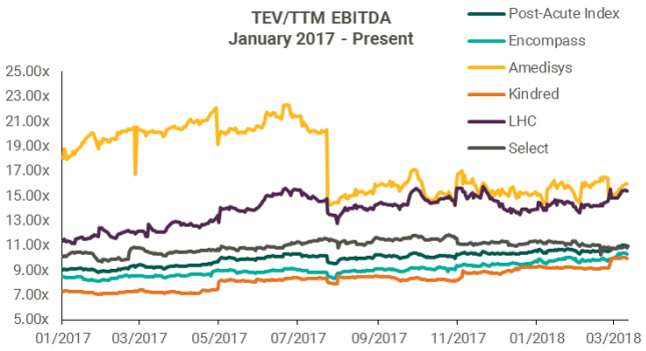
On November 7, 2017, CMS issued the FY 2018 final payment rule for the HSPA PPS which resulted in a hospice cap amount rate increase of 1.0%, a decline from the FY 2017 final payment rule which had previously resulted in a hospice cap amount rate increase of 2.1% (4).

"The hospice tends to trade at a slight premium to just pure home health businesses, both in the public and the private transactions"

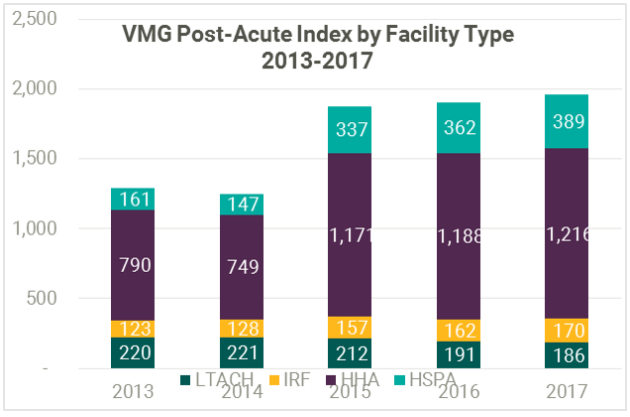
-Douglas Coltharp, CFO & EVP
Encompass Health Corporation
Q4 Earnings Call

POST-ACUTE CARE - M&A MARKET

The VMG Post-Acute Index consists of Encompass Health Corporation ("Encompass", formerly known as HealthSouth), Amedisys, Inc. ("Amedisys"), Kindred Healthcare ("Kindred"), LHC Group ("LHC"), and Select Medical Corp. ("Select"). The VMG Post-Acute Index ended 2017 with a TEV/TTM EBITDA multiple of 10.4x (9).



With the capital costs and regulatory pressure on LTACHs and IRFs as well as the continued shift toward lower cost outpatient settings, M&A volume for HHAs and HSPAs has remained elevated relative to IRFs and LTACHs. This trend can be seen in the portfolios of the public post-acute providers in the VMG Post-Acute Index. Of facilities owned by these companies from 2013 to 2017, the total number of LTACHs has decreased (4.1%) compounded annually, the total number of IRFs has increased 8.4% compounded annually, the total number of HHAs has increased 11.4% compounded annually, and the total number of HSPAs has increased 24.7% compounded annually (2).



As a result of the Hospital Readmissions Reduction Program, the MACRA, and the Medicare Bundled Payments for Care Improvement Initiative (BPCI), hospitals are increasingly incentivized to coordinate care in the post-acute setting in order

to reduce potential penalties that would occur if patients are readmitted or have poor outcomes. As a result, hospitals have an incentive to direct patients to better performing post-acute care organizations and settings. Further, the historically fragmented post-acute industry has proven an opportunity for consolidation and investment from private equity funds, particularly in the home health and hospice settings.

"Many of the providers in the public space and home health care are signaling a return to an appetite for acquisitions that's stronger than the past. And so I do certainly think that, that will create a frothier market."

-April Kay Bullock Anthony, CEO
Encompass Health Corporation
Q4 Earnings Call

In November 2017, LHC announced it had entered into a definitive merger agreement to acquire Almost Family, Inc. ("AF") in an all-stock, merger of equals transaction with an implied valuation of approximately $2.4 billion for the combined company (as of November 14, 2017). Shareholders of AF will receive 0.9150 shares of LHC for each share of AF outstanding and will own approximately 41.5% of the combined company at transaction close with LHC stockholders owning approximately 58.5%. AF will operate as a wholly-owned subsidiary of LHC. The transaction closed on April 2, 2018. The combined company had annual revenue of approximately $1.9 billion and Adjusted EBITDA of approximately $154.8 million for the year-ended December 31, 2017 based on pro forma income statements (2).

LHC was also involved in several JV deals with large health systems in 2017. In January 2017, LHC and LifePoint Health, Inc. ("LifePoint") completed a JV in which LHC will oversee management of LifePoint's 20 home health and 10 hospice locations plus all future home health and hospice acquisitions made by LifePoint. In September 2017, LHC and CHRISTUS Health completed a JV in which LHC will oversee management of CHRISTUS Health's seven home health locations, six hospice locations, six LTACHs, one community-based home care service provider, and one inpatient hospice unit. It should also be noted that in January 2017, AF completed its JV with CHS to acquire an 80% interest in CHS' 74 home health and 15 hospice locations for $128 million and an implied TEV/TTM EBITDA multiple of approximately 6.5x (including full run-rate synergies). After acquisition by LHC, AF still oversees the management of what is now 82 home health locations and 15 hospice locations from the JV with CHS (2).

Home health and hospice are not the only post-acute verticals where JV deals are common. In recent years, hospitals and health systems looking to free up inpatient resources for services with higher margins have been entering into JV relationships with for-profit operators in order to move their inpatient rehabilitation units to freestanding hospitals. Two such operators active with IRF JVs in 2017 and early 2018 were Select and Encompass.

In March 2017, Select and Dignity Health ("Dignity") announced a JV agreement to construct a new 60-bed hospital-based IRF in Las Vegas. Select will manage operations of the IRF as well as 11 Select-owned and one Dignity-owned outpatient rehabilitation clinic. Also in March 2017, Select and Riverside Health System announced a JV where Select will operate one 50-bed hospital-based IRF and one 25-bed LTACH in Virginia. Also included in the agreement is a new freestanding IRF to be built in early 2019. Select and Cleveland Clinic entered into their second and third JV agreements to operate IRFs in 2017 after their first in 2015. In October, the two companies agreed to open a new 60-bed hospital-based IRF in Beachwood, Ohio and in November they agreed to open a new 60-bed hospital-based IRF in Township, Ohio. In January 2018, Select and Banner Health announced a JV to combine operations of four hospital-based IRFs and 38 physical therapy centers in Arizona. In March 2018, Ochsner Health System opened the 56-bed hospital-based Ochsner Rehabilitation Hospital in partnership with Select (2).

In April 2017, Encompass entered into a JV with Memorial Hospital at Gulfport to operate a 33-bed hospital-based IRF in Mississippi. In July 2017, Encompass entered into a JV agreement with Heritage Valley Health System ("Heritage") to jointly own the 44-bed HealthSouth Rehabilitation Hospital of Sewickley located in West Virginia in which Heritage will contribute the IRF business from Heritage Valley Beaver Hospital to the JV. Under the JV, a new 55-bed replacement hospital will open in 2019. In February 2018, Encompass formed a JV with Saint Alphonsus Regional Medical Center to operate a 40-bed freestanding IRF in Idaho. In March 2018, Encompass and Premier Health announced plans for a JV that will build a 60-bed freestanding IRF in Ohio expected to be operational in early 2020. Also in March 2018, Encompass and Deaconess Health System announced plans for a JV to build a new 80-bed freestanding IRF in Indiana to replace HealthSouth Deaconess Rehabilitation Hospital and is expected to be operational in fall 2019 (2).

In December 2017 a definitive agreement was announced by a consortium of three companies to acquire Kindred. TPG Capital ("TPG"), Welsh, Carson, Anderson & Stowe ("WCAS"), and Humana Inc. ("Humana") announced the agreement which valued Kindred at approximately $4.4 billion. The valuation resulted in implied TEV/TTM Revenue and TEV/TTM EBITDA multiples of 0.6x and 9.2x, respectively (9). Under the terms of the transaction, Kindred's home health, hospice and community care business, Kindred at Home, will separate from Kindred and operate as a standalone company owned 40% by Humana and 60% by WCAS and TPG. Kindred's IRFs, LTACHs and contract rehabilitation services business will be separately owned and operated by WCAS and TPG under the Kindred brand. On April 5, 2018, it was announced that Kindred shareholders had approved the proposed transaction (2).

Given the capital requirements and regulatory pressure on LTACHs and IRFs, VMG expects M&A volume in post-acute to continue to focus on HHAs and HSPAs. The fragmented status of both the HHA and HSPA industries has left plenty of room for continued consolidation. Value-based payment and alternative payment models will continue to pressure health systems to reduce hospital readmissions and direct patients to more cost-effective settings across the post-acute vertical.

BEHAVIORAL HEALTH

SECTOR REPORT

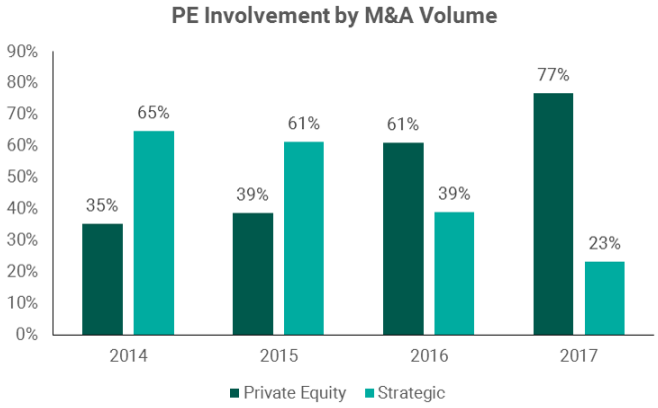
VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

The United States behavioral health facility ("BHF") market is comprised of over 12,000 facilities including psychiatric hospitals, general hospital specialty units, residential treatment centers (substance abuse) ("RTC"), and outpatient clinics. As of 2016, approximately 63% of BHFs were operated by private non-profit organizations, approximately 18% are operated by private for-profit organizations, and 19% are in the public sector. Of total BHFs in 2016, approximately 39% were outpatient mental health facilities, 22% were community mental health centers, 14% were RTCs, 10% were general hospital specialty units, 6% were psychiatric hospitals, and the remaining 9% were partial hospitalization or time treatment facilities, Veteran Administration medical centers, multi-setting mental health facilities and other types of BHFs (19).

The largest behavioral health companies in the U.S. are publicly-traded Acadia Healthcare Company, Inc. ("Acadia") and publicly-traded Universal Health Services, Inc. ("UHS"). As of 2017 year-end, Acadia's U.S. operations had 209 BHFs (8,900 beds) and Acadia's U.K. operations had approximately 373 BHF (also 8,900 beds). UHS' U.S. operations had 213 BHFs (20,800 beds) and UHS' U.K. operations had 115 BHFs (2,300 beds) (2).

In 2017, PE firms and their portfolio companies were acquirers in approximately 77% of the total transactions involving BHF facilities and platforms (measured by transaction volume). Strategic buyers accounted for the remaining 23% (5).

Many PE firms entering the behavioral health industry focus on acquisitions and development of smaller BHFs and adopt a hybrid build-and-buy model of growth. For example, BayMark Health Services Inc. ("BayMark"), a portfolio company of PE firm Webster Capital and the result of a merger in 2015 between BAART Programs and MedMark



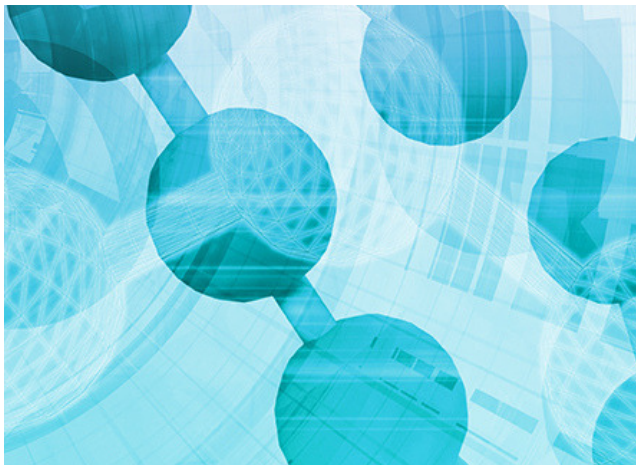
Treatment Centers, has been one of the most active acquirers of BHFs in 2017 and early 2018. Specifically, BayMark recently completed the following 7 transactions: Applegate Recovery in January 2017, an office-based opioid treatment center with four locations in Texas and Louisiana; The Coleman Institute in January 2017, a Virginia-based outpatient detoxification company with eight offices throughout the U.S. (BayMark's first acquisition of this type); Valley Alliance Treatment Services in July 2017, a West Virginia-based opioid treatment provider; Opiate Replacement Therapy Center of America in September 2017, a Louisiana-based opioid treatment provider; Private Clinic in December 2017, an opioid treatment program in Georgia; Health Care Resource Centers, Inc. in December 2017, a New England-based behavioral health provider with 15 treatment centers; and Canadian Addiction Treatment Centers in March 2018, the largest opioid addiction treatment provider in Canada with 72 opioid treatment programs and 19 pharmacies. In addition to the above, BayMark announced the opening of eight new locations in 2017 (2).

Several key trends are benefiting the highly fragmented behavioral health industry. The Mental Health Parity Act of 2008 raised mental health coverage to the level of physician health coverage and the ACA brought many new patients into the system with the expansion of Medicaid eligibility and funding. The 2016 revision of the Medicaid Institutions for Mental Diseases exclusion allows for Medicaid to now cover inpatient stays for patients in facilities with more than 16 beds. In accordance with the 21st Century Cures Act, the Department of Health and Human Services announced in April 2017 that it will provide $485 million in grants to help states combat opioid addiction, the first of two rounds of funding provided by the law. Finally, increased consumer and public awareness of mental health issues and treatment options has led to increased patient demand for behavioral health services (20).

In 2017, strategic operators such as Acadia and UHS developed BHFs primarily via de novo and JV growth models. Acadia added one 80-bed de novo psychiatric hospital in 2017 and expects to open a second 64-bed de novo RTC in 2018. Acadia's JV model is designed to allow them to enter a specified geographic area and form a JV to own, develop, and manage selected behavioral service lines as well as receive a management fee while meeting demands in particular markets that need more access to BHFs. In November 2017, Acadia opened a JV with Ochsner Health System to operate an 82-bed psychiatric hospital. Two additional proposed JVs received state approval for certificates of need in 2017; a 104-bed JV with University of Miami and a 144-bed JV with Tower Health. In 2018, Acadia expects to open a JV with Mount Carmel Health system to operate an 80-bed psychiatric hospital and a JV with Erlanger Health System to operate an 88-bed psychiatric hospital. UHS held a groundbreaking ceremony with Providence Health Care to announce a JV to operate a 100-bed freestanding behavioral health hospital expected to open in fall of 2018. In May 2017, UHS held another groundbreaking ceremony with Lancaster General Health to announce a JV for a $30 million 126-bed behavioral health hospital expected to open in the spring of 2018 (2).

"In the U.S., we've talked about the fact that we've been very focused on these integration or joint ventures with acute care hospitals and integrating with them, and penetrating their behavioral businesses."

-Steve Filton, CFO & EVP
Universal Health Services, Inc.
Q4 Earnings Call



There were several other notable transactions in the BHF sphere in 2017. In September 2017, publicly traded AAC Holdings, Inc. dba American Addiction Centers ("AAC") acquired AdCare, Inc. ("AdCare") as well as its affiliates and real estate assets for total consideration of $85.0 million and implied TEV/TTM Revenue and TEV/TTM Adjusted EBITDA multiples (excluding synergies) of approximately 1.7x and 10.0x, respectively (21). AdCare operates substance abuse facilities in Massachusetts and Rhode Island including a 114-bed hospital, a 52-bed RTC, and seven outpatient centers. Also in September 2017, PE firm Altamont Capital Partners ("Altamont") invested an undisclosed amount into Sequel Youth & Family Services ("Sequel"), a diversified behavioral health provider operating 44 programs across 19 states ranging from community-based programs to RTCs. As consideration for the investment, Altamont acquired a majority stake in Sequel (2).

On August 2, 2017 CMS released the FY 2018 Inpatient Psychiatric Facilities PPS policy changes and payment rates final rule. Based on the final ruling, the federal per diem base rate will increase 1.3% in FY 2018, which is a decline from the FY 2017 base rate increase of 2.4% (4).

In October of 2017, President Trump declared the opioid epidemic a national emergency. With the spotlight on the opioid crisis and population health as a whole, policy and regulatory changes will continue to drive the BHF industry. VMG expects consolidation to continue as value-based reimbursement takes hold and creates the need to mitigate both revenue risk by diversifying patient populations and the expense risk attributable to the capital-intensive technology required for effective quality reporting. As historically low corporate tax rates and interest rates provide PE firms and strategic buyers with growing capital reserves and access to credit, VMG expects these buyers to continue to pursue platform-building acquisition strategies in 2018.

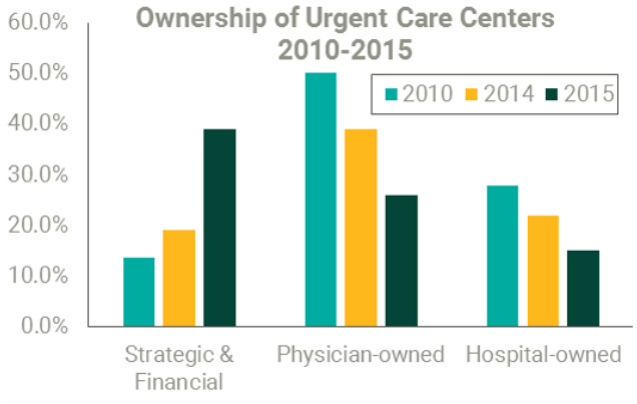
URGENT CARE CENTERS

SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

The number of Urgent Care Centers ("UCCs") in the United States has grown 6.1% compounded annually from 6,400 UCCs in 2014 to 7,639 UCCs in 2017 (22). The urgent care market is highly fragmented with the top twenty operators accounting for approximately 26.8% of the total UCCs. As of October 2017, Concentra (owned by Select Medical Corp.) and MedExpress (owned by UnitedHealth Group subsidiary Optum) were the largest operators with 312 and 232 UCCs, respectively (2,23).

The urgent care industry has witnessed a surge of strategic and financial ownership in recent years. Since 2010, the percentage of UCCs owned by strategic and financial investors increased from 14% of total center ownership in 2010 to 39% of total center ownership in 2015. During the same time period, UCCs owned by physicians and hospitals decreased from 78% of total center ownership to 41% of total center ownership (22). As of the writing of this article, data after 2015 is not available, but we expect the trends from 2015 have continued through 2016 and 2017.



Driving the strategic and financial interest in UCCs is the perceived potential for positive cash flow generation through expansion of an existing platform and/or operational changes. Thriving UCCs are generally able to

provide cash flow returns to strategic and financial investors due to either 1) high levels of volume in underserved markets or 2) leverage of mid-level providers relative to physician providers. Many financial investors are acquiring physician-owned and operated UCCs and implementing a staffing model more heavily reliant on lower cost mid-level providers. State laws regulate the amount of physician oversight required in individual UCCs.

There were several large UCC transactions in 2015 followed by a relative slowdown in 2016 and 2017. In March 2015, post-acute provider Select Medical Holdings Corporation ("Select") a private equity firm Welsh, Carson, Anderson & Stowe ("WCAS") announced they were entering into a JV, acquiring Concentra Inc. ("Concentra") and its 300 UCCs from Humana Inc. for a purchase price of $1.055 billion and an implied TEV/TTM Revenue multiple of 1.1x (9). Concentra would later be part of another transaction in 2017, as discussed below. In April 2015, UnitedHealth Group's subsidiary, Optum, announced it was acquiring MedExpress and its 141 UCCs from private equity firms General Atlantic, Sequoia Capital, and Highmark Capital for $1.5 billion (9). In May 2015, private equity firm ABRY Partners, LLC announced it was acquiring FastMed and its 87 UCCs from private equity firm Comvest Partners (2).

Following the M&A boom of 2015, transaction activity slowed down in 2016 and 2017 due to buyers' need to digest recent UCC purchases. However, strategic and financial buyers remained active. In January 2017, New Orleans-based Ochsner Health System acquired Millennium Health Management and its 12 UCCs and four occupational health clinics for an undisclosed amount. In April 2017, private equity firm Warburg Pincus acquired a majority stake in CityMD and its 68 urgent care centers. Financial terms for the deal were not disclosed but

Reuters reported the transaction valued CityMD at approximately $600 million. Additionally, it was announced in February 2018 that CityMD signed a definitive agreement to acquire New York-based STAT Health and its 12 urgent care locations for an undisclosed price (2).

In February 2018, Concentra (owned by Select) acquired the outstanding stock of U.S. Healthworks, an occupational health and urgent care business owned by Dignity Health ("Dignity"). The transaction resulted in an implied value of U.S. HealthWorks of approximately $753 million with an implied TEV/TTM EBITDA multiple of approximately 11.3x (24). The closed transaction resulted in Dignity owning 20% of the combined entity, Select owning 50.1% and the remaining 29.9% being owned by WCAS and private equity firm Cressey & Company (previously a minority investor in Concentra) (2).

Urgent care centers are reimbursed by Medicare according to the Medicare Physician Fee Schedule ("MPFS"). On November 2, 2017, CMS released the FY 2018 MPFS payment and policy changes final rule and increased the MPFS conversion factor by approximately 0.3% in 2018, an increase from the 2017 MPFS final rule which increased the MPFS conversion factor by approximately 0.2% (4).

VMG expects continued expansion in the UCC industry in 2018 driven by the healthcare industry's push to provide care in lower cost outpatient settings and increased consumer demand for cheap, convenient access to care. We expect an increase in volume of UCC patients due to the ACA creating newly insured patients every year, many without a primary care provider. Despite the growth in the UCC industry, M&A transaction volume is expected to stay below the peak 2015 levels as buyers continue to digest acquisitions and expand on previously acquired platforms.

DIALYSIS FACILITIES

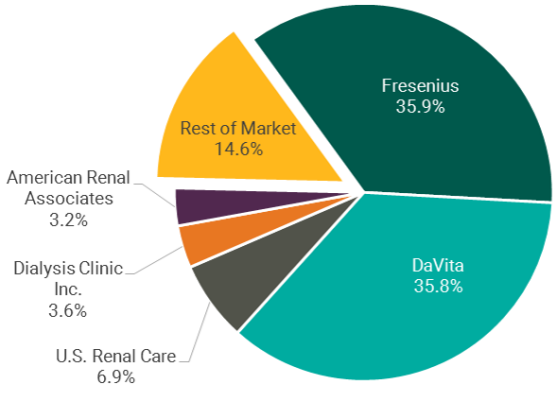
SECTOR REPORT

VMG Health's Healthcare M&A Report: 2017 Trends and 2018 Expectations

The total number of Medicare-certified outpatient dialysis facilities in the United States grew at a compound annual growth rate of 3.7%, increasing from 5,413 dialysis facilities in 2010 to 6,745 in 2016. As of 2016, approximately 94.0% of outpatient dialysis facilities were freestanding facilities with the remaining 6.0% being hospital-based, and approximately 88.0% were for profit facilities while 12.0% were nonprofit facilities. Since 2010, the number of freestanding outpatient dialysis facilities has increased by an average of 4.0% annually while the number of hospital-based outpatient dialysis facilities has declined by an average of (6.0%) annually. Approximately 82% of dialysis facilities are located in urban areas (1).

The dialysis industry is highly concentrated with the two largest dialysis operators, DaVita Healthcare Partners ("DaVita") and Fresenius Medical Care ("Fresenius") operating approximately 71.7% of the total outpatient dialysis facilities in the United States. U.S Renal Care, Dialysis Clinic Inc., and American Renal Associates, the next three largest dialysis companies combined operate approximately 13.7% of U.S. outpatient dialysis facilities. The rest of the market, single site and multi-site operators, account for approximately 14.6% of outpatient dialysis facilities in the U.S (25).

Market Share of U.S. Dialysis Companies (by # of Facilities)



On October 27, 2017 CMS released the CY 2018 End-Stage Renal Disease ("ESRD") PPS policy changes and payment rates final rule. Based on the final ruling, the ESRD PPS base rate will increase by approximately 0.4% in CY 2018, a decline from the CY 2017 final rule which increased the ESRD PPS base rate by approximately 0.5%. CMS projects total payments to hospital-based ESRD facilities to increase 0.7% and total payments to freestanding facilities to increase 0.5% in CY 2018 (4).

The ESRD Quality Incentive Program ("QIP") began in 2012 as mandated by MIPPA. The ESRD QIP measures both clinical performance and reporting outcomes for claims submitted by outpatient dialysis facilities. CMS has developed a methodology for calculating facility-level scores under the QIP. A facility's total performance score can range from 0 to 100 points, with 75% of the score determined based on clinical performance measures and the remaining 25% determined based on reporting performance. A sliding scale is implemented to link payment penalties and QIP performance. For payment year ("PY") 2018, facilities need to achieve a minimum score of 49 points to avoid a payment reduction (4).

"82% of patients and families fully educated on their treatment options would select a home modality"

-Fresenius Medical Care Investor Presentation Barclays Global Healthcare Conference March 2018

Both of the two largest dialysis operators, DaVita and Fresenius, closed significant transactions in 2017. In May 2017, DaVita completed their acquisition of Renal Ventures Management, LLC ("Renal Ventures") for approximately $360 million. Renal Ventures operates 38 dialysis centers in six states. The Federal Trade Commission ("FTC") approved the transaction in March 2017 under the condition that DaVita divest seven of their dialysis clinics, two in Texas and five in New Jersey, due to complaints that the acquisition was anticompetitive. The transaction was closed in August of 2015. Also in May 2017, DaVita acquired Purity Dialysis and their ten dialysis centers located in Wisconsin. Financial terms for the transaction were not disclosed. It should be noted that on December 6, 2017, DaVita announced the sale of its physician group, DaVita Medical Group ("DMG") to Optum Inc., subsidiary of UnitedHealth Group, Inc. DMG operates 300 clinics, 35 urgent care centers, and 6 surgery centers across 6 states. The transaction is expected to close in 2018 (2).

In August 2017, Fresenius signed an agreement to acquire NxStage Medical, Inc., a home dialysis equipment manufacturer, for approximately $2.0 billion. The transaction is being reviewed by the Federal Trade Commission and is expected to close in the second half of 2018 (2).

We expect the dialysis market to continue to grow, with the highest growth in at-home dialysis services. The two largest dialysis operators, jointly accounting for 71.7% of the total market, can be observed as industry leaders in the M&A market. Fresenius has stated clear goals of preparing itself for upcoming growth in at-home dialysis services (and has made an essential acquisition to further this goal in 2017). DaVita has shown commitment to re-aligning its core operating businesses by shedding DMG and focusing on de novo dialysis facilities. VMG expects transaction volume for dialysis facilities to trend neutral in 2018.

CONCLUSION

Driven by regulatory changes, VMG expects the healthcare industry as a whole to continue the push towards increasing service offerings, decreasing cost while improving quality, and taking advantage of economies of scale. The decision by healthcare entities to enter into transactions of any size will be one that is heavily scrutinized by regulators and stakeholders. Federal and state statutes generally provide that pricing in healthcare transactions should consider the Fair Market Value ("FMV") of the transferred business or asset. Securing an experienced healthcare financial advisor to perform a fair market value analysis can be a critical part of the due diligence process for any transaction.

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VMG HEALTH