

§ 999.5(d)(1)(C)

A statement of all of the reasons the board of directors of applicant believes that the proposed agreement or transaction is either necessary or desirable.

Background of the Decision to Seek a New Operator. In 2013, the dire financial condition and cash projections of DCHS led the DCHS Board and its advisors to the unquestionable conclusion that continuation of the Health System under Daughters of Charity sponsorship was no longer feasible and that a new operator should be sought to continue hospital services of the DCHS Health Facilities. Updated cash flow projections throughout 2014 have consistently shown that the combination of the uncertain future of DCHS's operations coupled with declines in volume, inadequate reimbursement rates from payors and high costs of salaries, wages and benefits will deplete DCHS's cash on hand for paying Health System expenses. Based on DCHS's internal cash flow projections, without any intervention DCHS would have fallen below minimum liquidity thresholds in the first quarter of fiscal year 2015 (July to September 2014) and would run out of cash in the third quarter of fiscal year 2015 (January to March 2015). In order to address the projected cash shortfall, DCHS closed a \$125 million short-term financing in July and August 2014 to provide cash to bridge the Health System's cash needs for a period estimated to be long enough to allow the closing of a transaction to occur.¹ Based on DCHS's internal cash flow projections, DCHS believes that this bridge facility will provide sufficient cash to support normal hospital operations through the fourth quarter of fiscal year 2015 (April to June 2015). At the end of that time, DCHS projects that it will have "days cash on hand" of 19 days, *i.e.* enough cash to pay 19 days of daily average operating expenses for running the Health System. The 19-day cash figure assumes that \$93 million had been drawn on the bridge financing. Without those additional funds, DCHS's cash on hand as of March 2015 would be negative five days. The bridge facility of \$125 million matures on July 10, 2015, meaning it must be repaid in full no later than that date or DCHS will be at risk of default on both the 2014 Bonds and the 2005 Bonds. The lender holds liens on substantially all the assets of the Health System. At that point, DCHS's operations, at least outside the protection of a bankruptcy proceeding, could not continue. (See **Exhibit A** for current information regarding cash projections.)

Priorities: The DCHS Board set several objectives for the change of control. First, pensions of current and retired employees and their beneficiaries should be protected. Second, major business partners, such as bondholders and vendors, should be repaid. Third, the collective bargaining agreements ("**CBAs**") of the Hospital Corporations should be honored by the successor; the CBAs entitle represented employees to assurance that DCHS's successor would agree to assume the CBAs. Fourth, the successor should make a strong commitment to continuing acute care services in the communities served by the DCHS Health Facilities by agreeing to maintain Medi-Cal and Medicare participation, indigent care and capital investment in the DCHS Health Facilities.

¹ The funds were provided by the issuance of the 2014 Bonds by California Statewide Communities Development Authority in July and August 2014. The funds are held by the 2014 Bond trustee and are released to DCHS on approval of the bondholders and bond trustee and the satisfaction of various conditions.

Very importantly, the change of control of the DCHS Health Facilities would need to address the fact that many of these obligations – notably pension funding and bond obligations – are binding on all of the Hospital Corporations. Multiple transactions would carry the risk that if even one of several failed to close the remaining Hospital Corporations (or their successors) could become subject to untenable liability for the shared obligations.² Otherwise, a risk would arise that individual transactions would not add up to cover all obligations. If any individual transaction failed to close, the remaining Hospital Corporations could be exposed to untenable liability for shared obligations.

The process of seeking a buyer or buyers is detailed in the sections of this application responding to §§ 999.5(d)(2). The DCHS Board engaged an investment banking firm, Houlihan Lokey Capital, Inc. (“Houlihan Lokey”), experienced in situations involving complex, distressed hospital systems to conduct a comprehensive offering of the DCHS Health Facilities. The sale process commenced in February 2014. One hundred and thirty-three health systems and other potential buyers were contacted who might have an interest in acquiring DCHS in its entirety, individual (or groups of) hospitals or other assets. Seventy-two potential buyers signed confidentiality agreements and received the confidential information memorandum summarizing key facts about the Health System. Twenty-nine potential buyers submitted first-round bids (first round bid deadline was March 21, 2014). Most potential buyers proceeded to the second round of the sale process, which provided them access to additional confidential information, the opportunity to meet with DCHS’s system and local hospital leadership and tour the various hospital campuses. As a result of the second round bids requested and received (second round bid deadline was May 21, 2014), the DCHS Board determined that no combination of separate bids for the DCHS Health Facilities was capable of providing a comparable level of satisfying objectives as set by the DCHS Board, and the DCHS Board proceeded to a final round consisting of only full system bidders. On the September 12, 2014 final bid deadline DCHS received six proposals, of which only three were substantial enough to merit comprehensive consideration by the DCHS Board. A fourth also received full consideration, despite its material inconsistency with bid requirements, because of its support by labor representatives. A summary of the key terms of the four final proposals is found in **Exhibits B.1 and B.2**.

The DCHS Board used eleven factors to evaluate the final proposals. These consisted of the following:

1. **Post-Closing Health Care Services:** The bidder’s commitment and ability to sustain health care services in the communities served by the DCHS Health Facilities after the transaction closes;
2. **Treatment of Pension Obligations:** The bidder’s treatment of the Health System’s pension obligations (including the RPHE and Church Plan), the level of future funding

² Specifically, the Retirement Plan for Hospital Employees is an ERISA plan for which all of the Hospital Corporations would have joint and several liability as members of a “controlled group” for ERISA purposes. The withdrawal of one Hospital Corporation that is a participating employer triggers joint and several liability on the part of all members of the controlled group. The withdrawal liability amount is estimated to be \$209 million. A combination of sales (in contrast to assumption of the RPHE plan by a single buyer) would need to generate sufficient sale proceeds to pay that liability as well as all other obligations of the Health System, including full repayment of the 2005 and 2014 Bonds secured by all Health System assets.

assurance provided to the pension beneficiaries and the financial wherewithal of the purchaser entities obligated to make future pension funding;

3. **Treatment of Collective Bargaining Agreements:** The bidder's willingness to assume the collective bargaining agreements "as is";
4. **Operational and Transactional Experience:** The bidder's experience and success in turning around distressed hospitals and breadth of experience in owning and operating acute care hospitals (with particular experience in California);
5. **Historical Service Quality:** An evaluation of the bidder's relative Patient Safety; Evidence Based Care; Readmission Rates; Mortality Rates; and Patient Satisfaction Scores in comparison to DCHS, the national average and other finalist bidders;
6. **Financial Wherewithal:** The bidder's financial strength measured in terms of its cash and other assets and its potential access to additional capital sources for DCHS's cash needs at closing and afterwards;
7. **Capital Commitment:** The bidder's willingness to invest in the DCHS Health Facilities after closing;
8. **Need for Bankruptcy:** Whether the bidder would require a bankruptcy court process to reduce liabilities as a condition of closing;
9. **Valuation:** The amount of distributable value of the offer measured in terms of liabilities of the Health System paid and assumed;
10. **Closing Risk:** The risk of the bidder not being willing or able to close because of financing contingencies, regulatory issues or other impediments to closing (consideration of the bidder funding a meaningful good-faith deposit was an important criteria); and
11. **Timeline:** The bidder's ability to meet the time frame of DCHS for closing in light of working capital erosion

In the DCHS Board's view, Prime's proposal satisfied each of these criteria in a substantive and unconditional way. The DCHS Board determined that no other proposal demonstrated similar strength and that each of the others was inferior in substantial ways. The DCHS Board studied DCHS's options carefully and weighed the strengths and weaknesses of the alternatives and that of Prime. In its deliberations, the DCHS Board and the boards of the Hospital Corporations each followed a tradition of St. Vincent de Paul of active discernment, a decision-making process rooted in reflection on scripture, prayer and evaluation of the choices to be made in light of the Vincentian Values of the Daughters of Charity.

1. **Post-Closing Health Care Services:** Prime committed to preserve the Health System's hospitals as general acute care hospitals with open emergency rooms for not less than five years after the closing, subject to physician availability, the needs of the community, and financial viability. [Definitive Agreement, § 7.8(b)]

2. **Treatment of Pension Obligations:**

- a. *The Church Plan:* Prime Healthcare committed to assume direct liability for the underfunded defined-benefit church plan (the “**Church Plan**”), to convert it into an ERISA plan and thereby assure its more than 16,000 beneficiaries of ERISA-level funding and protection of PBGC insurance. [Definitive Agreement, § 7.4(a)] The DCHS Board found Prime’s proposal far superior to any other on this critically important objective of the DCHS Board because of Prime’s legal and financial ability to back up that commitment with its full health system resources. No other bidder offered the backing of its entire health system balance sheet to support the Church Plan. Two other bidders in fact required DCHS to retain the Church Plan after closing; those bidders offered to make a specific contribution of funds in a lump sum or in annual installments, but beyond those funds there would be no financial support from the successor and DCHS would not have any means to fund shortfalls. The remaining bidder proposed the option of leaving the Church Plan in place with DCHS and converting it to an ERISA plan. The current Hospital Corporations that are the Church Plan’s participating employers would remain responsible for funding the Church Plan at an ERISA standard of funding, i.e. the Church Plan would remain as-is and subject to the risk of a failed turn-around, without new funds being contributed at closing or from a larger controlled group of affiliates.
 - b. *RPHE:* The Prime proposal also assumed the Retirement Plan for Hospital Employees (“**RPHE**”), a multi-employer pension plan in which the participating employers are Seton Medical Center (including Coastside), O’Connor Hospital, Saint Louise Regional Hospital, DCHS and certain other affiliates. [Definitive Agreement, § 7.4(a)] The assumption of RPHE will assure its beneficiaries that the full faith and credit of all of Prime’s subsidiaries in its controlled group would back-stop the liability. No other proposal offered similar support for the RPHE.
3. **Treatment of CBAs:** Prime agreed to assume the CBAs as they stand. The Definitive Agreement contemplates the opportunity to open discussions with union representatives before closing, but Prime did not condition its agreement to close the transaction on obtaining any concessions from unions. [Definitive Agreement, § 2.6(g)] Other proposals also agreed to assume the existing CBAs on their present terms as well, without directly requiring modifications pre-closing. In at least one case, however, the bidder’s main source of financing was conditioned on all unions ratifying changes to the CBAs, in effect creating a closing risk for DCHS that was outside DCHS’s control.
 4. **Operational and Transactional Experience:** Prime’s hospital system is the largest and most established of those of the three finalists with existing operations. It has the largest balance sheet and longest track record of successful turnarounds of distressed hospitals in both California and in other states. These facts entered into the DCHS Board’s evaluation of a number of factors, including the bidder’s ability to continue operations of the Health Facilities, to make good on the pension funding commitments and to deliver the full value of the commitment to service the Health System’s liabilities. In contrast, one bidder as a start-up owned no other hospitals and thus had no track record as an organization or

existing infrastructure, support services or other operational base that could provide economies of scale or risk-sharing opportunities as resources for a turn-around, and the other two bidders offered less robust platforms because of their smaller size.

5. **Historical Service Quality:** The DCHS Board received and evaluated a comparison of recent performance statistics of the three final bidders that have California-based operations. The comparison used nationally-recognized measures of patient safety, evidence-based care, readmission rates, mortality rates, and patient satisfaction to compare the three. Prime outperformed the other two finalists in most key areas, with 93% of its California hospitals ranking above the national averages on the measures. (See **Exhibit C**) The fourth finalist did not have any existing hospital operations in California or elsewhere and so could not be evaluated under this criterion. The DCHS Board also received detailed summaries based on publicly-available health department citations, federal and state health law enforcement sanctions and checks of all officers and directors against state and federal registers of sanctioned individuals. Prime's regulatory track record did not present a profile of greater penalties or other enforcement action than the other operators, notwithstanding allegations regarding Prime that had been posted publicly and transmitted to the media.
6. **Financial Wherewithal:** Houlihan Lokey requested and when provided, analyzed and presented financial information regarding the four finalists. Combined, Prime Foundation's and Prime's consolidated balance sheet have available cash and financing sources were material relative to the cash requirements of the closing payments (estimated to be approximately \$394 million) with considerable financing from lenders set Prime's proposal apart from the others in a way that not only satisfied closing requirements but provided the DCHS Board with assurance that Prime is a highly-solvent enterprise capable of backstopping the operations of the financially-distressed DCHS Health Facilities going forward while a financial turnaround is pursued. No other bidder had the commitment for all of the capital needed to close the transaction and no other bidder was prepared to use the financial wherewithal of its parent entity to ensure that the DCHS liabilities are honored. Two of the other bidders offered substantial but lesser financial depth and the fourth proposed merely to attempt a financial turnaround of the DCHS Health Facilities "on their own bottom" by assuming the Series 2005 bonds (over the stated objection of a majority of the bondholders), selling of the medical office buildings to raise working capital, multiple roll-over financial facilities to be used to refinance the 2014 Bonds (i.e., the bridge facility), managing DCHS as-is and attempting a financial turnaround without the support of a "financially sound organization," economies of scale to realize much needed overhead cost improvement, or risk-sharing with a larger hospital system.
7. **Valuation:** The estimated distributable value³ of Prime's offer of \$843 million materially exceeded the other three offers. The DCHS Board measured the value of the offers not

³ Calculated as the sum of the estimated cash consideration paid at closing plus the face value of assumed short and long-term liabilities. The distributable values of the other three bids were: \$803 million, \$710 million and \$690 million. The value of \$803 million, in addition, was a "best case scenario" because the value of the consideration was subject to reduction based on the bidder's requirement that the Daughters of Charity contribute cash at closing to fund a working capital shortfall requirement embedded in its proposed agreement.

only in terms of the dollar amount on paper of liabilities paid and assumed, but also the level of confidence in the bidder's balance sheet, experience in operations, depth of existing operations to support the Health Facilities and access to capital such that the assumed liabilities would be honored over the long term. For the reasons noted elsewhere in these factors, the distributable value of Prime's offer was not subject to uncertainty factors inherent in the others.

8. **Capital Commitment:** Prime committed to fund capital needs in the amount of \$150 million over three years following closing. The other finalists offered amounts ranging from \$200 million to \$300 million over five years.
9. **Need for Bankruptcy:** None of the finalists proposed or required that the transaction be closed through a bankruptcy court process. Allegations reported in the press that Prime had threatened to put the DCHS Health Facilities into bankruptcy in order to reduce or restructure obligations before closing or as a condition of closing were unfounded.

10. **Closing Risk:**

- a. *Uncertainties Created by Elements of Offers:* The DCHS Board considered the principal risk presented by Prime to be with regard to the ability of DCHS to obtain approval from the California Attorney General for the transaction given the opposition to Prime as buyer mounted well before the DCHS Board had final proposals from which to choose. Prime has demonstrated its ability to obtain regulatory approval from the Attorneys General in several states in the past four years, including Rhode Island, New Jersey, Kansas and Michigan. The other bidders presented their own uncertainties, principally the lack of concrete, final proposals for adequate treatment of the Church Plan and committed external financing. The bid of the firm proposing a management arrangement presented additional uncertainties regarding preservation of the tax-exempt status of the DCHS Health Facilities necessary to keep the 2005 bonds outstanding as well as opposition from the largest bondholder of the 2005 bonds.
 - b. *Protection for DCHS from Buyer Breach:* In order to create a material disincentive for a buyer to breach its agreement by failing to close, DCHS required each bidder to submit a substantial deposit upon signing a definitive agreement. Prime and two other bidders agreed; the fourth bidder did not, creating a unique exposure for DCHS.
11. **Timeline:** Each final bidder presented comparable commitments to proceed expeditiously to closing.