Report Prepared for:

Joint Legislative Commission of the Oklahoma Legislature

Merrill Lynch & Co.
April 27, 2006

Merrill Lynch

TABLE OF CONTENTS

Topic Page

A. EXECUTIVE SUMMARY 1

B. OVERVIEW OF TULSA HEALTHCARE MARKET 3

C. OVERVIEW OF TULSA REGIONAL MEDICAL CENTER 13

D. OVERVIEW OF OSU RESIDENCY PROGRAM 22

E. OVERVIEW OF STRATEGIC ALTERNATIVES 26

F. SUMMARY OF TRANSACTION 41

G. SUMMARY/CONCLUSIONS 44

Appendix

- *Overview of Strategic Alternatives Summary* *45*
- *Valuation of Tulsa Regional Medical Center* *47*

Glossary of Terms

AAA	–	Academic Affiliation Agreement
Ardent	–	Ardent Health Services LLC
CBM	–	Community-Based Model
CHS	–	Center for Health Services
CMC	–	Children's Medical Center Behavioral Health Services
DCF	–	Discounted Cash Flow
D.O.	–	Doctor of Osteopathic Medicine
EBITDA	–	Earnings Before Interest, Taxes, Depreciation and Amortization
FTE	–	Full-Time Equivalent
JV	–	Joint Venture
Hillcrest	–	Hillcrest HealthCare System
OCOM	–	Oklahoma College of Osteopathic Medicine and Surgery
OHCA	–	Oklahoma Health Care Authority
OSU	–	Oklahoma State University
OSU COM	–	OSU College of Osteopathic Medicine
PM	–	Pyramid Model
PMTC	–	Physician Manpower Training Commission
PPS	–	Prospective Payment System
Public Trust	–	Public Trust or Other Suitable Entity
SFHS	–	St. Francis Health System
SJHS	–	St. John Health System
State	–	State of Oklahoma
Task Force	–	Joint Legislative Commission of the State of Oklahoma
TRMC	–	Tulsa Regional Medical Center
Trust	–	Trust Formed to Facilitate AAA
Tulsa MSA	–	Tulsa Metropolitan Statistical Area
WACC	–	Weighted Average Cost of Capital

Executive Summary

In March 2006, Merrill Lynch was engaged as financial advisor by a Joint Legislative Commission of the State of Oklahoma ("the Task Force"), which was created to Study and Evaluate the Operations of the Oklahoma State University Center for Health Sciences and the Indigent Health Care System in the Tulsa Metropolitan Service Area. The Task Force issued a report in December 2005. Based on the contents of that report, Merrill was charged to analyze and evaluate the strategic financial alternatives of the Oklahoma State University ("OSU") medical residency program. This executive summary incorporates some of the summary text of that report with the recent findings and recommendations of Merrill Lynch.

Tulsa Regional Medical Center ("TRMC") opened its doors in 1944 as Oklahoma's first osteopathic hospital. It was not affiliated with any university. The osteopathic physicians who founded TRMC dedicated themselves to the training of new physicians, and have provided graduate medical education training to over 1,700 physicians. In 1972, the Oklahoma legislature created the freestanding Oklahoma College of Osteopathic Medicine and Surgery ("OCOM"). TRMC became the teaching hospital for the college. In 1988, Oklahoma State University merged with the OCOM.

TRMC has had a tumultuous recent history, having experienced changes in ownership four times in the past eight years. In 1999, TRMC became part of Hillcrest HealthCare System ("Hillcrest"), a not-for-profit health system created to more effectively compete against St. Francis Health System and St. John Health System in the Tulsa marketplace. In 2004, Ardent Health Services LLC ("Ardent"), a privately held, for-profit health system, acquired Hillcrest. In Spring 2005, Ardent was considering a plan to consolidate services at Hillcrest Medical Center and convert TRMC into either a long-term care or behavioral health facility. In lieu of executing on this plan, Ardent offered to lease TRMC to an OSU Trust Authority whereby Ardent would receive the following:

- $14 million a year for twenty-five years
- 50% of TRMC's net income over $14 million
- 2% management fee on gross receipts
- An option for another 25 years on the same terms

Under the Ardent proposal, lease obligations were to be guaranteed by Oklahoma taxpayers. The State of Oklahoma ("the State") would also be responsible for future subsidies as well.

In response to the lease versus consolidation issue, the Oklahoma State Legislature enacted SB234, which created the "Joint Legislative Commission to Study and Evaluate the Operations of the Oklahoma State University Center for Health Sciences and the Indigent Health Care System in the Tulsa Metropolitan Service Area". The duties and responsibilities of the Task Force were three fold:

- Audit and investigate the feasibility of leasing TRMC, including a recommendation towards the final solution of a stable teaching hospital for OSU
- Recommend whether OSU should receive a teaching subsidy for the provision of graduate medical education
- Evaluate the system design for healthcare in the Tulsa Metropolitan Service Area

In December 2005, the Task Force issued a Final Report. The report addressed the proposed Ardent/TRMC lease, as well as the teaching subsidy and system design (jointly). The report likewise contained a brief discussion of the disparity of healthcare funding between Oklahoma City and Tulsa, and presented a series of recommendations that emerged from the SB234 hearings. The Task Force concluded that the physician pipeline and healthcare system for both urban and rural areas within Oklahoma would be negatively impacted by the disruption of the OSU physician training programs at TRMC. Thus, the Task Force concluded that the State has a vested interest in the stability and maintenance of those programs.

The Task Force indicated that the lease option – as presented – appeared to be an undesirable alternative; however, it stated that the Task Force was not in the position to evaluate the lease proposal fully without consideration of other options. The Task Force indicated its desire to avoid undertaking a hastily crafted solution, and thus advised adopting a prudent level of care in the creation of a solution for TRMC and the OSU medical residency program. To that end, that Task Force advised engaging an outside expert opinion to evaluate the variety of options available to stabilize the OSU medical residency program in Tulsa, and requested legislative authority to retain consultants as needed to fulfill its statutory mission.

As previously stated, Merrill Lynch was engaged by the Legislative Services Bureau as a financial advisor to the Task Force for the purposes of analyzing and evaluating strategic financial alternatives of the medical residency training program at OSU. This report summarizes Merrill Lynch's work and conclusions regarding those alternatives. As part of the process, Merrill Lynch reviewed and analyzed the competitive Tulsa healthcare marketplace and Tulsa Regional Medical Center, specifically. Merrill Lynch met with the key leadership of OSU to understand its residency program and evaluated OSU's strategic alternatives against the information received and various analyses performed.

The alternatives that were identified and reviewed include:

I. Change OSU Residency Program from Pyramid Model to Community-Based Model Using a Variety of Urban and Rural Hospital Facilities

II. Build a New Teaching Hospital for OSU

III. Acquisition of TRMC

IV. Long-Term Lease of TRMC

V. Joint Venture or Partial Ownership of TRMC

VI. Academic Affiliation Agreement with TRMC

Merrill Lynch's final recommendation to the Task Force is that the State and OSU pursue an Academic Affiliation Agreement with TRMC. This alternative most efficiently and effectively achieves the stated objectives of securing long-term stability for the OSU medical residency program. The affiliation maintains the program's highly valued pyramid model organization at a cost to the State which is significantly lower than most other alternatives. Finally this alternative most closely aligns the dollars expended by the State to the direct maintenance and enhancement of the OSU educational and clinical experience.

Introduction

Tulsa is the 45th largest city in the U.S., with a population of 387,807 as of 2003 and healthcare is one of its largest industries. Three of the top five employers in the city are health systems (Hillcrest, St. Francis, St. John) with the other two being American Airlines and the Tulsa Public School System.

North Tulsa Population Demographics

Tulsa Regional Medical Center's service area is the city of Tulsa and its six surrounding counties which comprise the Tulsa Metropolitan Statistical Area ("Tulsa MSA"). TRMC is located in the northern section of Tulsa and generates a significant percentage of its admissions from this area. This region is home to a large percentage of Tulsa's indigent population. The towns in this region have a per capital income ranging from $11,000 to $20,000, which is below the per capita income of Tulsa, which is $21,534. The 65 years and older population of Tulsa's northern towns has a percentage of individuals below the poverty line that is significantly larger than Tulsa's average, which burdens northern Tulsa's healthcare systems with uninsured patients.

North Tulsa Demographic Data *(1)*

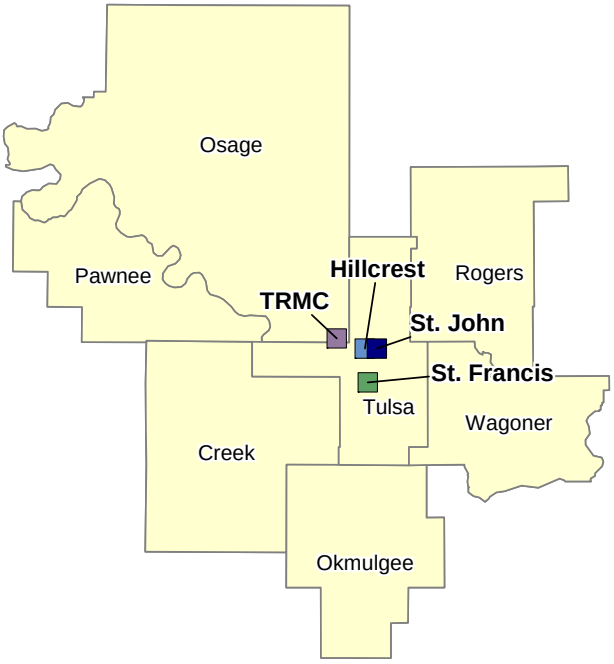
Town	Population	Per Capita Income	65 and older below Poverty Line
Tulsa	**393,049**	**$21,534**	**8.3%**
Owasso	18,502	19,417	11.1%
Skiatook	5,396	13,956	11.6%
Collinsville	4,077	17,699	7.3%
Turley	3,231	16,325	10.3%
Sperry	981	11,767	12.9%

(1) Source: www.census.gov

Health Systems and Hospitals

The hospital industry is fairly consolidated in the State. All of the hospitals in its two largest cities, Oklahoma City and Tulsa, are part of a larger health system and many of the rural facilities are tied into the urban facilities for both referral and economic reasons. While Tulsa's major hospital systems have reported positive net income in recent years, they must still manage the high number of uninsured hospitalized patients. The State as a whole has an estimated 700,000 residents without health insurance, which is approximately one in every five individuals. Oklahoma has the third highest percentage of residents without health insurance of all states in the country.

Tulsa MSA Map



Tulsa is home to 23 acute care hospitals, which have 2,626 inpatient beds and 122,708 inpatient hospital discharges annually, according to the most recent federal Medicare hospital data for 2003. The area's average daily occupancy rate is approximately 43% and the average length of stay is 4.7 days. Medicare and Medicaid account for 52% and 16% of inpatient volume, respectively.

Tulsa MSA Health System Summary [(1)]

Health System/Hospitals	Hospitals	Total Beds	Market Share
Hillcrest Health System	8	910	34%
St. Francis Health System	4	790	28%
St. John Health System	3	584	25%
Triad Hospitals	2	253	9%
Others	6	89	4%
Total	23	2,626	100%

(1) Source: HealthLeaders-InterStudy, 2005, Solucient, 2005. Market share is based on inpatient discharges for Tulsa MSA shown on previous page.

Tulsa MSA Hospitals [(1)]

Hospital	Beds	City
St. Francis Hospital	672	Tulsa
St. John Medical Center	559	Tulsa
Hillcrest Medical Center	401	Tulsa
Tulsa Regional Medical Center	281	Tulsa
SouthCrest Hospital	180	Tulsa
Wagoner Community Hospital	100	Wagoner
Claremore Regional Hospital	73	Claremore
St. Francis Hospital at Broken Arrow	66	Broken Arrow
Okmulgee Memorial Hospital	66	Okmulgee
St. Francis Heart Hospital	52	Tulsa
Henryetta Medical Center	41	Henryetta
Southwestern Regional Medical Center	39	Tulsa
Bristow Medical Center	30	Bristow
Orthopedic Hospital of Oklahoma	25	Tulsa
Pawnee Municipal Hospital	25	Pawnee
St. John Sapulpa	25	Sapulpa
Tulsa Spine Hospital	21	Tulsa
Cleveland Area Hospital	17	Cleveland
Fairfax Memorial Hospital	15	Fairfax
Pawhuska Hospital	15	Pawhuska

(1) Source: HealthLeaders-InterStudy, 2005, Solucient, 2005.

The Tulsa hospital market was historically a predominately not-for-profit market dominated by Hillcrest HealthCare System, St. Francis Health System and St. John Health System. In late 2004, market leader Hillcrest HealthCare, which has slightly more than one-third of total inpatient hospital discharges, was purchased by for-profit Ardent Health Services LLC. Ardent is a for-profit hospital management company based in Nashville, Tennessee, which also owns

Lovelace Health System in Albuquerque, New Mexico. Ardent recently divested its psychiatric hospital business to Psychiatric Solutions in July 2005 in order to focus on acute care hospitals.

Triad Hospitals, another for-profit hospital system, also operates in the service area, but in the outskirts of Tulsa with relatively small hospitals. Physician-owned specialty centers have also entered the market and are expected to bring additional competition to the market.

St. Francis Health System ("SFHS") and St. John Health System ("SJHS"), the two major not-for-profit hospital systems in Tulsa, have thrived despite the competition. Both are profitable and expanding. 672-bed St. Francis Hospital is the largest hospital in Tulsa and is the SFHS flagship hospital. 559-bed St. John Medical Center is the second largest hospital in Tulsa and is the SJHS flagship hospital.

The State has been sympathetic to healthcare provider concerns about the level of funding for the poor and uninsured and has provided assistance in the form of House Bill 1088. This Bill appropriates $38 million for the Oklahoma Health Care Authority to increase hospital Medicaid reimbursement rates. The Bill increases Medicaid reimbursement rates to 100% of Medicare.

Hillcrest HealthCare System

Hillcrest HealthCare System is the largest healthcare provider in Tulsa, Oklahoma, serving 35 of Oklahoma's 77 counties through 8 acute care hospitals and multiple primary-care and specialty clinics, long-term care facilities, and physician clinics.

Hillcrest Hospitals	Total Beds	City
Hillcrest Medical Center	401	Tulsa
Tulsa Regional Medical Center	281	Tulsa
Wagoner Community Hospital	100	Wagoner
Henryetta Medical Center	41	Henryetta
Bristow Medical Center	30	Bristow
Pawnee Municipal Hospital	25	Pawnee
Cleveland Area Hospital	17	Cleveland
Fairfax Memorial Hospital	15	Fairfax

Other Facilities
Helmerich Cancer Center
Center for Diabetes Management
James D. Harvey Center for Cardiovascular Research
Leta M. Chapman Breast Center
Alexander Burn Center
Kaiser Medical Center (physical rehabilitation facility)
H.A. Chapman Institute for Medical Genetics

Source: Company website.

Hillcrest's flagship hospital, Hillcrest Medical Center, offers specialty care in Level I cardiology services, orthopedic services, women's care, and cancer diagnostics and treatment.

Hillcrest provides graduate training for a quarter of the medical residents in the State through residency programs that are conducted in conjunction with the University of Oklahoma College

of Medicine in Tulsa and the Oklahoma State University College of Osteopathic Medicine. TRMC provides training for approximately 350 OSU medical students.

St. Francis Health System

St. Francis Health System is a locally owned and operated Catholic-based integrated delivery system comprised of four local acute care hospitals including a children's hospital, a free-standing heart hospital and heart emergency room operated in partnership with area cardiologists. The system is located primarily in the South Tulsa-Broken Arrow corridor.

St. Francis Hospitals	Total Beds	City
St. Francis Hospital (incl. Children's Hospital)	672	Tulsa
St. Francis Hospital at Broken Arrow	66	Broken Arrow
St. Francis Heart Hospital	52	Tulsa

Other Facilities
St. Francis Imaging Center
Sleep Disorder Center
Eastern Oklahoma Perinatal Clinic
Natalie Warren Bryant Cancer Center
Laureate Clinic and Psychiatric Hospital
Co-owner of CommunityCare Health Plans

Source: Company website.

St. Francis Health System's flagship hospital, 672-bed St. Francis Hospital, is an acute care tertiary and quaternary medical center, level I trauma center, and academic medical center. It is the largest hospital in Tulsa and admits nearly 38,000 patients per year and serves more than 70,000 patients in its emergency room.

Utilization Statistics

	2003	2004	2005
Licensed beds	904	871	871
Staffed beds	672	657	700
Inpatient admissions	34,850	37,976	37,924
Patient days	178,118	181,573	183,347
Emergency room visits	68,864	70,034	70,254
Outpatient visits	503,124	486,138	597,018
Outpatient surgeries	15,366	15,505	17,579
Total surgeries	25,984	26,557	28,133
Open heart surgeries	705	707	429
Newborn admissions	2,857	3,138	3,135
Medicare case mix index	1.73	1.71	1.59

Medicare is St. Francis' primary payor followed by managed care; however, St. Francis treats a significant amount of indigent patients. On a gross revenue basis, St. Francis is the largest

provider of uncompensated care in the city of Tulsa, in fact, St. Francis pays 14% of all uncompensated care in the State of Oklahoma[1].

Payor Mix

	2003	2004	2005
Medicare	41.73%	42.40%	41.52%
Medicaid	10.04%	9.15%	10.77%
Blue Cross	4.71%	5.47%	7.06%
Commercial Indemnity	2.27%	2.24%	2.46%
Managed Care	32.73%	31.67%	30.37%
Self Pay/Other	8.52%	9.07%	7.82%
Total	100.00%	100.00%	100.00%

Additional Facilities

St. Francis is building a new $56 million children's hospital to be attached to the northeast side of St. Francis Hospital. The 104-bed facility is scheduled for completion in the spring of 2007 and will have 20 more pediatrics beds than are now available at St. Francis. Additionally, the new children's hospital will free up 72 beds at the St. Francis Children's Hospital to be converted to adult use.

St. Francis is enjoying financial success and high patient satisfaction at its all-digital heart hospital. The St. Francis Heart Hospital has been extremely well received since opening in 2004. It boasts a 98% patient satisfaction score and is highly regarded by physicians.

St. John Health System

St. John Health System is a Catholic-sponsored, not-for-profit integrated delivery system that owns three hospitals in the Tulsa MSA, its primary one being St. John Medical Center, the second largest hospital in Tulsa. St. John Medical Center is a tertiary health care facility which is a regional leader in radiology, cardiology, oncology, urology, wellness, and physical rehabilitation. Secondary and selected tertiary care services are also provided by Jane Phillips Medical Center, and secondary acute care services and selected diagnostic services are provided by St. John Sapulpa.

St. John Hospitals	Total Beds	City
St. John Medical Center (incl. St. John Heart Institute)	559	Tulsa
St. John Sapulpa	25	Sapulpa
Jane Phillips Medical Center	136	Bartlesville

Other Facilities
LaFortune Cancer Center
Co-owner of CommunityCare Health Plans
Co-owner of Tulsa Life Flight air-ambulance service

Source: Company website.

[1] *Source: Final Report by Joint Legislative Commission dated December 15, 2005.*

St. John Sapulpa, which is located 15 miles southwest of Tulsa, has been designated as a critical access hospital by Centers for Medicare & Medicaid Services, which allows it to receive cost-based Medicare reimbursement. The hospital offers emergency, surgical, behavioral health programs, laboratory and diagnostic, occupational medicine, and rehabilitation services.

In partnership with the physicians from Tulsa Bone and Joint Associates, SJHS owns the Center for Joint Replacement located on the St. John Medical Center campus. Additionally, the St. John Heart Institute is a not-for-profit center of cardiac care excellence located at St. John Medical Center.

St. John Medical Center, the flagship hospital in St. John Health System, admits over 30,000 patients per year and serves nearly 50,000 patients in its emergency room.

Utilization Statistics

	2001	2002	2003
Beds in service	556	559	559
Total admissions	28,021	31,503	32,806
Total patient days	154,854	152,929	157,891
ALOS (excl. newborns)	5.36	5.20	5.15
Births	2,564	2,466	2,602
Emergency room visits	45,279	46,528	48,476
Outpatient visits (excl. ER & one day)	75,175	80,228	79,461
Total inpatient surgical cases	8,133	8,482	8,632
Total outpatient surgical cases	14,815	13,936	13,624

Source: St. John Health System Official Statement dated July 14, 2004.

Medicare is St. John's primary payor followed very closely by commercial insurance.

Payor Mix

	2001	2002	2003
Medicare	46%	44%	46%
Medicaid	9%	9%	10%
Commercial Insurance	41%	42%	38%
Self Pay	4%	5%	6%
Total	100%	100%	100%

Source: St. John Health System Official Statement dated July 14, 2004.

St. John Health System is a member of Tulsa-based Marian Health System, a not-for-profit Catholic healthcare system sponsored by the Sisters of the Sorrowful Mother. Marian Health System operates three additional regional health systems in Denville, New Jersey; Milwaukee, Wisconsin; and Wichita, Kansas.

Other Health Systems and Hospitals

Triad Hospitals

Triad Hospitals, a national for-profit hospital company based in Plano, Texas, owns two acute care hospitals in the Tulsa MSA, 180-bed SouthCrest Hospital and 73-bed Claremore Regional Hospital. Triad operates 52 hospitals and 10 ambulatory surgery centers nationally with approximately 9,125 licensed beds.

SouthCrest Hospital serves the south Tulsa community and has a medical staff of more than 650 physicians who represent all specialties. Since its opening in 1999, SouthCrest has invested $95 million in expansion projects and upgrades including the addition of the 32-bed Tulsa Heart Hospital on the sixth floor.

Claremore Regional Hospital is a community hospital just outside of Tulsa that serves 80,000 residents. Triad has invested about $15 million in expansion projects since July 2003.

Southwestern Regional Medical Center

Southwestern Regional Medical Center is a 39-bed specialty hospital in Tulsa that offers diagnostic and treatment therapies to cancer patients on both an outpatient and inpatient basis. It is owned by Cancer Treatment Centers of America, which also owns and operates cancer hospitals in Zion, Illinois, and Seattle, Washington.

New Construction

Each of the major Tulsa hospital systems is expanding. St. Francis is building a $56 million 104-bed Children's Hospital, scheduled to be completed in 2007. It is expected to convert existing pediatric beds into acute care beds at its main facility.

Ardent and St. John are both expanding in the rapidly developing suburb of Owasso, which is approximately 15 miles northeast of the city. St. John is building a new 50-bed hospital, which is scheduled to open in the spring of 2006, and Ardent is building the Bailey Medical Center, which is scheduled to open in 2007.

Physicians

There are approximately 1,750 physicians in the Tulsa MSA. More than half of Tulsa's physicians are specialists, with membership focused in some of the region's largest independent single-specialty groups like Oklahoma Oncology and Cardiology of Tulsa. Most primary-care physicians are employed by hospitals, although increasingly they are being employed by single-specialty groups in order to create a referral system that helps reduce costly hospital stays. Declining reimbursement for professional services and increasing costs will continue to convince physicians that investing in their own hospitals, diagnostic centers, and equipment is a potentially better alternative for them, regardless of the tension and conflict that often creates with providers.

Physician Organization Overview [1]

Organization	# of Physicians
Warren Clinic	150
Utica Park Clinic/Hillcrest Medical Group	131
OMNI Medical Group	80

(1) Source: HealthLeaders-InterStudy, 2005, Solucient, 2005.

Warren Clinic is affiliated and owned by SFHS. It has physician offices in ten northeastern Oklahoma cities, including 29 practice locations in Tulsa. Utica Park Clinic/Hillcrest Medical Group is an established primary care and specialty practice that provides medical care at 34 clinics in 19 cities. Utica serves the metropolitan area of Tulsa with 13 locations, while Hillcrest provides care to 13 rural communities outside Tulsa. OMNI Medical Group serves northeastern Oklahoma in approximately 30 different locations. St. John Medical Center is the group's sponsor.

Managed Care

Five HMOs and 23 PPOs serve the Tulsa MSA with a combined market penetration of nearly 35%. HMOs and fully insured PPOs share almost identical penetration in the local market. CommunityCare is the largest HMO and PPO in Tulsa. It has approximately 63% of HMO enrollment (and over 80% of Medicare HMO enrollment) and its PPO is the second-largest fully insured PPO behind Blue Cross and Blue Shield of Oklahoma.

The marketplace has begun to change with the arrival of two large, national health insurance carriers, PacifiCare of Oklahoma (owned by UnitedHealth) and BC/BS of Oklahoma (owned by Chicago-based Health Care Service Corp.). It is expected that these two organizations will be competitive in the Tulsa MSA.

There are no Medicaid HMOs in Oklahoma. The state Medicaid program, SoonerCare, contracts directly with physicians on a fee-for-service basis.

Managed Care Organization Overview [1]

HMOs	Enrollment	Market Share	PPOs	Enrollment	Market Share
CommunityCare	93,871	63%	BCBS of Oklahoma	104,328	67%
Aetna Health	21,637	15%	CommunityCare	33,862	22%
PacifiCare of Oklahoma	19,312	13%	CIGNA PPO	9,147	6%

Medicare HMOs	Enrollment	Market Share	Medicaid HMOs	Enrollment	Market Share
CommunityCare	22,397	81%	N/A	N/A	N/A
PacifiCare of Oklahoma	5,138	19%			

(1) Source: HealthLeaders-InterStudy, 2005, Solucient, 2005.

Medicaid

SoonerCare, the state Medicaid program administered by the Oklahoma Health Care Authority, pays primary-care providers a monthly capitated rate for fixed services and reimburses for non-capitated services on a fee-for-service basis. In the Tulsa MSA, there were 93,464 enrollees in SoonerCare as of December 2004, a decrease of almost 13% since December 2003. The 2005 Legislature passed House Bill 1088, which appropriated $63 million for the Oklahoma Health Care Authority, of which $38 million is to be spent on increasing hospital provider Medicaid rates.

Medicare

There were 128,849 Tulsa area residents eligible for Medicare services as of December 2004. CommunityCare and PacifiCare of Oklahoma enroll 21% of the Medicare market and the remaining local Medicare eligibles are covered by healthcare prepayment plans for private fee-for-service arrangements. Humana recently entered the market with its Medicare Advantage PPO. Within Tulsa, Blue Cross/Blue Shield of Oklahoma, CommunityCare, and Secure Horizons offer the Medicare Advantage option as an HMO or local PPO.

Description

Tulsa Regional Medical Center is a 331 licensed bed acute care hospital located in Tulsa, Oklahoma. TRMC was established in 1944 by a group of osteopathic physicians and provides healthcare services to residents of the city of Tulsa, surrounding counties and rural areas in northeastern Oklahoma.

TRMC is a full service acute care hospital, providing the following services: cardiovascular, emergency medicine, rehabilitation, obstetrics and gynecology, inpatient and outpatient surgery, and behavioral health services. TRMC offers nationally recognized vascular care, an expansive telemedicine program, comprehensive wound care, a sleep center, and oncology care.

The hospital serves as one of the leading osteopathic teaching hospitals in the country, and is the primary teaching hospital for graduates of the Oklahoma College of Osteopathic Medicine.

TRMC is owned and operated by Nashville, Tennessee-based Ardent Health Services LLC. Ardent is a for-profit hospital management company which also owns properties in Albuquerque, New Mexico. Ardent purchased the facility from Hillcrest HealthCare System in August 2004.

History and Background

Tulsa Regional Medical Center was founded in 1944 by a group of osteopathic physicians. It served as Oklahoma's first osteopathic hospital, but was not originally affiliated with any university. In 1972, the Oklahoma legislature created the freestanding Oklahoma College of Osteopathic Medicine to increase the number of primary care physicians for rural and underserved Oklahoma. TRMC became the teaching hospital for the college. In 1988, Oklahoma State University merged with the Oklahoma College of Osteopathic Medicine.

Tulsa Regional Medical Center has had several changes in ownership over the past decade. In 1996, HCA acquired the facility, but sold it just three years later to Hillcrest HealthCare System, converting it from for-profit to not-for-profit status. Hillcrest subsequently became the largest provider of healthcare in Tulsa. TRMC again changed ownership in August 2004 when Hillcrest was sold to Ardent.

Discussion of Services

Tulsa Regional Medical Center serves the acute and sub-acute healthcare needs of the Tulsa MSA and northeastern Oklahoma. It offers the full complement of services previously mentioned and in addition, its Children's Medical Center Behavioral Health Services ("CMC") provides inpatient

psychiatric care for children and adolescents on the TRMC campus. Comprehensive behavioral health services are incorporated into four specialized units including adolescent acute, residential, children's, and early adolescent units. CMC is the only psychiatric facility in eastern Oklahoma to offer an early adolescent unit, providing specialized care for children ages 10 to 13.

TRMC continues to provide services to rural communities through its telemedicine program. The program currently includes 20 regional hospitals, making it one of the largest telemedicine programs in the state. TRMC partners with Diagnostic Imaging Associates and Oklahoma State University College of Osteopathic Medicine to provide these advanced services. Patients in rural communities avoid having to travel long distances to receive diagnosis and treatment from physicians.

TRMC's Wound Care Clinic brings together a team of wound care specialists including physicians, nurses, therapists, and other medical professionals who utilize advanced treatments for non-healing wounds due to diabetes or other health conditions. The Wound Care Clinic offers the region's only hyperbaric oxygen therapy. TRMC also offers a complete and modern program for the diagnosis and treatment of patients with cancer. Oncology services include radiation therapy, chemotherapy, immunotherapy, and advanced oncology surgical techniques.

Physical Property Description and Capital Expenditure Needs

Tulsa Regional Medical Center was built in 1954. The hospital is housed in an eight-story building, plus a basement, encompassing total square footage in excess of 500,000 square feet.

TRMC is a 50-year-old facility that has been undercapitalized over the past few years. As a result, the hospital will need significant renovations over the next five years in order to remain competitive in the marketplace. Management estimates that the facility will require approximately $40 million in capital expenditures over the next five years.

Medical Staff

TRMC's active and associate medical staff is comprised of 235 physicians, 193 of whom are D.O.'s and 42 of whom are M.D.'s. A strong contingent of the medical staff was trained at OSU COM and are among the primary admitters to the hospital. In fact, physicians who are alumni of OSU generate nearly 55% of the admissions to the hospital, yet only make up 19% of the total staff of the hospital.

The chart below provides specific admissions by specialty of OSU-trained physicians versus all other physicians.

TRMC Data

The following tables and text provide data and commentary on the operational and financial performance of TRMC.

Admissions by Physician Class

	# of Physicians	Admissions Last 12 Months Feb-06	Avg. # of Admissions Per Physician
OSU Physicians			
Family Practice	9	1,728	192.0
General Surgery	4	411	102.8
Internal Medicine	7	2,999	428.4
OB/GYN	4	1,052	263.0
Pediatrics	9	1,322	146.9
Subtotal	**33**	**7,512**	**227.6**
Private Physicians			
Cardiology	6	1,044	174.0
Cardiovascular/Thoracic	4	287	71.8
Family Practice	32	676	21.1
Gastroenterology	2	2	1.0
General Surgery	8	102	12.8
Internal Medicine	17	832	48.9
Neonatology	2	298	149.0
Nephrology	3	353	117.7
Neurology	2	24	12.0
OB/GYN	5	93	18.6
Oncology	4	19	4.8
Orthopedic Surgery	10	195	19.5
Otorhinolaryingology	6	98	16.3
Pediatrics	7	42	6.0
Psychiatry	6	2,140	356.7
Rehabilitation	5	0	0.0
Urology	2	43	21.5
Miscellaneous	18	30	1.7
Subtotal	**139**	**6,278**	**45.2**
Total	**172** [(1)]	**13,790**	**80.2**
OSU Physicians as a % of Total	***19.2%***	***54.5%***	

(1) Includes physicians who have admitted patients in the last twelve months only.

TRMC employs both private physicians and physicians affiliated with OSU. There are greater than four times as many private physicians at TRMC than OSU physicians; however, OSU physicians account for more than half of all admissions to TRMC.

Utilization Statistics

	2003	2004	2005
Total admissions	12,517	13,631	13,855
Total admissions, less newborns	11,626	12,864	13,107
Other admissions	7,141	6,743	6,418
Patient Days	79,623	78,913	74,783
Patient Days, less newborns	77,569	77,274	73,125
ER visits	30,405	31,217	33,863
ER admissions	5,710	6,121	6,689
OP visits	37,134	39,551	35,211
OP surgeries	4,942	5,591	5,863
Cardiac Caths (LHC)	0	1,044	1,001
Angioplasty (PTCA)	0	286	215

Patient Days by Payor Class

	2002	2003	2004	2005
Payor Class				
Insurance	10,296	9,984	10,818	10,303
Medicaid	36,248	34,275	37,429	35,855
Medicare	35,227	30,840	25,760	23,599
Self Pay	3,382	4,524	4,906	5,026
Other	46	–	–	–
Total	85,199	79,623	78,913	74,783
Less: Newborns	(2,163)	(2,054)	(1,639)	(1,658)
Total	83,036	77,569	77,274	73,125
Payor Class				
Insurance	12.1%	12.5%	13.7%	13.8%
Medicaid	42.5%	43.0%	47.4%	47.9%
Medicare	41.3%	38.7%	32.6%	31.6%
Self Pay	4.0%	5.7%	6.2%	6.7%
Other	0.1%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

Admissions by Payor Class

	2002	2003	2004	2005
Payor Class				
Insurance	1,922	1,932	2,263	2,344
Medicaid	5,894	5,354	5,737	5,875
Medicare	4,403	4,086	4,256	4,157
Self Pay	880	1,145	1,375	1,479
Total	13,099	12,517	13,631	13,855
Less: Newborns	(973)	(891)	(767)	(748)
Total	12,126	11,626	12,864	13,107
Payor Class				
Insurance	14.7%	15.4%	16.6%	16.9%
Medicaid	45.0%	42.8%	42.1%	42.4%
Medicare	33.6%	32.6%	31.2%	30.0%
Self Pay	6.7%	9.1%	10.1%	10.7%
Total	100.0%	100.0%	100.0%	100.0%

The above data show that TRMC has experienced a declining trend with respect to overall patient days, and in particular with respect to Medicare patient days. The decline in patient days can be attributed to two factors; the ongoing focus on improved care management at TRMC, and the closure of the rehabilitation services unit at TRMC. In September 2004, rehabilitation services at TRMC were closed and consolidated at Hillcrest. Patients at TRMC's rehabilitation unit typically experienced longer lengths of stay per admission compared to the average for non-rehabilitation patients. As a result, TRMC has experienced a decline in patient days since September 2004, particularly with respect to Medicare patient days. Medicare admissions have declined as well, but the rate of decline has been less than Medicare patient days since the lost admissions to the rehabilitation unit have a disproportionate effect on patient days.

Gross Inpatient Revenue by Payor Class

	2002	2003	2004	2005
Payor Class				
Insurance	32,715,859	33,222,549	42,002,484	46,291,185
Medicaid	58,218,360	55,340,725	64,856,625	64,603,820
Medicare	89,800,816	84,017,316	89,389,097	104,237,879
Self Pay	10,974,688	16,474,941	18,897,381	22,065,726
Other	172,276	–	–	–
Total	191,882,000	189,055,531	215,145,587	237,198,610
Less: Newborns	(1,499,351)	(1,427,291)	(1,238,250)	(1,194,481)
Total	190,382,648	187,628,240	213,907,336	236,004,128
Payor Class				
Insurance	17.0%	17.6%	19.5%	19.5%
Medicaid	30.3%	29.3%	30.1%	27.2%
Medicare	46.8%	44.4%	41.5%	43.9%
Self Pay	5.7%	8.7%	8.8%	9.3%
Other	0.1%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%
Revenue Per Admission				
Insurance	17,022	17,1,6	18,561	19,749
Medicaid	9,878	10,336	11,305	10,996
Medicare	20,395	20,562	21,003	25,075
Self Pay	12,471	14,389	13,744	14,919
Total	14,649	15,104	15,784	17,120
Total less newborns	15,700	16,139	16,628	18,006
Revenue Per Patient Day				
Insurance	3,178	3,328	3,883	4,493
Medicaid	1,606	1,615	1,733	1,802
Medicare	2,549	2,724	3,470	4,417
Self Pay	3,245	3,642	3,852	4,390
Total	2,252	2,374	2,726	3,172
Total less newborns	2,293	2,419	2,768	3,227

Gross Outpatient Revenue by Payor Class

	2002	2003	2004	2005
Payor Class				
Insurance	18,669,896	23,240,822	26,270,354	31,338,783
Medicaid	11,405,760	17,218,065	16,812,624	20,716,350
Medicare	15,978,913	28,071,867	39,936,359	49,156,702
Self Pay	10,644,953	9,959,732	11,677,014	14,576,760
Other	11,860	–	–	–
Total	56,711,383	78,490,485	94,696,350	115,788,595
Payor Class				
Insurance	32.9%	29.6%	27.7%	27.1%
Medicaid	20.1%	21.9%	17.8%	17.9%
Medicare	28.2%	35.8%	42.2%	42.5%
Self Pay	18.8%	12.7%	12.3%	12.6%
Other	0.0%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%
Revenue Per Admission				
Insurance	1,098	1,311	1,358	1,684
Medicaid	632	807	833	1,018
Medicare	879	1,455	1,883	2,563
Self Pay	856	784	854	989
Total	3,465	4,356	4,929	6,253

Gross inpatient and outpatient revenues at TRMC have increased from 2002 to 2005. Recent increases in gross inpatient revenues can be attributed to price increases that Ardent implemented at TRMC in February 2005 and January 2006. In February 2005, Ardent instituted price increases on a select group of services and procedures. The rationale for the price increase was to re-price services and procedures that Ardent believed were under priced. The price increase in January 2006 was an across-the-board increase of 5% on prices for all services and procedures at TRMC.

Gross Medicare outpatient revenues showed a significant increase in 2003 along with continued increases in 2004 and 2005. These increases are directly attributable to two factors: 1) the decision to move the long-term acute care hospital to the TRMC campus in January 2003; and 2) improvements in case management that identified suitable acute care patients at TRMC and moved them to the long-term acute care hospital, thereby freeing additional acute care beds for new patients.

Payor Mix

TRMC has maintained a relatively stable payor mix for the past four years. The Federal Medicare program is the hospital's primary payor, accounting for over 40% of the hospital's revenue with Medicaid accounting for 24.2%.

Total Revenue by Payor Class

	2002	2003	2004	2005
Payor Class				
Insurance	52,215,149	62,417,184	68,272,839	77,629,968
Medicaid	70,740,520	78,292,880	81,752,139	85,320,170
Medicare	107,488,141	119,512,820	129,325,456	153,394,581
Self Pay	21,966,835	28,333,739	30,491,508	36,642,486
Other	179,087	–	–	–
Total	252,589,732	288,556,622	309,841,941	352,987,206
% of Total:				
Insurance	20.67%	21.63%	22.03%	21.99%
Medicaid	28.01%	27.13%	26.39%	24.17%
Medicare	42.55%	41.42%	41.74%	43.46%
Self Pay	8.70%	9.82%	9.84%	10.38%
Other	0.07%	–	–	–
Total	100.00%	100.00%	100.00%	100.00%

Ardent Impact on TRMC

Since its acquisition of Hillcrest in 2004, Ardent has pursued a number of initiatives that have resulted in marked improvement in operations at TRMC. The following describes some of the initiatives and the positive impact they are having on TRMC.

Productivity

Since it gained control of operations at TRMC, Ardent has focused on improving productivity standards at TRMC. Productivity improvements have come through improvements in supply utilization, expense control, and case management. As a result, TRMC has experienced significant improvements in productivity measures, and was recognized in 2005 for having the highest productivity standards of any of Ardent's hospitals.

Integration

Another strength that Ardent has brought to TRMC is its emphasis on integration. Ardent has brought renewed focus to TRMC to extract the benefits of being part of an integrated health system. It has concentrated its efforts on improving inter-facility cooperation and referral patterns from sister facilities. At present, TRMC receives coverage for neurology and neurosurgery from physicians at Hillcrest.

Emergency Room

Approximately 50% of admissions to TRMC are generated from the emergency room. Thus, it is no surprise that improving emergency room operations at TRMC has been a high priority for

Ardent. Over the last 18 months, TRMC has experienced improvements in turnaround time, and decreases in the number of patients that leave without being seen and in the number of hours the emergency room is on divert. In fact, TRMC has consistently had the lowest number of hours on divert of all the hospitals in the Tulsa area.

Background and Historical Information

In 1972, SB 461 created the Oklahoma College of Osteopathic Medicine and Surgery. The emphasis of the college was to train doctors of osteopathic medicine ("D.O.s") for careers in general practice serving the citizens of Oklahoma, and in particular, those citizens living in rural areas. OCOM merged with Oklahoma State University in 1988, and was subsequently designated a Center for Health Sciences ("CHS") by the Oklahoma legislature in 2001.

Today, the OSU College of Osteopathic Medicine ("OSU COM") is a nationally recognized educational institution. According to US News & World Report, it ranks among the highest in the nation in 2006, ranking 11th in Rural Medicine, 16th in Family Medicine, and 54th in Primary Care. The OSU COM currently has approximately 75 full-time faculty members, and accepts approximately 90 medical students per year. Nearly 90% of OSU COM graduates enter into general practice each year. In addition, there is an OSU-trained D.O. physician practicing in nearly every one of the 77 counties in the State of Oklahoma.

Description of Residency Program

TRMC is the largest training ground for graduates of osteopathic medical schools. TRMC is approved by the AOA to fill 154 residency slots of which 122 are currently funded. Graduates of OSU COM fill approximately two-thirds of the current slots, and graduates of other U.S. osteopathic medical schools fill out the remaining one-third.

Residency Slots

Specialty	Approved	Funded	Filled
Internship	35	23	23
Anesthesiology	6	6	6
Cardiology	6	3	3
Diagnostic Radiology	12	10	8
Emergency Medicine	12	11	11
Internal Medicine	15	15	15
Interventional Radiology	1	1	0
Interventional Cardiology	3	1	0
Family Practice	18	14	14
General Surgery	9	9	9
Nephrology	3	1	1
OB/GYN	8	7	9
Ophthalmology	4	3	3
Orthopedics	8	8	8
Otolaryngology	5	3	3
Pediatrics	9	7	7
Total	**154**	**122**	**120**

The purpose of the residency program is to sufficiently train residents to be competent physicians and to pass certification in an osteopathic specialty. The residency program builds upon a broad-

based osteopathic medical education and upon an intern training program that has exposed the individual to the major clinical fields of medicine and surgery. From this experience, the resident can undertake specialty training which provides the knowledge and skills requisite for specialty practice. Residents perform rotations in several medical specialties which include substantial interaction with patients, their families, and clinical staff. Each residency program is tailored to requirements of the specific discipline; however, all programs include some combination of specialized training rotations within each discipline, outpatient services, and didactic education through structured reading programs, lecture series, and conferences.

OSU currently operates a pyramid model for its residency program at TRMC. The pyramid model is an educational model that is centered on a single teaching hospital. The teaching hospital houses the residency program, and is the epicenter of an integrated learning environment. The community-based model is an educational model that is not centered on a single teaching hospital. In the community-based model, the residency program and learning environment are dispersed across multiple facilities.

The pyramid model is the preferred model because of its centralized nature, which facilitates interaction among faculty, staff, residents, and medical students at all levels of inpatient and outpatient care. Teachers and residents are present in all major hospital departments, and have continual interaction. Large teaching hospitals typically have a higher volume and diversity of cases than smaller hospitals, and ordinarily have higher quality measures than do non-teaching hospitals. Community-based residency programs are typically housed in smaller community hospital, which are unlikely to provide the residents with the volume or diversity of cases needed to provide a higher-quality educational experience for residents. Community-based programs are also more likely to have increased administrative complexity and costs because it is spread out across multiple facilities and geographies.

Direct Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Revenue

GME has multiple sources of funding, including Medicare and Medicaid, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, university and hospital practice plans, state and local governments, and third-party payers. Medicare is the largest provider of GME funds, followed by Medicaid. States contribute $2.3 billion in Medicaid dollars to GME. There are three basic sources of state funds for GME: Medicaid, state tax revenues, and private payers. Most states rely on Medicaid dollars to pursue GME reforms, and many states also leverage a small portion of their general-fund appropriations—independent of Medicaid—to support undergraduate medical education. About $200 million of the $3 billion in general-fund support for medical education is directed to GME activities, mostly to underwrite family practice residency programs that can help expand the pool of primary care doctors. Forty-three states make GME payments through their traditional Medicaid fee-for-service program. Under the fee-for-service system, states have traditionally paid for GME by incorporating it into hospital payment rates or by passing through these costs and directly paying teaching hospitals. Virtually all states have GME funds flowing to teaching hospitals.

Medicare pays for a portion of the cost of medical education for residents and fellows through direct and indirect medical education payments to teaching hospitals. There are direct GME costs, which include the resident's stipend, payments to teaching physicians, program administration costs, and other costs directly attributable to educational activities. The direct GME payment is intended to cover the hospital's compensation to teaching physicians for time

spent on GME program administration and general teaching and supervision of residents. In addition, payments may be made under the Medicare physician fee schedule for professional services furnished by the physician or by a resident under the medical direction of the teaching physician. GME payments are based on 1984 hospital-specific costs per resident, updated for inflation. A hospital's payment is the product of three factors: (a) the hospital's per resident payment amount; (b) a weighted count of full-time equivalent ("FTE") residents training in the facility, capped at the number of FTEs training in 1996; and (c) the hospital's Medicare patient share, based on the ratio of Medicare patient days to total patient days in the acute inpatient setting.

In addition, there are indirect medical education costs. The IME adjustment is a percentage add-on to the prospective payment system ("PPS") rates for teaching hospitals, and was established to recognize the higher patient care costs of teaching hospitals. These are higher patient care costs associated with teaching hospitals, such as treating sicker patients, using more diagnostic tests, and longer patient visits or hospital stays. IME payments are based on a formula that raises inpatient payments by about 5.5 percent for every 10 percent increase in the ratio of residents to hospital beds. As with the GME formula, the resident count used in the IME formula is capped. If the caps were to increase, GME and IME payments would rise.

Direct GME costs for a single residency program are typically incurred by multiple entities: the program sponsor, the faculty practice plan affiliated with the sponsoring institution, and the hospitals and ambulatory sites that provide training. Each site's direct costs for GME depend on its negotiations and arrangements with other entities involved in the training program over issues such as which party will assume the costs of the resident's salary and teaching physician compensation. Patient care revenues provide most of the support for GME. However, Medicare and, in some States, Medicaid, make explicit payments to teaching hospitals for their GME costs. These payments recognize that equipping future physicians with the competencies to provide high-quality care is in the public interest. Private payers have also traditionally paid higher amounts to teaching hospitals to support the costs of training residents, and to some extent, the charity care provided by teaching hospitals. State support for GME typically occurs through appropriations to State-operated medical schools or residency training grants (about $185 million). In addition, Federal appropriations under the Public Health Service Act support primary care residency programs and other health professional education ($300 million) and children's teaching hospitals ($40 million). Thus, the flow of funds among the participants in GME activities is complex and frequently involves cross-subsidies between medical schools, teaching hospitals, and other training sites.

Revenue Sources

The Graduate School Education Program at TRMC received IME and GME revenues of $19.3 million in Fiscal Year 2005. The GME and IME revenue received from State and Federal sources for residency support is integral to TRMC's ability to serve OSU. A majority of this revenue comes from the Oklahoma Health Care Authority ("OHCA") and the remainder comes from Medicare. GME funding through OHCA is a critical component to the medical school program and provides the primary source for physician faculty salaries. In addition, the Physician Manpower Training Commission ("PMTC") funds approximately 1% of the revenues. PMTC's purpose is to enhance medical care in rural and underserved areas of the state by administering residency, internship, and scholarship incentive programs that encourage medical and nursing personnel to practice in rural and underserved areas. The Oklahoma Health Care Authority

through the Dean's GME fund has an increased role in the funding of Graduate Medical Education, nearly eclipsing state appropriations to OSU.

Revenue Uses

GME and IME direct expenses totaled $14.7 million for Fiscal Year 2005. Other expenses included payment to OSU and IME funds, intern and resident salary and benefits, OSU faculty teaching support, and malpractice insurance for the residents.

Schedule of OHCA IME and DME Revenues and Expenses

Revenues	
Medicare IME	$4,197,310
Medicare GME	2,157,874
OHCA GME	5,963,576
OHCA IME	6,142,061
Physicians Manpower Training Commission	860,376
Total Revenues	**$19,321,197**
Expenses	
Intern and Resident Salaries and Benefits	$6,009,284
Return of OSU state matching funds	1,824,810
Other Intern and Resident Costs	1,783,062
OSU Faculty Teaching Support (Full & Part time)	2,019,714
Malpractice Insurance for OSU Residents	2,330,071
OSU Clinic Leases on TRMC property	682,271
Total Expenses	**$14,649,212**
Revenue from medical education programs	**$4,671,985**

Overview of Strategic Alternatives

Merrill Lynch has identified and reviewed a number of different potential strategic alternatives available to the State in regard to the long term stabilization of the residency program of the Oklahoma State University College of Osteopathic Medicine. The alternatives considered include:

I. Change OSU Residency Program from Pyramid Model to Community-Based Model Using a Variety of Urban and Rural Hospital Facilities

II. Build a New Teaching Hospital for OSU

III. Acquisition of TRMC

IV. Long-Term Lease of TRMC

V. Joint Venture or Partial Ownership of TRMC

VI. Academic Affiliation Agreement with TRMC

The following sections describe each strategic alternative and provide an overview of the relative advantages and disadvantages of each alternative.

I. Change OSU Residency Program from Pyramid Model to Community-Based Model Using a Variety of Urban and Rural Hospital Facilities

Description

OSU currently operates a Pyramid Model for its residency program at TRMC. The Pyramid Model ("PM") is an educational model that is centered on a single teaching hospital. The teaching hospital houses the residency program, and is the epicenter of an integrated learning environment. The Community-Based Model ("CBM") is an educational model that is not centered on a single teaching hospital. In the CBM, the residency program and learning environment are dispersed across multiple facilities.

Advantages

The primary advantages of changing the OSU COM residency program from a PM to a CBM include:

Maintains OSU COM Residency Program

One of the main advantages of changing the OSU COM residency program from a PM to a CBM is that it maintains OSU COM residency program and is a decision that OSU COM can implement on its own accord without having to depend on the owners of TRMC.

Secures Control and Provides Stability

Electing to change the teaching model to a CBM would secure control of and provide stability for the OSU COM residency program. Changing the model would eliminate the instability of relying on a single, unaffiliated hospital partner. It would spread the risk across multiple facilities, and could provide a permanent solution for the OSU COM residency program.

Limited Cost to the State of Oklahoma

Changing the teaching model of the residency program to a CBM is relatively inexpensive compared to other strategic alternatives that would require the State of Oklahoma to expend significant funds. Unlike all other alternatives, changing the teaching model of the residency program would not require a major upfront investment of capital and has limited potential for recurring appropriations. Re-organization of the OSU COM residency program may potentially be funded through OSU, thereby eliminating the need for additional legislation.

Disadvantages

The primary benefits of changing the OSU COM residency program from a PM to a CBM are that it maintains and secures control and stability for the residency program at a relatively low financial cost. However, changing the structure of the program to a CBM has several disadvantages that may outweigh the benefits:

Community-Based Model not Favored by Medical Schools, Residents, or Applicants

With a CBM, patient-care infrastructure and the learning environment are dispersed across multiple facilities, resulting in less interaction and less exchange of information among faculty,

staff, residents, and medical students. Community-based residency programs are typically housed in smaller community hospitals, which are unlikely to provide the residents with the volume or diversity of cases needed to support a top-quality medical education. As a result, the CBM is not the preferred option for medical schools, residents, or applicants to residency programs.

Pyramid Model is an Effective Teaching Model

The centralized nature of the PM facilitates interaction among faculty, staff, residents, and medical students at all levels of inpatient and outpatient care. Teachers and residents are present in all major hospital departments, and have continual interaction. Large teaching hospitals typically have a higher volume and diversity of cases than smaller hospitals, and ordinarily have higher quality measures than do non-teaching hospitals. As a result, teaching hospitals – and therefore residency programs that utilize the PM – provide a higher-quality educational experience for residents. This is one of the main reasons why many of the top medical schools in the U.S. choose the PM for their residency programs. For example, Harvard Medical School recently made the decision to alter its medical training from a decentralized model to a centralized model in which students will stay in a single facility to maximize their educational and practical learning. Although the PM is typically built around a single teaching hospital, the model does not preclude the option of contracting with other facilities for development of satellite programs, which can maximize the learning effort and support centers of excellence at the contracted facility.

Increased Administrative Complexity and Cost

A CBM requires managing relationships with multiple facilities. If OSU were to migrate it residency program to a CBM, it would likely incur one-time costs associated with the changeover to the CBM, as well as higher recurring administrative costs from the increased burden of managing its program and residents across multiple facilities and geographies.

II. Build a New Teaching Hospital for OSU

Description

The State commits to funding (directly or indirectly) construction of a new hospital in Tulsa. The new hospital would serve residents of the Tulsa metropolitan service area and would act as the permanent home of the OSU COM residency program.

Advantages

Construction of a new hospital is a straightforward, albeit expensive, solution to the instability that has vexed the OSU COM residency program in its recent history. The advantages of this alternative include:

Provides New Teaching Hospital and Maintains Pyramid Model

This alternative would provide the OSU COM with a new, state-of-the-art teaching hospital, and would allow it to maintain the preferred PM for its residency program.

Establishes a Flagship Hospital & Secures Control and Stability

This alternative would establish a flagship hospital and a permanent home for the OSU COM residency program. The OSU COM would secure (directly or indirectly) operational and financial control of a teaching hospital, and would no longer be subject to the uncertainty of having to partner with an unaffiliated entity that may among other things may not share its commitment to the educational mission of the residency program.

Disadvantages

Construction of a new hospital is a straightforward alternative whose main benefits are its simplicity and permanency. However, there are several disadvantages to this alternative that may outweigh the benefits:

Significant Upfront Cost to the State of Oklahoma

Construction of a new hospital is an expensive proposition that would require significant upfront investment by the State. Construction of a new, 250-bed hospital could cost the State approximately $187.5 to $250.0 million, based on new hospital construction cost estimates of $750,000 to $1.0 million per bed. In addition, the project would require the construction of additional physician clinic and office space, which would be a cost in addition to the one million per bed cost.

Unfavorable Market Dynamics

The market dynamics for the Tulsa MSA are unfavorable to the construction of a new hospital. The market for healthcare services in the Tulsa MSA is highly competitive, with several well-capitalized for-profit and not-for-profit health systems competing directly with one another.

Currently, Ardent Health Services (parent company of Hillcrest HealthCare System), Saint Francis Health System, and St. John Health System hold market shares in the Tulsa MSA of 34%, 28%, and 25%, respectively, and together hold combined market shares of 87% based on inpatient discharges. Triad Hospitals, a national, for-profit hospital company, operates

SouthCrest Hospital and Claremore Regional Hospital in the Tulsa MSA, and holds a market share of 9% based on inpatient discharges. In addition, local, physician-owned specialty hospitals have a strong presence in the Tulsa MSA and control nearly 16% of inpatient market share. (Market shares may add to more than 100% due to overlap among the categories.)[2]

The competitive nature of the market is also reflected in announced as well as ongoing construction projects. Current competitors in the Tulsa MSA are challenging each other across multiple service lines and are investing significant capital to upgrade and expand their facilities and capabilities. Examples of current or planned capital spending include:

- St. John Health System plans to open a 50-bed hospital in Owasso, a nearby Tulsa suburb in 2006
- Ardent Health Services plans to open the Bailey Medical Center in Owasso in 2006
- Ardent plans to open a Spine and Orthopedic Center in 2006 and a heart hospital tower at Hillcrest Medical Center in 2007
- Saint Francis plans to open a new 104-bed children's hospital in 2007

Building a new hospital, unaffiliated with the existing stronger hospital players threatens the long-term viability of the Hospital itself.

Limited Operating and Financial Leverage

A newly constructed hospital would operate as a stand-alone facility. As a stand-alone facility, it would not have the negotiating leverage with payors that its multi-facility competitors currently enjoy. It would lack the scale and volume of a multi-facility health system, and would have comparatively less leverage when contracting with commercial managed care payors and other ancillary service providers. Without the leverage of operating within a multi-facility health system, the new hospital would likely be disadvantaged on a cost basis relative to its competitors. Given the highly competitive nature of the Tulsa MSA, the long-term viability of a stand-alone facility that is disadvantaged from a cost basis relative to its competitors is uncertain. In addition, the new hospital may not be able to develop the broad base of physicians that it needs to maintain a strong flow of patient referrals to the hospital.

Equity Risk Exposure for the State of Oklahoma

This alternative has an elevated risk profile for the State. Depending on how the alternative is structured, the State would assume (directly or indirectly) the full operational and financial risk of operating the new hospital. By assuming such risks, the State would potentially be exposed to providing ongoing support to the hospital in the form of recurring appropriations to fund hospital operations, capital expenditures, and other financial needs, particularly if the Hospital is serving Medicare and indigent care patients at the discretion of OSU COM.

National Trends Move in Opposite Direction

Over the past decade, the trend has been toward the privatization of government-owned hospitals. The increasing complexity and risk of operating a hospital in combination with the increasing strength and leverage of hospital provider and payor consolidation has driven non-hospital managers/owners out of the business.

[2] *Source: HealthLeaders/InterStudy, 2005.*

Residency Slots Tied to a Hospital's Provider Number

Under current Medicare guidelines for Graduate Medical Education, funding for medical residency programs is linked directly to the Medicare provider number of a hospital or other healthcare services provider. Under this alternative, the new hospital would be required to submit a new application for funding for the residency program. Although approval of the application is likely, it is not certain. (In addition, the status of the residency slots at TRMC would be questionable during and after construction of the new hospital.) If the application were approved, there would be a net loss of GME funding (compared to current funding levels at TRMC) over the near term due to Medicare rules that provide partial, but increasing, levels of funding to the program over a period of three years, at which time funding stabilizes at fully funded levels.

III. Acquisition of TRMC

Description

The State commits to funding (directly or indirectly) the acquisition of TRMC. TRMC would continue to serve residents of the Tulsa MSA and would act as the permanent home of the OSU COM residency program.

Advantages

The acquisition of TRMC is a straightforward, albeit expensive, solution to the instability that has vexed the OSU COM residency program in its recent history. The advantages of this alternative include:

Maintains Teaching Hospital and Pyramid Mode, Leverages Existing Strengths

The acquisition of TRMC would allow the OSU COM to maintain its existing teaching hospital and continue to follow the preferred PM for its residency program.

Establishes a Flagship Hospital & Secures Control and Stability

The acquisition of TRMC would establish a flagship hospital and a permanent home for the OSU COM residency program. The OSU COM would secure (directly or indirectly) operational and financial control of a teaching hospital, and would no longer be subject to the uncertainty of having to partner with an unaffiliated entity that among other things, may not share its commitment to the educational mission of the residency program.

Feasible Transaction Structure

Ardent has indicated its willingness to consider the sale of TRMC at a reasonable market valuation. Based on current market valuation trends, TRMC is valued in the range of approximately $125-$160 million. Therefore, the Acquisition of TRMC, while still expensive in its own right, would be less expensive to the State than constructing a new hospital. In addition, positive cash flows from the acquired hospital could potentially support a bond offering that would likely reduce the appropriations needed from the State to fund the acquisition.

Disadvantages

The main benefits of acquiring TRMC are the feasibility of effecting a transaction and the permanency of the solution for the OSU COM residency program. However, there are several disadvantages to this alternative that may outweigh the benefits:

Significant Upfront Cost to the State of Oklahoma

The acquisition of TRMC, although potentially less expensive than constructing a new hospital, is still an expensive proposition that would require significant upfront investment by the State. Current valuation trends support premium multiples for profitable facilities. The acquisition of TRMC is likely to require an upfront investment by the State in the range of approximately $125-$160 million. Once acquired, the State would need to provide additional funding for capital and operating expenditures required by OSU to ensure the quality of its residency program.

Age of Facility

TRMC is an aging facility that will need additional capital expenditures over the next 3-5 years to upgrade and support infrastructure, technology, equipment, and programmatic enhancements. At present, management estimates capital expenditures for TRMC to be approximately $40 million over the next five years. This does not necessarily include capital and operating expenditures specifically required to maintain the quality of the teaching program.

Loss of Operating and Financial Leverage

The acquisition of TRMC would convert TRMC from a multi-hospital facility to a stand-alone facility operating in a highly competitive environment. As a stand-alone facility, TRMC would lose the operating and financial leverage that it currently enjoys as part of Hillcrest HealthCare System (which is owned by Ardent). Without the leverage of operating within a multi-facility health system, TRMC would likely be disadvantaged on a cost basis relative to its competitors. Given the highly competitive nature of the Tulsa MSA, the long-term viability of a stand-alone facility that is disadvantaged from a cost basis relative to its competitors is uncertain.

Potential Loss of Physician Referral Base

As a stand-alone facility, TRMC may not be able to maintain its current broad base of physicians that refer patients to the hospital. Currently, approximately 25% of inpatient referrals to TRMC originate from physicians or physician groups that are owned by or affiliated with Hillcrest.

Equity Risk Exposure for the State of Oklahoma

The acquisition of TRMC has an elevated risk profile for the State. Depending on how the alternative is structured, the State would assume (directly or indirectly) the full operational and financial risk of operating TRMC. By assuming such risks, the State would potentially be exposed to providing ongoing support to TRMC in the form of recurring appropriations to fund hospital operations, capital expenditures, and other financial needs.

National Trends Move in Opposite Direction

Over the past decade, the trend has been toward the privatization of government-owned hospitals. The increasing complexity and risk of operating a hospital in combination with the increasing strength and leverage of hospital provider and payor consolidation has driven non-hospital managers/owners out of the business.

Funds Appropriated by State to Acquire Facility go to Owner/Shareholder, Not to the Residency Program

The funds appropriated by the State for the acquisition would not provide a direct financial benefit to the OSU COM residency program. The money would be paid directly to the Owner/Shareholder. In addition, the State would have to allocate additional funds for capital expenditures or other direct support of the residency program.

IV. Long-Term Lease of TRMC

Description

The State commits (directly or indirectly) to leasing TRMC from Ardent. In exchange for annual lease payments, Ardent would relinquish to the State or an affiliated entity full operational control of, and financial responsibility for, TRMC. TRMC would continue to serve residents of the Tulsa MSA and would act as the long-term home of the OSU COM residency program.

Advantages

Entering into a long-term lease of TRMC would provide a long-term solution to the instability that has vexed the OSU COM residency program in its recent history. The advantages of this alternative include:

Maintains Teaching Hospital and Pyramid Model, Leverages Existing Strengths

The long-term lease of TRMC would allow the OSU COM to maintain its existing teaching hospital and continue to follow the preferred PM for its residency program.

Establishes a Flagship Hospital & Secures Control and Stability

A long-term lease of TRMC would establish a flagship hospital and a permanent home for the OSU COM residency program. The OSU COM would secure (directly or indirectly) operational and financial control of a teaching hospital, and would no longer be subject to the uncertainty of having to partner with an unaffiliated entity that among other things, may not share its commitment to the educational mission of the residency program.

Feasible Transaction Structure

Ardent has indicated its willingness to consider a long-term lease of TRMC, provided that it is awarded the management contract for TRMC.

Limited Upfront Cost to the State of Oklahoma

The long-term lease option would not require a large upfront investment by the State. Annual costs would consist primarily of an annual lease payment and any necessary capital expenditures. These costs would be partially or fully funded from cash flows from operations of TRMC. However, the lessee would assume full financial and operational responsibility for running the hospital, and should cash flows from operations be insufficient to meet obligations for annual lease payments, capital expenditures, and other costs, the lessee would be responsible for providing funds to make up the difference.

Therefore, the State would likely be subject to an ongoing commitment to provide funding to cover any liabilities arising from any shortfalls in cash flows from operations. Funding to meet this commitment could come in a variety of forms ranging from individual appropriations to a State funded back-up or stabilization fund that would receive appropriations as necessary and serve as a backstop to ensure payment of lease payments and/or funding for necessary capital expenditures when TRMC's cash flows from operations prove to be insufficient to cover them.

Disadvantages

The main benefits of a long-term lease of TRMC are the limited upfront costs to the State and the long-term solution it provides to the recent instability associated with the OSU COM residency program. However, there are several disadvantages to this alternative that may outweigh the benefits:

Age of Facility

TRMC is an aging facility that will need additional capital expenditures over the next 3-5 years to upgrade and support infrastructure, technology, equipment, and programmatic enhancements. Under typical lease arrangements, the lessee – and hence the State – would be responsible for all such expenditures. At present, management estimates capital expenditures for TRMC to be approximately $40 million over the next five years. In addition, the $40 million in capital expenditures might not necessarily represent all the dollars OSU would require to maintain a quality teaching program.

Loss of Operating and Financial Leverage

A long-term lease of TRMC would convert it from a member hospital in a multi-hospital health system to a stand-alone facility operating in a highly competitive environment. As a stand-alone facility, TRMC would lose the operating and financial leverage that it currently enjoys as part of Hillcrest Health System (which is owned by Ardent). Without the leverage of operating within a multi-facility health system, TRMC would likely be disadvantaged on a cost basis relative to its competitors. Given the highly competitive nature of the Tulsa MSA, the long-term viability of a stand-alone facility that is disadvantaged from a cost basis relative to its competitors is uncertain.

Potential Loss of Physician Referral Base

As a stand-alone facility, TRMC may not be able to maintain its current broad base of physicians that refer patients to the hospital. Currently, approximately 25% of inpatient referrals to TRMC originate from physicians or physician groups that are owned by or affiliated with Hillcrest.

Equity Risk Exposure for the State of Oklahoma

A long-term lease of TRMC has an elevated risk profile for the State. Depending on how the alternative is structured, the State would assume (directly or indirectly) the full operational and financial risk of operating TRMC. By assuming such risks, the State would potentially be exposed to providing ongoing support to TRMC in the form of recurring appropriations to fund hospital operations, capital expenditures, and other financial needs. Under typical lease arrangements, the lessee – and hence the State – would be responsible for all such expenditures.

Long-Term Lease Is Subject to Renewal

A long-term lease is not a permanent solution. Eventually, the long-term lease agreement with Ardent or its successor will expire. Renewal of a satisfactory lease with Ardent or its successor is not necessarily guaranteed.

National Trends Move in Opposite Direction

Over the past decade, the trend has been toward the privatization of government-owned hospitals. The increasing complexity and risk of operating a hospital in combination with the increasing strength and leverage of hospital provider and payor consolidation has driven non-hospital managers/owners out of the business.

Lease Payments Benefit Owner/Shareholder, Not Teaching Program

The lease payments made by the State for the acquisition would not provide a direct financial benefit to the OSU COM residency program. The money would be paid directly to the Owner/Shareholder. In addition, the State would have to allocate additional funds for capital expenditures or other direct support of the residency program.

V. Joint Venture or Partial Ownership of TRMC

Description

The State commits, through a Public Trust or other suitable legal entity ("Public Trust"), to enter into a 80%/20% joint venture ("JV") with Ardent. In exchange for receiving a 20% equity investment in TRMC, Ardent would agree to share, on a limited basis, governance, and hence operational and financial control, of TRMC with the Public Trust. TRMC would change its name to Oklahoma State University Medical Center. The Oklahoma State University Medical Center would be the permanent home of the OSU COM residency program, and would continue to serve residents of the Tulsa MSA.

Advantages

A JV would provide a permanent solution to the instability that has vexed the OSU COM residency program in its recent history by giving the State a partial ownership and say in the operations of TRMC. The advantages of this alternative include:

Maintains Teaching Hospital and Pyramid Model, Leverages Existing Strengths

A JV would allow the OSU COM to maintain its existing teaching hospital and continue to follow the preferred PM for its residency program.

Establishes a Flagship Hospital & Secures Control and Stability

A JV would establish a flagship hospital and a permanent home for the OSU COM residency program. The OSU COM would secure (directly or indirectly) limited governance rights and responsibility for TRMC. OSU COM would have supermajority rights over the residency program at TRMC.

Feasible Transaction Structure

Ardent has indicated its willingness to consider entering into a JV with OSU for the stability of the residency program.

Reduced Upfront Cost to the State of Oklahoma

A JV would require a reduced upfront investment by the State compared to construction of a new hospital or acquisition of TRMC, but a greater upfront investment compared to the long-term lease alternative. Based on current valuation trends, a 20% equity investment in TRMC could cost the State approximately $25-$35 million. As a JV partner, the State would be liable for its share of any capital expenditures or other costs that could not be met by TRMC's cash flows from operations.

Continued Operating and Financial Leverage

The JV alternative allows TRMC to remain within a multi-hospital system. As part of the larger Hillcrest HealthCare System, it would retain negotiating leverage with third-party payors as well as the cost synergies associated with multi-hospital systems, such as back office saving and other infrastructure rationalizations. The JV option likewise allows TRMC to keep intact the existing base of physicians that refer patients to the hospital.

Disadvantages

The main benefits of a JV are the reduced upfront costs to the State compared to other alternatives, the control gained through governance rights, and the permanent solution it provides to the recent instability associated with the OSU COM residency program. However, there are several disadvantages to this alternative that may outweigh the benefits:

Funds Appropriated by State to Acquire Facility go to Owner/Shareholder, Not to the Residency Program

The State's investment in the JV through a Public Trust would not provide a direct financial benefit to the OSU COM residency program. The money appropriated by the State to the Public Trust would be paid directly to the Owner/Shareholder. The Public Trust would receive an equity stake in the joint venture for its investment, but the OSU COM residency program would not benefit directly from the money appropriated to the Public Trust. The funds used to purchase the equity stake would not be available for capital expenditures or other direct support of the residency program.

Equity Risk Exposure for the State of Oklahoma

A JV has an elevated risk profile for the State. JV partners would be responsible for the operational and financial risk of operating the hospital. By assuming such risk, the State would potentially be exposed to providing recurring appropriations to meet its financial obligations as a JV partner. In addition, if the State were to not respond to a capital call, its equity position would be diluted.

Age of Facility

TRMC is an aging facility that will need additional capital expenditures over the next 3-5 years to upgrade and support infrastructure, technology, equipment, and programmatic enhancements. The JV partners would be pro rata responsible for all such expenditures. At present, management estimates capital expenditures for TRMC to be approximately $40 million over the next five years. The State would be responsible for approximately $8 million in projected capital expenditures over the next five years. This does not necessarily include capital and operating expenditures specifically required to maintain the quality of the teaching program. Should its share of cash flows from operations be insufficient to meet its capital expenditure and other obligations, the State would need to provide additional funding to meet its obligations to make up the difference.

VI. Academic Affiliation Agreement with TRMC

Description

The OSU COM and Ardent enter into an Academic Affiliation Agreement ("AAA"). The AAA would be a 50-year contractual arrangement to achieve governing control and stability of the residency program. Appropriated funds would be earmarked for direct support of the OSU COM residency program, not for equity or lease payments to Owner/Shareholder.

Advantages

An AAA would provide a long-term (50-year) contractual solution to the instability that has vexed the OSU COM residency program in its recent history. The advantages of this alternative include:

Maintains Teaching Hospital and Pyramid Model, Leverages Existing Strengths

An AAA would allow the OSU COM to maintain its existing teaching hospital and continue to follow the preferred PM for its residency program.

Establishes a Flagship Hospital & Secures Control and Stability

An AAA would establish a flagship hospital and a permanent home for the OSU COM residency program. The OSU COM would secure through a contractual arrangement nearly all of the governance rights it would have gained through an equity or lease arrangement with Ardent. OSU COM would control the residency program at TRMC.

Feasible Transaction Structure

Ardent has indicated its willingness to consider an AAA with the OSU COM.

Reduced Upfront Cost to the State of Oklahoma

An AAA would require a reduced upfront investment by the State compared to building a new hospital or acquiring or leasing TRMC.

Appropriated Funds Go Directly to the OSU COM Residency Program

Under an AAA, appropriated funds would be earmarked specifically to support the OSU COM residency program. Appropriated funds would provide direct support to the residency program in the form of new or upgraded teaching facilities, physician recruitment, capital equipment, office space and infrastructure, and would not pass directly to the Owner/Shareholder.

No Equity Risk Exposure for the State of Oklahoma

Unlike the New Construction, Acquisition of TRMC, Long-Term Lease of TRMC, and Joint Venture alternatives, the AAA alternative does not expose the State to the risk associated with owning and/or operating a hospital.

Continued Operating and Financial Leverage

An AAA does not alter TRMC's status as a member hospital in the Hillcrest HealthCare System. As part of the Hillcrest HealthCare System, TRMC would retain negotiating leverage with third-party payors as well as the cost synergies associated with multi-hospital systems, such as back office saving and other infrastructure rationalizations. The AAA option likewise does not alter

TRMC's current relationships with physicians and keeps intact the existing base of physicians that refer patients to the hospital.

Disadvantages

An AAA would provide a long-term, contractual solution to the instability that has vexed the OSU COM residency program in its recent history. However, it has some disadvantages, including:

AAA Is Subject to Renewal

The AAA is a contractual relationship that is subject to renewal after the initial 50-year term. Renewal of the AAA on terms acceptable to both the OSU COM and Ardent or its successor is not necessarily guaranteed.

Age of Facility

TRMC is an aging facility that will need additional capital expenditures over the next 3-5 years to upgrade and support infrastructure, technology, equipment, and programmatic enhancements. OSU COM will be vested in ensuring that TRMC offers state-of-the-art equipment and services that maintain the quality of the residency programs. Management estimates the funds required over the next five years to be approximately $40 million.

Summary of Transaction

NOTE: The following is a summary description of the proposed transaction, an Academic Affiliation Agreement, as of April 26, 2006. The terms of the Agreement are still being reviewed and have not been finalized.

The proposed transaction is an Academic Affiliation Agreement between a to-be-formed trust ("Trust") benefiting the State of Oklahoma, OSU, and Ardent (or their respective affiliates). The AAA is a contractual relationship that achieves many of the governance and other advantages of a traditional joint venture relationship in which each party would own an equity interest in the business. Rather than paying Ardent directly for such governance rights and a portion of the profits generated by the operation of the hospital, the AAA contemplates the Trust spending funds in a manner that directly or indirectly improves the residency program. The AAA, in short, is a one time commitment by the Trust to fund approximately $40 million in capital expenditures in exchange for a contractual relationship with Ardent that will provide for the long-term stability and viability of the OSU residency program.

Highlights of the AAA are as follows:

General

- The Oklahoma legislature establishes the Trust and appropriates funds necessary to satisfy certain one time capital expense obligations that benefit the residency program. The obligations of the parties under the AAA are conditioned upon such appropriation and the necessary approval of the Governor of Oklahoma.
- The Trust commits to fund approximately $40 million in capital expenditures for new equipment, equipment replacement, facility renovations, and other improvements during the first five years of the term of the AAA.
- After the first five years, the Trust and/or OSU will have the right but not the obligation to fund additional capital expenditures that will benefit the residency program.
- Ardent will continue to pay for the ordinary capital expenditures/maintenance obligations in connection with the operation of TRMC.
- OSU will have a significant degree of control over the management and operation of the residency program at TRMC (including the right to make all policy level decisions with respect to the residency program). In addition, the Trust and/or OSU will have the ability to control the manner in which the appropriated funds are expended.
- Ardent will maintain its current ownership of TRMC and continue to be responsible for the daily operations of the hospital.
- OSU agrees to provide TRMC with a right of first refusal with respect to the establishment of new educational service lines and new diagnostic treatment services.
- The hospital would be operated under the name of Oklahoma State University Medical Center.

Governance

- A ten-member Board of Trustees will be formed in which both Ardent and OSU shall have equal representation. At least four members (two appointed by OSU and two by Ardent) will be Doctors of Osteopathy on the active medical staff of TRMC.
- Although it will serve as the "governing body" for JCAHO and AOA accreditation purposes, the Board of Trustees will generally act in an advisory capacity to Ardent's governing board. As such, the Board of Trustees will, among other matters, participate in the development of applicable budgets, develop a mission statement for the hospital, provide input with respect to the addition or termination of service lines, oversee the Indigent Care Policy, and grant/withhold medical staff privileges.
- A six-member Liaison Committee will be formed in which both Ardent and OSU shall have equal representation. The Liaison Committee will be solely responsible for matters that the AAA specifies require the mutual consent of Ardent and OSU. Such matters include, without limitation, changes to the service lines used in connection with the residency program, altering the number or specialty of participants in the residency program, establishing a budget for the residency program, and approving contracts for hospital based physician services that have a direct impact on the residency program.
- OSU appointed members of the Liaison Committee will have unilateral authority to make policy decisions with respect to the residency program and to decide whether TRMC/OSU may enter into affiliation agreements with other medical institutions with respect to the residency program.

Right of First Refusal

- In the event that Ardent sells one or both of the hospitals it operates in the Tulsa area to an unaffiliated third-party, the Trust will have a right of first refusal with respect to a proposed sale of TRMC. Were TRMC to be sold to another party, the Trust would have the option to purchase it at fair market value less the sum of the net book value (as determined in accordance with American Hospital Association guidelines) of any assets acquired with funds provided by the Trust.

Term and Termination

- The initial term of the AAA shall be 50 years following the approval of the appropriations by the Oklahoma legislature and the Governor.
- Either party may terminate the AAA in the event of (i) the bankruptcy of the other party; (ii) the exclusion of the other party from a governmental payor program; or (iii) the failure of the other party to cure a breach of the AAA within a specified cure period (generally 30 days).
- Upon the termination of the AAA due to Ardent's bankruptcy or the consolidation of TRMC's operations with another facility, OSU would have the right to purchase the hospital for an amount equal to its fair market value (less the net book value of assets paid for by the Trust) or to receive an amount equal to the net book value of the assets paid for by the Trust.
- Upon the termination of the AAA as a result of Ardent's uncured breach of the AAA or upon Ardent's termination of the AAA due to a material reduction in funding or due to a

material adverse change in the payor mix as a result of the AAA, the Trust would have the right to receive an amount equal to the net book value of assets paid for by the Trust.

- Ardent would have the right to terminate the AAA in the event that a material reduction in governmental payments for medical education costs occurred or in the event that a material adverse change in the payer mix occurred as a result of the AAA.

Transition Period

- In the event that the term of the AAA expires or is otherwise terminated, Ardent or any successor must first give the Trust and OSU notice of at least two full legislative sessions (defined as two annual sessions beginning the first Monday in February and concluding the last Friday in May) to relocate the residency program. Special legislative sessions shall not be included in the determination of the transition period.

Summary/Conclusions

The Oklahoma State University College of Osteopathic Medicine has trained doctors for careers in general practice for the purpose of serving the citizens of Oklahoma, particularly those people living in rural areas, for over 30 years. OSU COM has graduated over 2,000 physicians and OSU graduates practice in nearly all of Oklahoma's 77 counties.

OSU COM's residency program is housed at Tulsa Regional Medical Center, which has proven to be in recent years an unstable home. The ownership of TRMC has been in flux for the past eight years, most recently changing hands in 2004 from when Hillcrest HealthCare System was purchased by for-profit Ardent Health Services LLC. The frequent changes in ownership, along with Ardent's discussion of consolidating services to Hillcrest Medical Center, have created instability in the residency program.

The State of Oklahoma and OSU would like to ensure the continuation and stability of the residency program. To that end, a thorough review and analysis of the State's and OSU's strategic alternatives was conducted. The strategic alternatives reviewed included:

I. Change OSU Residency Program from Pyramid Model to Community-Based Model Using a Variety of Urban and Rural Hospital Facilities

II. Build a New Teaching Hospital for OSU

III. Acquisition of TRMC

IV. Long-Term Lease of TRMC

V. Joint Venture or Partial Ownership of TRMC

VI. Academic Affiliation Agreement with TRMC

While each of the alternatives had its merits, most had significant drawbacks. Alternative I maintains and secures control and stability for the residency program at a relatively low financial cost, but the pyramid model has been recognized as a superior teaching model compared to the community-based model. Thus, implementing Alternative I potentially threatens the quality and attractiveness of the residency program itself. Alternatives II, III, IV and V are straightforward alternatives, whose main benefits are simplicity and stability. Alternatives II, III, and IV come at a significant financial cost to the State, and each exposes the State to equity risk. Alternative V is requires less upfront investment, but still carries equity risk. The market dynamics are highly unfavorable to a single hospital owner, with significant risk of losing the patient referral base. Thus the long-term viability of a new or existing stand-alone hospital is questionable. Money spent by the State secures bricks and mortar ownership for the State, but does not directly benefit the residency program.

Merrill Lynch's recommendation is for the State to pursue Alternative VI, an Academic Affiliation Agreement with TRMC. The AAA secures control and long-term stability for the program with reduced upfront costs to the State. The appropriated funds provide direct support to the residency program with no equity risk exposure to the State. The AAA keeps the pyramid model intact. While the AAA is a 50-year contractual arrangement subject to renewal, it is expected that the residency program and TRMC will mutually benefit from this type of partnership.

Appendix

Overview of Strategic Alternatives Summary

Alternative	Advantages	Disadvantages	Financial Cost
Change OSU Residency Program from Pyramid Model to Community-Based Model	■ Maintain OSU COM residency program ■ Secures control and provides stability ■ Limited cost to the State	■ Community-based model not favored by medical schools, residents, or applicants ■ Pyramid Model is an effective teaching model ■ Increased administrative complexity and cost	■ Limited to cost of re-organization for medical residency program
New Hospital Construction	■ Provides new teaching hospital and maintains preferred Pyramid Model for the residency program ■ Establishes a flagship hospital and permanent home for the residency program ■ Secures control and stability	■ Significant upfront cost to the State ■ Unfavorable market dynamics ■ Limited operating and financial leverage ■ Equity risk exposure for the State ■ National trends move in opposite direction ■ Residency slots tied to hospital provider number	■ Upfront investment of approximately $187.5-$250.0 million by the State to build a new hospital ■ Additional costs for new physician clinic and office space ■ Ongoing potential for additional appropriations from the State
Acquisition of TRMC	■ Maintains teaching hospital and Pyramid Model, leverages existing strengths ■ Establishes a flagship hospital and permanent home for the residency program ■ Secures control and stability ■ Feasible transaction structure	■ Significant upfront cost to the State ■ Age of facility; need for additional capital expenditures ■ Loss of operating and financial leverage ■ Potential loss of physician referral base ■ Equity risk exposure for the State ■ National trends move in opposite direction ■ Funds appropriated by State to acquire facility go to Owner/Shareholder	■ Upfront investment of approx. $125-$160 million by the State to acquire TRMC ■ Approximately $40 million in capital expenditures over next 5 years ■ Ongoing potential for additional appropriations from the State
Long-Term Lease of TRMC	■ Maintains teaching hospital and Pyramid Model, leverages existing strengths ■ Establishes a flagship hospital and a long-term solution for the residency program ■ Secures control and stability ■ Feasible transaction structure ■ Limited upfront cost to the State	■ Age of facility; need for additional capital expenditures ■ Loss of operating and financial leverage ■ Potential loss of physician referral base ■ Equity risk exposure for the State ■ Long-term lease subject to renewal ■ National trends move in opposite direction ■ Lease payments benefit Owner/Shareholder, not teaching program	■ No upfront investment by the State ■ Approximately $40 million in capital expenditures over next 5 years ■ Annual lease payment and capital and other expenditures funded in full or in part by cash flows from operations ■ Ongoing potential for additional appropriations from the State

Alternative	Advantages	Disadvantages	Financial Cost
80%/20% Joint Venture	■ Maintains teaching hospital and Pyramid Model, leverages existing strengths ■ Establishes a flagship hospital and permanent home for the residency program ■ Secures control and stability ■ Feasible transaction structure ■ Reduced upfront cost to the State ■ Continued operating and financial leverage	■ Funds appropriated by State to acquire facility go to Owner/Shareholder ■ Residency program would not benefit directly from the funds appropriated to purchase the equity stake in TRMC ■ Equity risk exposure to the State as JV partner ■ Age of facility; need for additional capital expenditures	■ Upfront investment by the State of approximately $25-$35 million to acquire 20% stake in TRMC ■ State responsible for pro rata share of capital expenditures over next 5 years or face dilution ■ Ongoing potential for additional appropriations from the State ■ Potential for equity dilution if capital call unmet
Academic Affiliation Agreement	■ Maintains teaching hospital and Pyramid Model, leverages existing strengths ■ Establishes a flagship hospital and long-term solution for the residency program ■ Secures control and stability ■ Feasible transaction structure ■ Reduced upfront cost to the State ■ Appropriated funds provide direct support to the residency program ■ No equity risk exposure for the State ■ Continued operating and financial leverage	■ Academic Affiliation Agreement is a contractual arrangement that is subject to renewal ■ Age of facility; need for additional capital expenditures	■ Upfront investment by the State of approximately $40 million, which will go toward capital and other expenditures that directly support the residency program at TRMC

I. Valuation of Tulsa Regional Medical Center

There are several generally accepted valuation methodologies used to approximate fair market value for healthcare operations. These include Comparable Transaction Analysis, Comparable Company Analysis, and Discounted Cash Flow Analysis. The following sections discuss each in greater detail.

Comparable Transaction Analysis

Comparable Transaction Analysis consists of a review of the transaction value multiples of relevant historical transactions. For the valuation of TRMC, we evaluated the transactions that met the following criteria:

1) Geography: U.S. hospital transactions only
2) Size: Minimum of 100 beds
3) Value: Transaction value of at least $50 million
4) Date: January 2003 to Present

We analyzed transactions that met these criteria, and for transactions where sufficient information was available, estimated transaction valuation multiples. The most common multiples reviewed for comparable transaction analysis for hospital mergers and acquisitions are transaction value as a multiple of revenue and transaction value as a multiple of earnings before interest, taxes, depreciation and amortization ("EBITDA"). The table below summarizes the results of the comparable company analysis. A detailed list of comparable transactions can be found in Section II of the Appendix.

Summary of Comparable Transaction Analysis Valuation Range

Transaction Value as a Multiple of:	
Revenue	**EBITDA**
0.70x – 0.90x	7.0x – 9.0x

Comparable Company Analysis

Comparable Company Analysis consists of a review of the trading valuation multiples of publicly-traded companies. The appropriate universe of companies to analyze for the purposes of valuing TRMC is the universe of publicly-traded hospital management companies in the U.S. Currently, there are seven primary publicly-traded hospital management companies: HCA, Tenet Healthcare, Triad Hospitals, Universal Health Services, Health Management Associates, Community Health Systems and LifePoint Hospitals. For Comparable Company Analysis of publicly-traded hospital management companies, the most common multiple used for valuation purposes is Market Capitalization (which is defined as the market value of the equity plus net debt and minority interest) as a multiple of projected future EBITDA. The table below summarizes the results of the Comparable Company Analysis. A detailed list of valuation multiples for each company can be found in Section II of the Appendix.

Summary of Comparable Company Analysis Valuation Range

Market Capitalization as a Multiple of EBITDA	
2006E	**2007E**
7.0x – 8.0x	6.5x – 7.5x

Discounted Cash Flow Analysis

Discounted Cash Flow ("DCF") Analysis consists of projecting the future free cash flows of the company and then discounting them to their present value using a weighted average cost of capital ("WACC") that reflects the return investors expect to earn given the risk of the investment.

For our DCF analysis, we projected EBITDA and free cash flow for TRMC for the next five years using conservative assumptions for revenue growth rate, operating income margins, and management's estimate for future capital expenditure requirements, and calculated a terminal value based on an exit multiple of EBITDA in Year 5. Projected cash flows and the terminal value were discounted to present value using a WACC that was an average of the WACCs for the seven publicly-traded hospital management companies, adjusted to reflect the higher risk of TRMC, which is a single hospital with significantly more risk than a large, public company with a well-diversified portfolio of hospitals. The table below summarizes the assumptions used in the DCF analysis. A detailed review of the DCF analysis can be found in Section II of the Appendix.

Summary of Discounted Cash Flow Analysis Assumptions

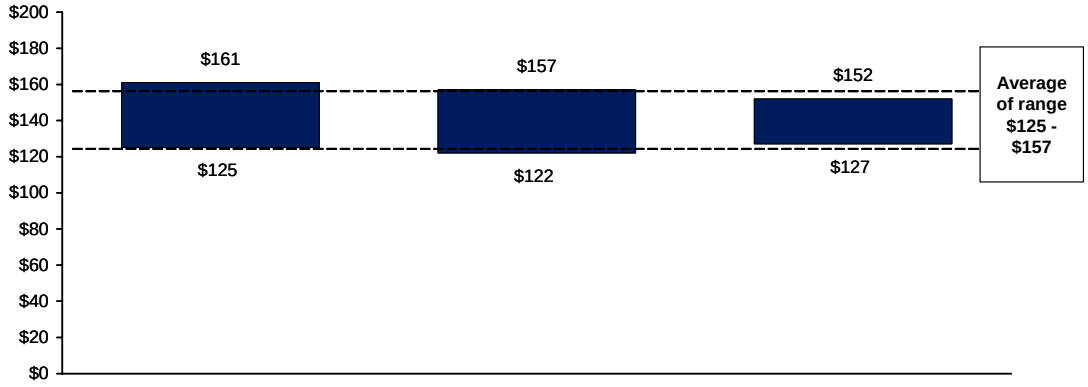
Discounted Range	Terminal Value Multiple Range
12.0% – 14.0%	7.0x – 9.0x 2010E EBITDA

Valuation Summary

Using Comparable Transaction Analysis, Comparable Company Analysis, and DCF Analysis, we determined the ranges of relevant valuation multiples and applied them to the appropriate TRMC metrics to calculate a value range for TRMC. Using this approach, the resulting value range for TRMC was $122 million on the low end to $161 million on the high end. Taking the average of low- and high-end values, we estimate the value of TRMC to be $125-$157 million.

Having set the lower and upper bounds on the value of TRMC based on this approach, we then performed a qualitative review of value drivers to more accurately reflect the value of TRMC (see Section III of the Appendix). Based on this qualitative review, we believe TRMC should be valued in the lower end of the $125-$157 million valuation range. The chart below presents a graphic summary our valuation analysis.

Valuation Summary
(Dollars in Millions)



Methodology	Comparable Transaction Analysis & Comparable Company Analysis		DCF Analysis
Metric	**LTM Jan-06 Total Revenue**	**LTM Jan-06 EBITDA**	**N/A**
Valuation Range	0.70x – 0.90x	7.0x – 9.0x	7.0x – 9.0x 2010E EBITDA; WACC: 12.0% – 14.0%
Statistics	$179	$17.5	N/A

II. Valuation Data

Comparable Transaction Analysis
(Dollars in Millions)

Date	Target	State	Acquirer	Purchase Price	Beds	Revenue	Purchase Price to: Beds	Purchase Price to: Revenue
10/24/05	3 Triad Hospitals	Texas	Signature Hospital Company	$75.0	355	$104.2	211,268	0.72x
07/28/05	Five rural hospitals (HCA)	TN/LA/WA/OK	Capella Healthcare	260.0	783	279.1	332,056	0.93x
07/27/05	Thomas Hospital	Alabama	Gulf Health Hospitals	69.0	124	88.5	556,452	0.78x
07/14/05	Five rural hospitals (HCA)	VA/WV	LifePoint Hospitals	286.0	1,117	375.5	256,043	0.76x
06/30/05	Bradley Memorial Hospital	Tennessee	Community Health Systems	76.5	174	72.6	439,655	1.05x
05/09/05	Danville Regional Medical Center	Virginia	LifePoint Hospitals	229.3	350	180.0	655,143	1.27x
04/22/05	Medi-Partenaires (UHS)	France	Barclays Private Equity	346.1	674	218.0	513,526	1.59x
02/07/05	San Pablo Hospitals (UHS)	Puerto Rico	Centro Medico/HIMA	120.0	610	N/A	196,721	N/A
12/10/04	Deaconess Hospital	Oklahoma	Triad Hospitals	145.0	313	145.0	463,259	1.00x
11/10/04	Hollywood Presbyterian Medical Center (Tenet)	California	CHA Medical Group	69.0	434	136.7	158,986	0.50x
10/12/04	St. Vincent//MetroWest Medical Center (Tenet)	Massachusetts	Vanguard Health System	126.7	768	353.2	164,974	0.36x
09/30/04	4 Orange County Hospitals (Tenet)	California	Integrated Healthcare Holdings	72.0	760	350.0	94,737	0.21x
08/16/04	Province Healthcare	N/A	Lifepoint Hospitals	1,716.0	2,772	866.7	619,048	1.98x
08/11/04	3 Hospitals (Bon Secours)	Florida	Health Management Assoicates	279.0	657	195.0	424,658	1.43x
07/29/04	Spanish operations	Texas	Mercapital	190.0	875	147.1	217,143	1.29x
07/23/04	Vanguard Health System	Tennessee	Blackstone	1,781.6	3,666	1,716.5	485,979	1.04x
07/19/04	Four Acute Care Hospitals in L.A. area (Tenet)	California	AHMC, Inc.	100.0	609	286.0	164,204	0.35x
05/28/04	Centro Medico Teknon (Tenet)	Spain	General Healthcare Corp.	85.4	257	N/A	332,296	N/A
05/20/04	Memorial Medical Center	New Mexico	Province Healthcare Company	152.8	286	144.0	534,266	1.06x
05/17/04	Brownsville Medical Center (Tenet)	Texas	Valley Baptist Health System	82.0	243	N/A	337,449	N/A
05/11/04	HillCrest Healthcare System	Oklahoma	Ardent Health Services	281.2	N/A	543.0	N/A	0.52x
05/05/04	IASIS Healthcare	Tennessee	Texas Pacific Group	1,328.7	2,257	1,088.0	588,702	1.22x
05/03/04	5 Behavioral Health Facilities	GA/CO	Universal Health Systems	105.0	406	120.0	258,621	0.88x
04/16/04	Redding Medical Center (Tenet Healthcare)	California	Hospital Partners of America	55.0	246	N/A	223,577	N/A
04/15/04	Phoenixville Hospital	Pennsylvania	Community Health Systems	104.0	143	100.0	727,273	1.04x
03/10/04	Overland Park Regional/Indedpence Regional	KS/MO	HCA	136.0	726	188.0	187,328	0.72x
12/17/03	Greater SE Community Hospital (4 facilities)	Washington D.C.	Doctors Community Healthcare	151.0	980	N/A	154,100	N/A
10/01/03	Vista Health System (3 hospitals)	California	Universal Health Services	122.0	405	160.0	301,235	0.76x
09/03/03	Pendleton Mem. Methodist Hospital (90%)	Louisiana	Universal Health Services	108.0	306	120.0	352,941	0.90x
09/02/03	Four Tenet Healthcare Facilities	Arkansas	Triad Hospitals	176.0	633	250.0	278,041	0.70x
09/01/03	Mercy Hospital	Illinois	Three organizations	50.0	368	162.6	135,870	0.31x
08/25/03	Five Tenet Healthcare Facilities	FL/MO/TN	Health Management Associates	515.0	1,061	400.0	485,391	1.29x
08/08/03	HealthSouth Doctors' Hospital	Florida	Baptist Health South Florida	115.0	281	212.5	409,253	0.54x
08/07/03	North Central Health Services (50%)	Indiana	Sisters of St. Francis Health	130.0	485	210.0	268,041	0.62x
06/01/03	Mercy Health Center	Texas	Community Health Systems	131.0	326	160.0	401,840	0.82x
05/09/03	Pottstown Mem. Medical Center	Pennsylvania	Community Health Systems	87.0	299	120.0	290,970	0.73x
03/20/03	Two Providence Health hospitals	Washington	Health Management Associates	112.5	289	125.0	389,273	0.90x
01/14/03	Southside Regional Hospital	Virginia	Community Health Systems	92.0	408	110.0	225,490	0.84x
						Trim Mean	**$343,251**	**0.87x**
						Median	**332,056**	**0.84x**

There are a limited number of transactions with publicly available EBITDA figures. There were three $1.0+ billion transactions in 2004 with published EBITDA figures. The transactions include:

- Blackstone Group's acquisition of Vanguard Health Systems in July 2004 for $1.75 billion, a 9.0x multiple of 2004E EBITDA
- LifePoint Hospitals' acquisition of Province Healthcare in August 2004 for $1.70 billion, a 11.1x multiple of 2004E EBITDA
- Texas Pacific Group's acquisition of IASIS Healthcare in May 2004 for $1.40 billion, a 7.6x multiple of 2004E EBITDA.

Given that any transaction with TRMC would be a single-facility transaction, the multiples for these transactions are less relevant than those of more comparable sized transactions.

Comparable Company Analysis

(Dollars in Millions, Except Per Share Amounts)

Company	Close on 4/24/06	% of 52 wk Week High	Market Value [1]	Market Cap. [2]	Market Cap/EBITDA [3] 2006E	Market Cap/EBITDA [3] 2007E	P/E [4] 2006E	P/E [4] 2007E	5-Yr. EPS Growth Rate [4]	P/E/G 2007E
Urban Providers										
HCA	$46.04	78.6%	$20,096	$30,903	7.0x	6.3x	14.3x	12.6x	11.6%	1.23x
Tenet Healthcare *	8.61	65.9%	4,042	7,365	10.3x	8.6x	NA	NA	10.5%	NA
Triad Hospitals	42.64	75.9%	3,807	5,301	7.1x	6.4x	14.8x	13.2x	13.8%	1.08x
Universal Health Services	50.73	79.6%	3,180	3,492	7.3x	6.6x	19.3x	17.0x	12.8%	1.51x
				Mean	**7.1x**	**6.5x**	**16.1x**	**14.3x**	**12.7%**	**1.27x**
				Median	**7.1x**	**6.4x**	**14.8x**	**13.2x**	**12.8%**	**1.23x**
Rural Providers										
Health Management Assoc.	$21.05	78.9%	$5,155	$6,123	7.5x	6.8x	13.7x	12.1x	13.7%	1.00x
Community Health	37.47	92.0%	3,775	5,113	8.0x	7.0x	17.2x	14.8x	16.0%	1.07x
LifePoint Hospitals	29.66	57.5%	1,719	3,246	7.3x	6.8x	13.3x	11.7x	14.5%	0.92x
				Mean	**7.6x**	**6.9x**	**14.7x**	**12.9x**	**14.7%**	**1.00x**
				Median	**7.5x**	**6.8x**	**13.7x**	**12.1x**	**14.5%**	**1.00x**
Urban & Rural Companies				**Mean**	**7.4x**	**6.7x**	**15.4x**	**13.6x**	**13.7%**	**1.13x**
				Median	**7.3x**	**6.7x**	**14.5x**	**12.9x**	**13.7%**	**1.07x**

** Excluded from summary statistics.*

(1) Treasury Stock Method.

(2) Market Capitalization = Market Value + Debt + Preferred Stock + Minority Interest.

(3) Source: Merrill Lynch and Wall Street research; includes investment income.

(4) Source: EPS estimates and Growth Rate estimates from Merrill Lynch and Wall Street research.

Discounted Cash Flow Analysis
(Dollars in Millions)

	Year ended December 31,				
	2006	**2007**	**2008**	**2009**	**2010**
Total Net Revenue	$193.8	$203.5	$213.7	$224.4	$235.6
EBITDA	$20.0	$21.4	$22.9	$24.5	$26.2
EBIT	$14.2	$15.1	$16.0	$17.1	$18.1
Taxes @ 35.0%	(5.0)	(5.3)	(5.6)	(6.0)	(6.3)
Tax Affected EBIT	9.2	9.8	10.4	11.1	11.8
Depreciation and amortization	5.8	6.3	6.8	7.4	8.0
Capex: Routine	(4.0)	(4.0)	(4.3)	(0.5)	(0.5)
Capex: Facility Needs/Special Projects	(8.0)	(6.5)	(2.3)	(5.8)	(5.8)
Change in Net Working Capital	(1.5)	(0.7)	(0.8)	(0.8)	(0.8)
Free Cash Flow	**1.5**	**4.9**	**10.0**	**11.4**	**12.7**
Growth Rates					
Total Net Revenue	*10.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Margins					
EBIT	*7.3%*	*7.4%*	*7.5%*	*7.6%*	*7.7%*
Depreciation and amortization	*3.0%*	*3.1%*	*3.2%*	*3.3%*	*3.4%*
Net Working Capital	$14.5	$15.3	$16.0	$16.8	$17.7
NWC as a % of Total Revenue	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*

	Discounted Cash Flows	PV of Terminal Value as a Multiple of 2010E EBITDA			Firm Value		
Discount Rate	(2006-2010)	7.0x	8.0x	9.0x	7.0x	8.0x	9.0x
12.0%	$26.9	$103.9	$118.7	$133.6	$130.7	$145.6	$160.4
12.5%	26.4	101.6	116.1	130.6	128.0	142.5	157.1
13.0%	26.0	99.4	113.6	127.8	125.4	139.6	153.8
13.5%	25.6	97.2	111.1	125.0	122.8	136.7	150.6
14.0%	25.2	95.1	108.7	122.3	120.3	133.9	147.5

III. Summary Discussion of Qualitative Review

Factors considered in the qualitative review of TRMC included: financial performance, age of facility, nature of competitive marketplace, sources of patient admissions, and type of facility (urban or rural). A summary discussion of the factors influencing value follows.

Financial Performance – TRMC Generates a Significant Amount of EBITDA.

Despite operating in a highly competitive marketplace, TRMC has been able to maintain healthy EBITDA margins and cash flow. The hospital generated $17.8 million in EBITDA in FY2005 with an EBITDA margin of 10.1%. For FY2006, Ardent estimates EBITDA will improve to $20.0 million with an EBITDA margin of 11.0%. In the past few years, a significant number of hospital transactions involved hospitals that were struggling and had limited cash flow. In the instances where transactions involved hospitals that generated a material amount of EBITDA, transaction multiples were at the upper end of the range, reflecting the premium buyers were willing to pay for hospitals with strong financial performance.

Aging Facility – Significant Capital Expenditures over the Next Five Years

TRMC was built in 1954 and is expected to require approximately $40 million in capital expenditures over the next five years in order to remain competitive. Saint Francis Health System and St. John Health System, its two primary competitors have significantly newer facilities.

OSU Physicians Responsible for Approximately 55% of Patient Admissions

OSU physicians are responsible for approximately 55% of patient admissions at TRMC. If OSU physicians were to alter their admissions patterns, a significant amount of TRMC admissions and revenue would be at risk.

Hillcrest Medical Group Responsible for 25% of Inpatient Referrals to TRMC

Physicians groups that are affiliated or owned by Hillcrest Medical Center are responsible for approximately 25% of patient referrals to TRMC. If Ardent is no longer involved in the operations of TRMC, the hospital runs the risk of losing a significant revenue source.

Urban Hospitals Typically Trade at a Discount to Rural Hospitals

Urban hospitals typically operate in highly competitive environments and have limited pricing power. For that and a number of other reasons, urban hospitals usually trade at a discount to rural hospitals, which tend to operate in less competitive markets. The publicly-traded hospital management companies with primarily urban hospitals (HCA, Tenet, Triad, UHS) have historically traded 0.5x–1.0x less than rural hospital management companies (HMA, Community, LifePoint) on an EBITDA multiple basis.

Conclusion

While TRMC generates a significant amount of cash flow, there is a significant amount of risk involved in a potential acquisition of TRMC; therefore, the facility would be valued in the lower end of the $125-$160 million valuation range.