Analysis of Politics & Data: Why You Should NOT Buy Hospitals

Lowering THC to UnderPerform on Valuation, $13PT

Summary

When the right answer to the question, "What will happen to the ACA, Medicaid and Medicare?' is we don't and can't know, we see it as dangerous ground for investing. To explain, we explore how the GOP can eliminate the 60 vote rule, jam repeal without replace and get Medicaid block grants and Medicare premium support/privatization through Congress in a very big hurry. We use a custom AHD dataset and our companies' data to show the impact of reform, but also a more disturbing and continued downward trend in volumes and EBITDA that would make us worry about hospitals absent the Trump Triumph. Finally, we show that as bad as repeal would be, a shift to 'Caid mgd care and Medicare Advantage would have a much more severe negative impact on EBITDA. THC trades at a premium to HCA, which seems inappropriate given FCF and risks: we retain our other ratings/PTs, but lower THC to Underperform, $13PT.

Company	Symbol	Price (11/21)	Rating Prior	Rating Curr	PT
Community Health Systems, Inc.	CYH	$5.81	–	U-P	$3.00
HCA Holdings, Inc.	HCA	$72.94	–	Neutral	$78.00
LifePoint Health, Inc.	LPNT	$57.45	–	Neutral	$50.00
Quorum Health Corp	QHC	$7.05	–	Neutral	$3.00
Tenet Healthcare Corp.	THC	$17.01	Neutral	U-P	$13.00

Source: Bloomberg and Mizuho Securities USA

Key Points

Even though we don't and can't know what will happen to health policy, we believe that we can help investors to understand the politics and process that could unfold from here, and give investors things to watch for and worry about: Congress can do anything it wants to on the first day, and if we led the GOP, we'd reset cloture at a simple majority and jam legislation through the Senate as fast as we could. Otherwise, the GOP risks becoming Obama-like and frittering away any political momentum and capital it has and may not be able to push repeal or replace through. SO WATCH FOR A VOTE ON THE FILIBUSTER RULE, IF IT GOES, REPEAL ALONE MAY HAPPEN.

We think investors are *missing the bigger picture: Medicaid Block grants that shift to mgd care and Medicare privatization are far more dangerous for hospitals than the loss of the ACA.* We estimate that there is a 48% reduction in rev per admit between the 'Caids and 17% decline from FFS 'Care to MA for HCA using its own data. WATCH FOR BLOCK GRANTS AND PREMIUM SUPPORT and sell if they are enacted.

But the AHD data & hospitals' own ER visit volumes showed a more disturbing sharp downward trend. In our view, fee-for-value patient-centered care only augments this trend and won't go away even if there's full repeal. THIS is what should worry hospital investors the most: no matter what happens with the ACA, hospitals are emptying out - and hospital investing is always and ever about the volumes.

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A Reader's Guide

This is Not 'Normal'

In the days since the election, this analyst has been greatly disturbed by a number of things that have happened, but for the purpose of this report, she'll concern herself with only those issues that affect investment decisions in health care and particular for the nine health care stocks she covers. It is impossible for this analyst to cover health care without also covering and understanding politics. Washington has been infamous for dealing the sector 'exogenous whacks' that create tidal waves of change in the industry from time to time. We're not exaggerating: the BBA'97 mandate to move from cost-plus reimbursement to prospective payment, coupled with the actions of managements led directly to the bankruptcy of most of the publicly traded subacute/SNF companies. We saw that coming in a report in January 1998 (Atlas Shrugged, Part I). We are sounding that same kind of warning again, but this time for the entire sector.

What's troubling us is that investors are, once again, assuming that they know what will happen when it is fundamentally impossible to know. There are broad assumptions being made like, "they won't let 20 million people go without coverage," or "they'll keep value-based care," or "Medicaid block grants could be positive for…" or "they'll privatize Medicare and that's good for managed care stocks."

Ask why those views are held, what factual basis there is for holding those positions and *the answer comes back exactly the same way every time, from both investors and the management teams of the companies they are buying*:

> "We really don't *know."*
>
> "We really have no way of *knowing.*"

To us, that's just dangerous. It's just asking for another exogenous whack to the portfolio performance, in our view.

We understand why investors have bid up hospitals, managed care and other providers since the morning after: because it's our job to take positions, because we're used to political cycles in which there is a distribution of potential outcomes with a well-defined mean and shape, and because the worst case is nearly impossible to believe under normal circumstances, much less by a fundamentally optimistic stock market. And, stock charts and history tells us that buying these sharp declines in health care stocks is 'normally' the right thing to do.

But if there is one clear point that is evident from this election cycle it's this*: This situation is NOT NORMAL. Anything could happen and anything that COULD happen would be bad for hospitals – and we show why in this report. And that makes the current bullish move very wrong, in our view.* The rules of engagement have been violated: there is no 'GOP' health care platform and there is little informed debate on the subject as yet. We have a President-elect who defied all norms of accepted political behavior and won on a platform of changing Washington

and America and who is not exactly a consensus builder (not even with voters as he lost the popular vote).

What we've seen here is akin, in our view, to introducing an element of chaos into the nice normal distribution of potential political outcomes that we are used to seeing in the aftermath of great political change. There is no normal distribution now because there is no mean or most likely outcome.

Who can say for sure that the Ryan plan (A Better Way) should be the mean? Who can say that the Trump transition sites' bare bones outline is the mean? Who can say that the Cloture rule requiring 60 votes to end a filibuster and call a vote for passage of legislation in the Senate won't change on opening day? Who can say that there will be Medicaid block grants and/or what the level of spending will be? Who can say that the GOP won't cut Medicare or move to a premium support model that creates millions of uninsured 85 year olds?

No one.

Not a single one of us.

Not companies, not investors, not politicians, not analysts.

No one.

With no political rules, no normal platform around which we as investors can coalesce, how can we invest the sector?

- By remembering the rules for hospital's success and hoping they still hold,
- By identifying endpoints even if the shape of the distributions of outcomes is unknown and hoping that the worst case has a low probability of occurring,
- By understanding the implications of each potential outcome, few of which are good, but some of which are at least interesting,
- By then valuing the companies using some view of appropriate discounts to multiples….

…we hope to at least put some rules around a fundamentally unknowable situation and thereby mitigate the risk of investing in the sector. We do this because we understand that health care investors may simply not be able to do what we really think they should do….and that is to just walk away.

Fundamental Rules of Health Care Investing… Skolnick's Rules Still Hold

The first rule: Methodology change is more dangerous to health care companies and stocks than price change – and volumes always matter.

The second rule is this: With great change comes great opportunity…eventually… and we'll add this…not only to the 'long side' of investing.

A third rule: Congress makes the rules…it can do pretty much anything that it has the votes to do.

And that's where will start.

What Can Congress Do? And What Would We Do If We Were Running the GOP Process?

Here's the point: investors are fundamentally assuming that changing the ACA in any way will take a long time or will be difficult to do. The underlying reason for this is that the GOP doesn't have 60 votes in the Senate. So presumably the Democrats could filibuster or otherwise put up a fuss and somehow prevent the evisceration or repeal of the ACA.

Not quite true.

The Majority Senate Party Can Change the Rules on Day 1: Watch for Repeal of the Filibuster/60 Vote Rule

The first test of whether the GOP really has the guts to fully repeal or even repeal/replace the ACA will come on the first day of the new session of Congress in January. That's the day on which the rules say that the incoming leadership can change the Senate rules. The 60 vote rule is formally called 'cloture' and was amended from 67 votes (actually 2/3rds) in 1975, i.e., the Senate reduced the number of votes needed to end a filibuster from 67 to 60 at that time (and under a Democratic majority). So long as there was a Democrat in the White House, it really didn't hurt the GOP to have it in place because of the President's veto. On the other hand, with the Democrats in power, the 60 vote rule made it nearly impossible for the Senate to pass legislation, even when the Dems theoretically had 60 votes in 2009. It did take nearly 18 months in power before the Democrats could even get the ACA passed (because of infighting) and even then it lost the 60th vote and had to use the 'nuclear option' of reconciliation. But for most of that time, the 60 vote rule served the GOP well.

- Now the shoe is on the other foot and the GOP would be smart to take a lesson from the Democrats, i.e., not do what they did: the surest way to pass

repeal or repeal replace would be to get rid of the 60 vote/filibuster rule and implement a simple majority cloture rule. The GOP plays to win, and the stakes will never be more in their favor to jam through their platform (so long as it is acceptable to Donald Trump) than now, at least in this analyst's view.

- Note that the GOP might only have to deal with the easier Cloture vote for two years. If the GOP retains the Senate in the next midterms, it could put the 60 vote threshold back in place. And if the Dems win the Senate in the midterm, they'd still want to prevent easy passage of legislation, especially if their majority is slim, so they might put it back in place.

It remains to be seen whether this would be done as at least a couple of GOP senators have come out strongly against eliminating the filibuster rule: Lindsay Graham and Orrin Hatch. Point being, of course, that the GOP has been in the minority more than in the majority and it likes the notion of being able to fully debate and prevent legislation with which it disagrees from being voted upon.

But that's just two voices.

- **IF the GOP gets rid of the 60 vote rule on day one, that is NOT GOOD NEWS for hospitals and the uninsured.**

- **IF the GOP doesn't get rid of the 60 vote rule, then complete repeal will be more difficult, but still not impossible: there are several pieces of must-pass legislation that could force the Democrats' hands.**

Assuming 60 Votes are Still Required, Does the GOP Get Rid of the ACA Sooner or Later? If the GOP Wants the ACA Gone, It Needs to Do It FIRST, Not Last…

Much of the discussion we've read and conversations we've had has been around the timing of when/if Congress could act. Some are on the side of 'it will take a while to repeal/replace,' while others aren't so sure. But for now, the 'it will take a while' side seems to be dominating the investor conversations. That's okay if the GOP gets rid of the 60 vote/filibuster rule because it's a whole lot easier for a party to coalesce around an idea needing 51 votes than 60.

- But watch the right wing of the House. Some of the most conservative GOP members are pushing for immediate repeal. Several of them have been quoted as demanding full repeal immediately, with replacement later.

- From their perspective, we have to say that we think those voices are strategically correct.

- Frankly, we think ACA repeal comes *first* and *replace comes later.*

Not that we want to give the new Congress and administration any advice, but…we'll make an observation using a little history of the ACA to illustrate why we think that the GOP should aggressively pursue repeal immediately if it wants to get it done:

> When Obama was elected in 2008 and took office, he made two strategic mistakes in our view, one that has left us in the situation we're in with the ACA (both in terms of uncertainty about its future and the structure of the law itself).
>
> Mistake #1: Taking too long.
>
> Mistake #2: Allowing Congress the freedom to decide what health reform should look like instead of leading with a clear plan.
>
> The Obama process started off well, with the then-new President calling together both Democratic and GOP Congressional leadership to tell them in no uncertain terms that he wanted health reform done. That's about when the good part ended. After that, the Senate and the House went their separate ways, with House Democrats fighting over single payer versus a private solution and the Senate Finance Committee struggling to please enough people to retain the 60 votes. Even when they had the power, the Dems frittered it away. It took the Senate Finance Committee months to come up with the disaster that the exchanges have become (for the record, we're not a fan of them and never believed the mandate was strong enough to work). Months went by with no progress. Then Senator Ted Kennedy passed away and his seat was taken by Republican Scott Brown. There went the 60th vote.

They took too long. There was no clear plan, i.e., Obama didn't say, 'here's what it needs to look like – write the language and get it done, now.'

Somehow, we don't see Donald Trump making that mistake.

To be clear, the message is this:

- **In our view, if the GOP truly wants to get repeal and/or repeal/replace done, then it needs to be the *first* item on the agenda.**
- **If the GOP truly wants to REPEAL then it has to get rid of the 60 Vote Cloture Rule. Otherwise, the best the GOP can do is reconciliation, which can only partially repeal the ACA (the money part).**
- **The mandate from the Trump White House needs to be VERY clear. And Congress needs to feel the pressure from Trump's political capital and get it done.**
- **Otherwise, the longer it takes, history tells us that the less likely it is that full repeal or repeal/replace gets done. Give our legislators time to argue**

and they will. That's one of the few things we can still count on in the rules of politics.

We can only hope that the Trump administration doesn't read this report. We think we're okay on that.

Assuming 60 Votes are Still Required…What Vehicles Could the GOP Use to Pass Repeal and/or Replace?

The key to the strategy here will be passing legislation in the House regarding programs that are viewed as essential by the Democrats.

- A quick budget referendum: the GOP failed to get a budget passed last year and the government has been operating on continuing resolutions for some time. The next expiration of the latest continuing resolution in is mid-March 2017, so putting a budget in place that spans the first 100 days would be important – even if it's only another short-term deal.

- Again, getting rid of the 60 Vote Rule would make this abundantly easy – repeal along with the budget, with replacement to come later (and thus creating either a kick-can-down-road scenario or a make-or-break situation that forces the Dems to vote for any replacement that's even remotely tolerable).

- Or, because the GOP was smart (or lucky) in that it only agreed to a two-year extension of CHIP, the popular and nearly-bipartisan children's health insurance program that covers millions of poor kids, CHIP reauthorization could be the must-pass carrier for repeal/replace or some variety thereof.

    - The program sunsets at the end of fiscal 2017 – 9/30/17 – unless Congress acts to reinstate it.

    - Never mind that it was originally a Hillary Clinton/GOP bipartisan idea – we think the GOP could use it to force the Democrats to accept a repeal/replace/de-fund addendum.

- In addition, the delays of the medical device manufacturers' tax and the tax on managed care that were pay-fors for the ACA also sunset soon. The device tax was suspended for two years in legislation signed by President Obama on 12/18/15. The managed care tax was suspended for one year in March 2016.

Both of those items would, of course, be eliminated in full repeal, but the CHIP reauthorization is separate. So watch for discussion of the budget and CHIP in the new Congress.

The Most Obvious Strategy: Use the Budget or CHIP to Force a Vote, Then Reconciliation Repeals/De-Funds the ACA

If the GOP lets the budget issue ride until March, the CHIP would become the carrier must-pass legislation. Assuming the Dems have to vote for CHIP, the GOP House would pass a CHIP reauthorization, the Senate would be forced to vote for it. Meanwhile, the GOP House passes a repeal/replace bill of some design. Then the Senate leadership takes that bill and shoves the House repeal into the CHIP reauthorization bill as an amendment, on which only a majority vote is required. Of course, this is easier if the Cloture rule is amended to require only a majority to end a filibuster, but as this was how the Dems essentially got the ACA passed, we'd think that the GOP would be able to do the same thing.

De-funding the ACA is Probably Easier and Maybe Comes Earlier than Full Repeal

There's a funny little thing that most folks forget about the ACA that actually bears remembering: the ACA is non-severable. One can't repeal it in part, at least theoretically, but rather must do it 'in-whole' without risking a court challenge by the Dems (assuming the Dems have their acts together at all on this issue). But there are parts of the ACA that required Congress to fund it annually or periodically that made it vulnerable. That's in part why the risk protections for insurers failed (the other part was a really bad formula). So the GOP could do this again, this time taking full aim at the subsidies for buying insurance on the exchanges and for out of pocket costs for the very poor. (Gee, if we didn't know better, we'd think the GOP had something against poor people.)

Again, the issue is the Senate and Cloture. Reconciliation via must-pass legislation would work here too.

Repeal Without Replace: How the GOP Can Force the Dem's Hand to Get a GOP Replacement (and lots of other things) Through without Compromise

Again risking informing the GOP about a potential strategy that might work to achieve its purported repeal goal, we'll offer another thought.

If we were really to play political hardball, here's what we'd do:

Get the House to pass a full repeal bill that sets a deadline of Jan 1, 2018 or sooner. Pass it via reconciliation and get it signed.

That forces the Dems to cooperate with the GOP to pass a replacement bill real, right quick, i.e., so that the replacement takes effect by Jan 1, 2018.

Presumably, the Dems couldn't risk not replacing it with something, even if that something leads to a nearly complete reversal of the coverage expansion. And by the way, this is also how the GOP could shove Medicaid block grants, premium

support/privatization of Medicare and other unpalatable ideas to the Dems through the Senate.

It remains to be seen whether the GOP is willing to take the risk that it gets repeal done, but no replacement. Of course, press quotes about GOP voters not caring whether they lose their coverage or not may empower the party to take that risk.

Might Nothing Happen?

Veterans of political wars and Congress (same difference?) have often told us that it is much harder to be the party in leadership than in the minority. What surprised us was that it was ex-Republican staffers who told us this – it's surprising because the GOP generally has seemed to be better able to a) have an agenda; b) demand and hold loyalty to the party line; and therefore c) pass legislation even if it is later vetoed.

So might nothing happen? Sure. But it would be a more realistic possibility if the Dems were in leadership than with the GOP.

But the point is that we have to go back to the beginning: the right answer is, 'we don't know.'

Quantifying the Impact of Repeal and Trump's Repeal/Replace

It would be comfortable and convenient if the Ryan plan (www.betterway.gop) were the likely replacement for the ACA. It's a consensus plan developed by interested GOP legislators and it's at least a somewhat complete replacement plan. But as recent press reports have pointed out, there are many plans being discussed or that have been sponsored by GOP legislators and there is only one 'plan' on the transition site for the incoming administration. Indeed, we think the only one that we can rely upon as reflecting what the President-elect believes is the one on the transition website.

The RAND Corporation recently released its assessment of the impact on the number of uninsured of the Trump plan. It was reproduced in part in a recent Wall Street Journal article. See the original Rand posting here. The entire study was funded by The Commonwealth Fund and it is available here.

The authors of the study used the following as the 'Trump plan.'

1. Full repeal, no replacement.
2. Health insurance premiums become fully tax deductible.
3. Converting Medicaid to block grants.
4. Allowing sale of health insurance across state lines.

The authors then looked at the impact on the deficit and the number of uninsured as a result of implementing these policies, with the changes measured relative to baseline.

Baseline was defined as 251.6 million insured in the US in calendar 2018.

Exhibit 1: Rand Corporation Estimates of Trump Plan Impact

Table 1. Impact of proposed policies relative to the Affordable Care Act, 2018

	Number of insured (millions)	Federal deficit (billions $)
Trump plan		
Repeal ACA	-19.7	+33.1
Repeal ACA + tax deduction for premiums	-15.6	+41.0
Repeal ACA + Medicaid becomes block grant	-25.1	+0.5
Repeal ACA + allow insurers to sell across state line	-17.5	+33.7
Repeal ACA + other policies combined	-20.3	+5.8

Source: Company reports and Mizuho Securities USA estimates

Studying the Deltas in the RAND Study Tells Us Just How Bad it Could Be

Repealing the ACA only: RAND estimates that 19.7mm would lose coverage and raise the deficit by $33.1B (remember, the ACA had cuts that 'paid for' the increase in coverage). In addition, RAND estimates that out of pocket costs would be $4,700 in the individual insurance market (per Commonwealth fund site). Do we need to note that this is worst case scenario? Probably not.

But the worst case under repeal is not as bad as 'losing everyone' becomes some were previously insured. As the hospital companies have pointed out, some percentage (40% to 50%) of those coming in with exchange coverage were previously seen at the hospital with some sort of insurance coverage. Indeed, even the CMS data supports this notion: about 75% of the enrollees in Obamacare this year are renewing policies and only 25% are purchasing new coverage. In 2014, a widely-cited McKinsey study found that 74% of those who enrolled through the exchanges were previously insured. The combination of those two data points strongly suggests that the worst case isn't full loss of insurance for all covered by the ACA and being seen in our covered companies' hospitals.

But what's really troubling here in the context of both hospital and managed care stocks is the RAND estimate for Repeal plus Medicaid Block Grants. That's a reduction of 25.1mm covered lives, more than the number currently covered by 'reform' and, by the way, a net delta from repeal-alone of a $32.6B reduction in the deficit. As there is no difference to the repeal-alone individual market assumption, the out of pocket costs would remain at $4,700 per person in that market.

In other words, RAND is telling us that Medicaid block grants will CUT government spending in 2018 relative to repeal alone and is effectively assumed to be budget neutral in 2018 without repeal.

An implied loss of 5.4mm Medicaid covered lives by implementing block grants hits hospitals right between the eyes. The Medicaid expansion was the most clear benefit to hospitals from the ACA.

And there could be implications for Medicaid managed care plans too: that loss of 5.4mm covered lives likely hits those plans squarely between the eyes too.

→ **Selling insurance across state lines is not a panacea according to this data:** The delta between just repealing and repeal+crossing state lines is only an increase of 2.2mm covered lives versus full repeal.

That's because out of pocket costs would significantly increase from $4,700 per person to an estimated $5,700 per person on average (less for younger, healthier people). So much for affordability.

Notice that RAND is implicitly assuming that there would not be community rating, i.e., that this would be an underwritten insurance market. We note that underwriting individual insurance would likely be a positive for managed care companies participating in such a market.

We'll digress from the RAND commentary and note this on our own accord: we have no idea how or if such insurance products would be regulated. The differences across states exist because states now control such regulations, which included mandated reserve levels as well as some degree of plan premium and benefit designs to ensure that consumers get the benefits they pay for. We'll also note that in several states the job of insurance commissioner is an elected one and one that has launched several high profile political careers. It will be interesting to see how a party that supposedly is in favor of states' rights will handle the political fall-out from disbanding state-specific insurance sales. We even wonder whether the Federal government has the power/authority to take this power away from the states. Not that a little thing like the Constitutionality of a law matters that much when considering such ideas in abstract.

We'll leave it to the lawyers to decide, but conclude with this thought about crossing state lines: **Investors should not hang their hats on such an idea replacing much of the benefit hospitals and health plans have seen from the ACA. As the RAND model shows, selling insurance across state lines without some sort of subsidy and/or high risk pool (i.e., the current exchange pools) just isn't going to work.**

Tax deductibility is only as fair as the tax system: According to the study, average out of pocket costs would be $3,500 per person, but would be *lower* for *higher income people* than for lower income people. That should make the average voter happy ….not. (Is this what happens when someone who doesn't understand the tax code proffers a solution to a candidate who has vowed to reform the tax code? Or will tax code reforms fix this impact from the regressive nature of taxation?

By the way, it still would leave 75% of those currently insured under the ACA out in the cold and back in hospital's ERs as no pay heads.

What's the combined effect? According to RAND, the combined impact of all of these Trump proposals would be to reduce the number of insured by 20.3mm and increase the Federal deficit by $5.8B.

That is, if this is all that Trump does with health care, if the Ryan plan isn't implemented (but he does include Medicaid block grants too), in our view this is unequivocally bad for hospitals: at best they'll only lose 26% of those insured lives, i.e., the 26% that were newly insured according to estimates in 2014. At worst, they'll lose all of the 'newly insured' and maybe more depending on whether Medicaid block grants result in restricted eligibility.

It's not good for Medicaid managed care either: even if block grants send states toward managed care, a repeal+block grant scenario means that lives would be cut first and then new states would be added. At best we see a pause in growth, if not a contraction in earnings.

Assessing the Impact of the ACA on Our Covered Hospitals: AHD Time Series Data

In the early days after the ACA was implemented, i.e., during 2014 and early 2015, HCA, THC, CYH and LPNT were routinely asked for and provided data about the impact of reform on their businesses. However, as new enrollment slowed and exchanges became more troubled, hospital investors began to view the 'reform play' as essentially done. Thus, pre-election hospital stocks already were viewed with less favor and lower multiples than during the height of the reform frenzy. But exchanges weren't the only, or even the most visible, positive impact of the coverage expansion: Medicaid was.

As we recently purchased a custom dataset (sorry, we can't provide it) from AHD that includes Medicare + Medicaid inpatient days and discharges, lengths of stay and revenue, EBITDAR and rent, we can actually see what the cost reports filed by each hospital contained from 2011 to 2015.

The data is interesting. In the tables below, we show the results for all hospitals and for each of HCA, CYH, LPNT and THC, in that order. But there are a few caveats:

1. This is INPATIENT ONLY for volumes and thus NOT a complete analysis of the impact of Medicaid expansions on the companies or the industry. We do NOT have ER visits, which would be a crucially important metric to analyze in a complete analysis. We have what we have and it's still instructive in our view.

2. The sum of discharges or patient days is less than that reported by the companies for the period because the AHD data seems to exclude commercial managed care data for volumes, but includes it for revenue and EBITDAR. It includes Medicare Advantage and Medicaid HMO patient days for all periods, but not Medicaid HMO discharges for 2011-2013.

3. Thus, patient days are more reliable in this dataset than discharges. We calculated discharges where data was missing by dividing HMO Medicaid patient days by the Medicaid average length of stay. We believe this to be a reasonable proxy.

4. Note also that this is NOT same store. It is total company for each year. Thus, HCA had 143 hospitals in 2015 and 142 hospitals in 2013 in the AHD database. However, major acquisitions are included in all years (e.g., HMA for CYH and Vanguard for THC).

5. The usual caveats about EBITDA and AHD data apply: this is the best we can get. It's not complete, we know that. But it is directionally correct as a rule and therefore instructive. But, we can't measure the second and third order impact on the companies from reform, i.e., the number of ASC procedures done for newly insured patients that wouldn't have been done there before at either managed care or Medicaid rates. We don't have outpatient data on volumes. But still, the surge in hospital industry performance from 2013 to 2014 and over the period to 2015 is instructional.

Still, we make the following important observations:

- **The Medicaid Expansion mattered to hospitals:** The average increase in Medicaid patient days from 2013 to 2014 was 3.1% and ranged from 2% for HCA to 5.6% for CYH. The increase for all hospitals was 4.3%.
    - **Medicaid days increased 1,057,730 from 2013 to 2015 for the industry as a whole.**
    - **Assuming that was purely due to the expansion and assuming an average of $1,000 per Medicaid patient day, that's $1.057B in revenue that would be lost if the expansion goes away.**
    - **Even at a 5% margin, that matters.**

- **How much did the industry grow in 2014? A mere $10B in incremental industry EBITDA.** The increase in EBITDA for the industry as a whole from 2013 to 2014 was a rather astonishing 11.3%, even as total patient days fell. That was a dollar increase of nearly $10B, from $85.9B in 2013 to $95.6B in 2014.

- **But investors appear to have been right to discount the expansion in 2015: industry EBITDA went right back down to $84.75B as Medicaid days fell by (1.5%) versus 2014.** For our covered companies, HCA showed a 4% increase in Medicaid days; CYH showed a (5%) decrease (on fewer hospitals); LPNT showed a (7.9%) decrease and THC showed a (0.3%) decrease. Again, this is not same store, but rather the total from the AHD cost report data.

- **It's the delta from 2013 to 2015 in total Medicaid days that we think matters more:**

    - HCA saw an increase of 100,000 Medicaid days from 2013 to 2015 according to the AHD data. That's $100mm of revenue at $1,000 per day.

    - AHD says that THC saw an increase of 62,914 Medicaid patient days during that same period, or an estimated $62.9mm in incremental revenue.

    - For CYH, the AHD data suggests that Medicaid days increased by 2,807 from 2013 to 2015, implying a much smaller $2.8mm revenue base (but the discharge data suggests a much bigger increase of more than 29,000 discharges, which at an average revenue per discharge of $6,000 would be $174mm, which seems more logical to us given management's comments about the positive impact of reform on its business on multiple conference calls). Finally, LPNT

    - LPNT's AHD dataset shows an initially surprising decline in Medicaid days of (8,993) from 2013 to 2015, until we put it in the context of the steep overall decline in admits and inpatient days shown by the company during this period.

Exhibit 2: The Impact of the Medicaid Expansion from AHD Data – All Hospitals

All Hospitals - includes Rehab, LTACH and Psych: Medicaid and EBITDA 2011 to 2015					
$ in millions	**2011***	**2012***	**2013***	**2014***	**2015**
Medicaid FFS Acute Discharges	5,045,662	4,718,343	4,543,347	4,228,779	3,751,849
Medicaid HMO Acute Discharges	671,697	573,568	963,058	1,705,026	2,662,949
Total Medicaid Discharges	5,717,359	5,291,911	5,506,405	5,933,805	6,414,798
YOY % change		-7.4%	4.1%	7.8%	8.1%
Total Discharges	35,294,963	34,989,028	34,316,863	33,647,017	32,404,107
YOY % change		-0.9%	-1.9%	-2.0%	-3.7%
Medicaid FFS Acute Patient Days	25,451,388	24,167,573	22,591,537	22,496,708	19,815,190
Medicaid HMO Acute Patient Days	13,099,017	14,713,930	16,214,904	17,968,184	20,048,981
Total Medicaid Days	38,550,405	38,881,503	38,806,441	40,464,892	39,864,171
YOY % change		0.9%	-0.2%	4.3%	-1.5%
Total Patient Days	186,390,360	181,651,715	178,849,977	178,251,396	171,705,042
YOY % change		-2.5%	-1.5%	-0.3%	-3.7%
Net Patient Revenue	772,446	793,923	$ 816,157	$ 855,652	$ 850,729
YOY % change			2.8%	4.8%	-0.6%
EBITDAR	$ 91,755	$ 80,503	$ 89,893	$ 99,842	$ 88,949
Rent	3,827	4,037	4,033	4,272	4,198
EBITDA	$ 87,928	$ 76,466	$ 85,860	$ 95,570	$ 84,751
YOY % change		-13.0%	12.3%	11.3%	-11.3%
EBITDA Margin	11.4%	9.6%	10.5%	11.2%	10.0%
* No cost report data for HMO discharges - calculated by MSUSA by using Patient days/ALOS					

Sources: AHD custom data set, 2011-2015, MSUSA estimates

Exhibit 3: Our Covered Companies

HCA: Medicaid and EBITDA 2011 to 2015					
$ in millions	2011*	2012*	2013*	2014*	2015
Medicaid FFS Acute Discharges	168,263	161,695	170,469	158,749	121,707
Medicaid HMO Acute Discharges	129,677	175,222	188,109	186,066	163,323
Total Medicaid Discharges	297,940	336,917	358,578	344,815	285,030
YOY % change		13.1%	6.4%	-3.8%	-17.3%
Total Discharges	1,582,218	1,633,953	1,637,224	1,637,647	1,645,847
YOY % change		3.3%	0.2%	0.0%	0.5%
Medicaid FFS Acute Patient Days	791,241	776,714	799,107	806,567	653,974
Medicaid HMO Acute Patient Days	589,163	817,955	872,522	897,750	1,118,211
Total Medicaid Days	1,380,404	1,594,669	1,671,629	1,704,317	1,772,185
YOY % change		15.5%	4.8%	2.0%	4.0%
Total Patient Days	7,714,908	7,775,960	7,857,347	7,914,017	8,037,262
YOY % change		0.8%	1.0%	0.7%	1.6%
Net Patient Revenue	29,744	28,493	$ 29,231	$ 30,389	$ 31,740
YOY % change			2.6%	4.0%	4.4%
EBITDAR	$ 5,655	$ 5,756	$ 6,241	6,754	$ 7,401
Rent	201	193	176	178	177
EBITDA	$ 5,455	$ 5,563	$ 6,065	$ 6,576	$ 7,223
YOY % change		2.0%	9.0%	8.4%	9.8%
EBITDA Margin	18.3%	19.5%	20.7%	21.6%	22.8%
* No cost report data for HMO discharges - calculated by MSUSA by using Patient days/ALOS					

Community: Medicaid and EBITDA 2011 to 2015					
$ in millions	2011*	2012*	2013*	2014*	2015
Medicaid FFS Acute Discharges	148,945	143,051	139,720	136,163	130,065
Medicaid HMO Acute Discharges	51,768	66,332	80,311	84,778	118,986
Total Medicaid Discharges	200,713	209,383	220,031	220,941	249,051
YOY % change		4.3%	5.1%	0.4%	12.7%
Total Discharges	952,622	913,160	872,321	882,285	788,972
YOY % change		-4.1%	-4.5%	1.1%	-10.6%
Medicaid FFS Acute Patient Days	580,915	526,095	480,138	488,890	373,853
Medicaid HMO Acute Patient Days	199,742	250,726	283,620	317,820	392,712
Total Medicaid Days	780,657	776,821	763,758	806,710	766,565
YOY % change		-0.5%	-1.7%	5.6%	-5.0%
Total Patient Days	4,158,890	3,951,100	3,789,832	3,816,992	3,537,945
YOY % change		-5.0%	-4.1%	0.7%	-7.3%
Net Patient Revenue	17,124	16,914	$ 16,503	$ 23,650	$ 17,188
YOY % change			-2.4%	43.3%	-27.3%
EBITDAR	$ 3,331	$ 2,737	$ 2,463	1,911	$ 2,226
Rent	198	203	197	207	188
EBITDA	$ 3,133	$ 2,534	$ 2,266	$ 1,704	$ 2,038
YOY % change		-19.1%	-10.6%	-24.8%	19.6%
EBITDA Margin	18.3%	15.0%	13.7%	7.2%	11.9%
* No cost report data for HMO discharges - calculated by MSUSA by using Patient days/ALOS					

Sources: AHD custom data set, 2011-2015, MSUSA estimates

Exhibit 3: Continued

LifePoint: Medicaid and EBITDA 2011 to 2015					
$ in millions	2011*	2012*	2013*	2014	2015
Medicaid FFS Acute Discharges	36,478	30,528	25,180	23,038	21,636
Medicaid HMO Acute Discharges	12,514	21,191	23,830	23,041	24,160
Total Medicaid Discharges	48,992	51,719	49,010	46,079	45,796
YOY % change		5.6%	-5.2%	-6.0%	-0.6%
Total Discharges	202,318	196,529	191,242	181,029	144,645
YOY % change		-2.9%	-2.7%	-5.3%	-20.1%
Medicaid FFS Acute Patient Days	128,391	96,488	84,548	83,820	72,180
Medicaid HMO Acute Patient Days	43,443	73,959	78,552	83,578	81,927
Total Medicaid Days	171,834	170,447	163,100	167,398	154,107
YOY % change		-0.8%	-4.3%	2.6%	-7.9%
Total Patient Days	831,769	789,427	770,329	741,729	573,594.
YOY % change		-5.1%	-2.4%	-3.7%	-22.7%
Net Patient Revenue	3,741	3,462	$ 3,468	$ 3,540	$ 3,070
YOY % change		-7.5%	0.2%	2.1%	-13.3%
EBITDAR	$ 434	$ 437	$ 408	426	$ 362
Rent	27	28	24	25	25
EBITDA	$ 407	$ 409	$ 384	$ 400	$ 338
YOY % change		0.4%	-6.2%	4.3%	11.0%
EBITDA Margin	10.9%	11.8%	11.1%	11.3%	11.0%
* No cost report data for HMO discharges - calculated by MSUSA by using Patient days/ALOS					

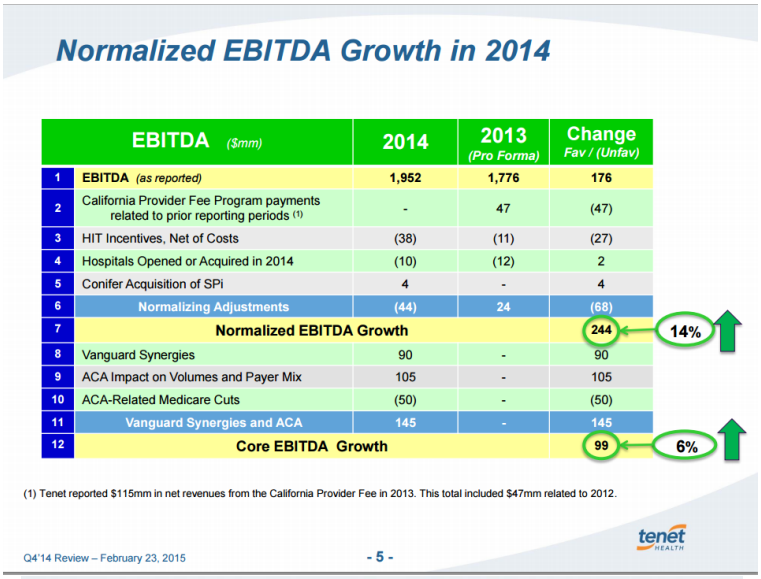
Tenet Healthcare: Medicaid and EBITDA 2011 to 2015					
$ in millions	2011*	2012*	2013*	2014*	2015
Medicaid FFS Acute Discharges	91,179	90,466.	110,586	98,449	55,654
Medicaid HMO Acute Discharges	75,826	64,056	78,527	109,478	139,458
Total Medicaid Discharges	167,005	154,522	189,113	207,927	195,112
YOY % change		-7.5%	22.4%	9.9%	-6.2%
Total Discharges	670,781	668,095	651,285	659,577	661,515
YOY % change		-0.4%	-2.5%	1.3%	0.3%
Medicaid FFS Acute Patient Days	460,214	457,416.	433,864	459,527	362,937
Medicaid HMO Acute Patient Days	450,991	471,366	507,718	547,865	641,559
Total Medicaid Days	911,205	928,782	941,582	1,007,392	1,004,496
YOY % change		1.9%	1.4%	7.0%	-0.3%
Total Patient Days	3,151,031	3,089,596.	3,020,304	3,089,335	3,047,239
YOY % change		-1.9%	-2.2%	2.3%	-1.4%
Net Patient Revenue	11,323	11,359	$ 11,572	$ 12,189	$ 12,776
YOY % change					
EBITDAR	$ 1,398	$ 1,521	$ 1,593	1,660	$ 1,946
Rent	64	82	68	76	72
EBITDA	$ 1,334	$ 1,439	$ 1,524	$ 1,584	$ 1,874
YOY % change		7.9%	5.9%	3.9%	18.3%
EBITDA Margin	11.8%	12.7%	13.2%	13.0%	14.7%
* No cost report data for HMO discharges - calculated by MSUSA by using Patient days/ALOS					

Sources: AHD custom data set, 2011-2015, MSUSA estimates

What Have Some of the Companies Said About the Impact?

In 2014, **THC** reported a net benefit of $45mm to EBITDA from the ACA, or 2.3% of EBITDA. In 2015, THC expected the net benefit of reform to be $16mm on a midpoint of the outlook range of $2.1B. That's less than 1%, net of cuts. Taken together, over the two year period, the ACA helped THC's EBITDA by $61mm – plus perhaps another 1% of EBITDA in 2016, or another $24mm by our estimate. But the cuts over that period were $134mm and that's nontrivial pressure on EBITDA in our view. Note that THC recently characterized its ACA volumes as 'mostly' previously insured, but we spoke to the company and believe that the right ratio is just over 50%.

Exhibit 4: Actual 2014 and Expected Impact on 2015 EBITDA Outlook from the ACA for THC

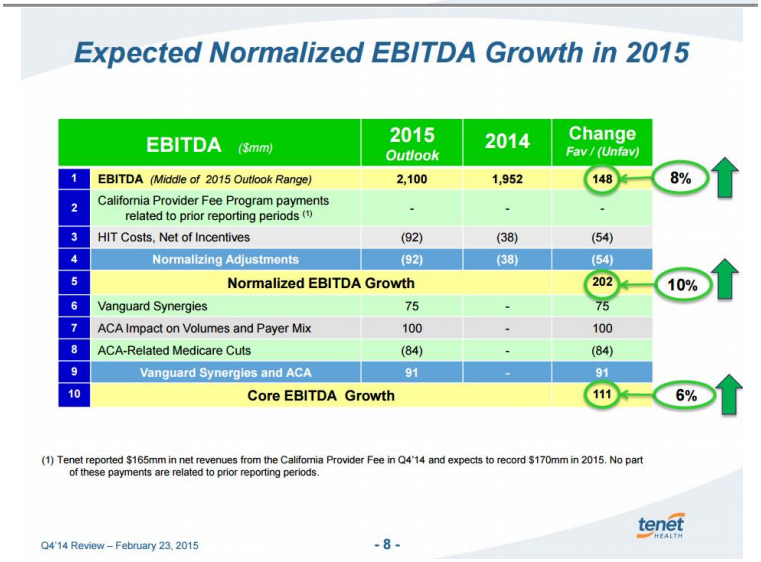


Normalized EBITDA Growth in 2014

	EBITDA ($mm)	2014	2013 (Pro Forma)	Change Fav / (Unfav)
1	EBITDA (as reported)	1,952	1,776	176
2	California Provider Fee Program payments related to prior reporting periods (1)	-	47	(47)
3	HIT Incentives, Net of Costs	(38)	(11)	(27)
4	Hospitals Opened or Acquired in 2014	(10)	(12)	2
5	Conifer Acquisition of SPi	4	-	4
6	Normalizing Adjustments	(44)	24	(68)
7	Normalized EBITDA Growth			244 (14%)
8	Vanguard Synergies	90	-	90
9	ACA Impact on Volumes and Payer Mix	105	-	105
10	ACA-Related Medicare Cuts	(50)	-	(50)
11	Vanguard Synergies and ACA	145	-	145
12	Core EBITDA Growth			99 (6%)

(1) Tenet reported $115mm in net revenues from the California Provider Fee in 2013. This total included $47mm related to 2012.

Q4'14 Review – February 23, 2015 - 5 -



Expected Normalized EBITDA Growth in 2015

	EBITDA ($mm)	2015 Outlook	2014	Change Fav / (Unfav)
1	EBITDA (Middle of 2015 Outlook Range)	2,100	1,952	148 (8%)
2	California Provider Fee Program payments related to prior reporting periods (1)	-	-	-
3	HIT Costs, Net of Incentives	(92)	(38)	(54)
4	Normalizing Adjustments	(92)	(38)	(54)
5	Normalized EBITDA Growth			202 (10%)
6	Vanguard Synergies	75	-	75
7	ACA Impact on Volumes and Payer Mix	100	-	100
8	ACA-Related Medicare Cuts	(84)	-	(84)
9	Vanguard Synergies and ACA	91	-	91
10	Core EBITDA Growth			111 (6%)

(1) Tenet reported $165mm in net revenues from the California Provider Fee in Q4'14 and expects to record $170mm in 2015. No part of these payments are related to prior reporting periods.

Q4'14 Review – February 23, 2015 - 8 -

Sources: Tenet Healthcare 4Q14 Investor Slide Presentation available at
http://investor.tenethealth.com/sites/tenethealth.investorhq.businesswire.com/files/doc_library/file/Fourth_Quarter_2014_Results_Webcast.pdf

In its 4Q14 conference call, CYH said the following (Bloomberg Transcript page 5/13):

> *Based on various data points on Medicaid and exchange business, we believe we recognize the net benefit after government deductions in the amount of $120 million to $125 million from the Affordable Care Act for all of 2014.*

CYH reported $2.779B in EBITDA on a guidance basis for 2014, which implies that the ACA impact was 4.4% of EBITDA at the midpoint of the range in the quote above. CYH noted elsewhere in that transcript that it believed that approximately 50% of its ACA-related 18,000 adjusted admits for that year were previously insured. It is not clear if this net benefit excludes the EBITDA earned on the 50% of adjusted admits that it believed were previously insured. If so, then the incremental EBITDA would have been only 2.2% at the midpoint of the range.

HCA said in its 4Q15 conference call that the ACA contributed 6% of full year EBITDA or $475mm of the $7.915B reported in that year. HCA also said that at least 40% of its ACA-related volume was previously insured.

How Bad is Bad? Bad, But Maybe Not as Bad as We Thought…

- We think it is that full repeal would at best mean that anywhere from 1% to 6% of our covered companies' EBITDA could go away.

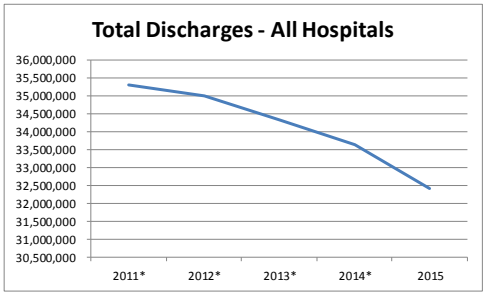
- But the worst-worst case would be if the expansion evaporates and the Medicare rate cuts stay in place – but the DSH formula depends on the number of uninsured and an increase in that number would alleviate the DSH cut pressures.

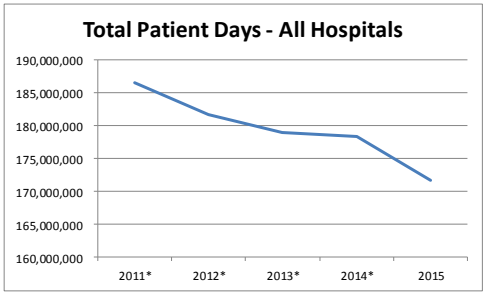
- Still for companies that are already experiencing fundamental pressures from underperforming assets, the repeal of the ACA just deepens an already impressive hole. They'd have to dig harder and longer to get out.

What Really Concerns Us When Looking at the AHD Data Isn't Reform…It's the Reversion to Old Volume Trends and They Weren't Good

Look at the All Hospital table again. In fact, we'll look at it another way…a picture:

Exhibit 5: A Disturbing Industry Trend



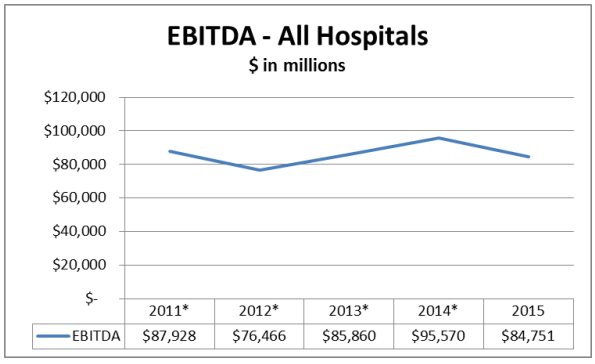


Sources: AHD custom data set, 2011-2015, MSUSA estimates

Folks, this is not good: it looks like the real benefit of the ACA was merely to slow the rate of decline of industry volume metrics. If the ACA goes away, will it merely accelerate the reversion to a declining trend for volumes?

Indeed, EBITDA tells the same story:

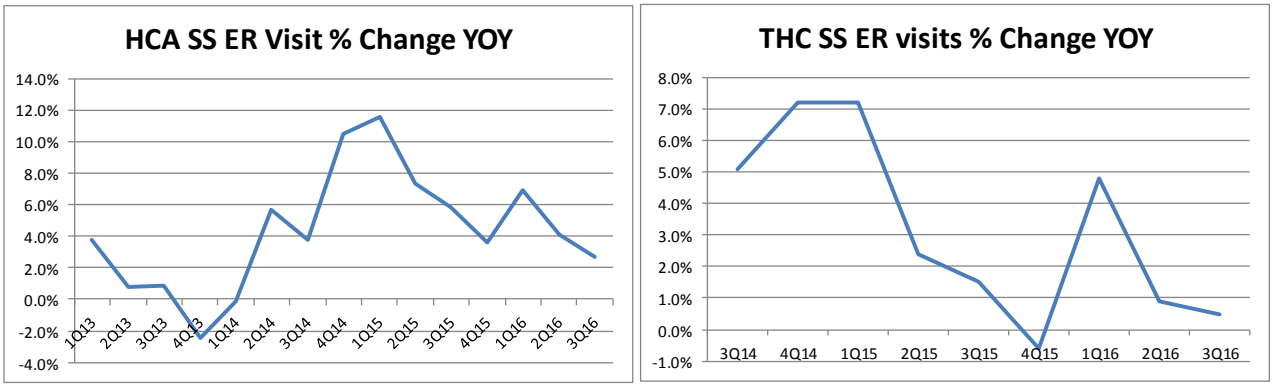
Exhibit 6: All-Hospital EBITDA – Lower in 2015 than in 2011



Sources: AHD custom data set, 2011-2015, MSUSA estimates

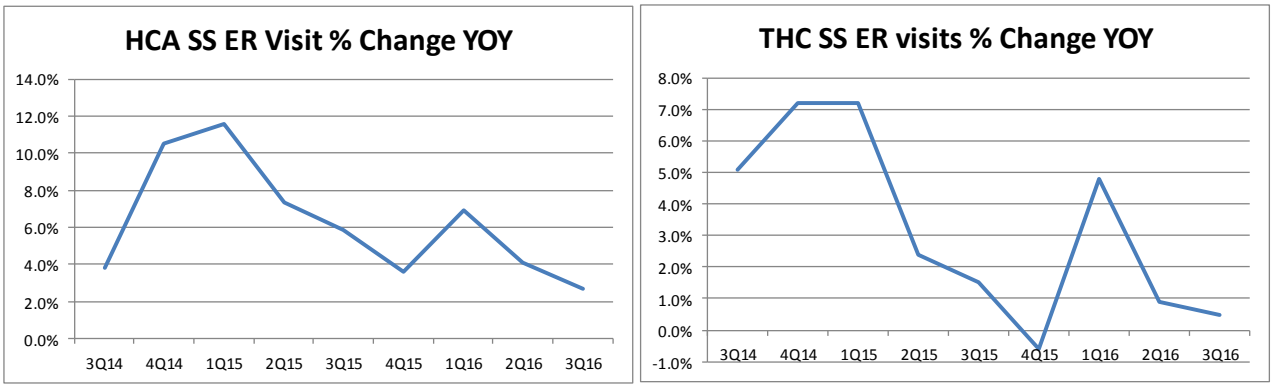
We have also noted that ER visits appear to be reverting to a pre-ACA trend as well. While HCA reported a 3Q16 increase in ER visits of 2.7%, that's down from prior years' growth rates: ER visits were up in 3Q15 by 5.8%. A similar pattern emerges for THC, even when using data restated for the significant portfolio realignment completed in early 2016. Exhibit 7 shows the data we have for both companies. Exhibit 8 shows the data we have for the same time periods.

Exhibit 7: HCA and THC ER Visits



Sources: Company reports and investor presentations, MSUSA estimates

Exhibit 8: HCA and THC ER Visits – This Should Worry Hospital Investors



Sources: Company reports and investor presentations, MSUSA estimates

The distributions are essentially identical. This was the impact of the HCA.

And here's the point: the ER is the front door of the hospital. About 60% of admits come through the ER. When ER visits are down or when growth slows, admit growth must also slow.

What we are seeing here is first the steep increase in ER visits largely due to the ACA, both exchanges and Medicaid. The newly insured, or more completely insured

with subsidies, finally had access to health care, but likely didn't have a primary care doc. So the ER was the first stop. As those patients were distributed among the primary care practices, ER visit growth slowed, finally becoming negative for THC in 4Q15 and slowing rather dramatically for HCA in that same quarter. Seasonality, population shifts likely pushed the growth rate up in 1Q16, but absent that impact, the growth rate declined again to even lower levels than the previous year….and it is likely that it is *paying heads in the beds that are contributing to this decline, not just the decline in no pay heads.*

What if This Slowing ER Growth Rate is Actually Due to Another Part of the ACA, i.e., Patient-Centered, Value-Based Care & Payments?

HCA attributed its slowing ER growth rate to competition from freestanding ERs. While we're sure HCA is seeing that if it says it is, we also think that something else is at work here…an increasingly activist managed care industry that is actively seeking to prevent ER visits from happening in the first place.

We know from our OptumCare due diligence trip that an increasing number of primary care practices are changing their own and their patients' behavior. They're advocating urgent care centers as a viable ER alternative (e.g., MedExpress) or using technology via smartphone apps to connect patients with doctors and physician assistants to advise them on the appropriate setting: even seniors are using smartphone apps to have video calls with practitioners at Southwest Medical in Las Vegas. OptumCare isn't likely the only forward-looking physician organization that's trying to reduce ER visits. For example, physician-health plan ACOs, of which there are several hundred, succeed when hospital days fall. The best way to do that is to prevent the ER visit in the first place. Then there's PM Pediatrics, a personal favorite: an urgent care center just for kids that gets very busy on Saturday nights.

Indeed, when one speaks to 'enlightened' primary care physicians, they all understand that once they let their patients enter the ER doors, costs explode…and quality doesn't necessary improve with it. That's a burden that hospitals have to overcome if they want to protect their flanks, in our view.

Now let's relate this back to the core topic of this report: reform and the ACA.

Many of these incentives to reduce the cost of care, to restructure these health care transactions by redirecting patients to care in the 'right place,' are the result of the part of the ACA that deal with 'pay for performance,' or value-based care.

- **To us, this is the single most important thing that would go away with repeal. It has the most far-reaching implications: by repealing the mandate that Medicare lead the march into a fee-for-value world, will the GOP throw us back to a world in which fee for service incentives leads to increased heads in beds without regard to outcome - and quality-based selection of the site of care? To abandon the one thing that really has the potential to truly *reform health care?***

We strongly suspect, although we as yet have no way to prove, that providers and payers have embraced fee-for value, otherwise known as 'right care, right time, right place, for the right reason, at the right price,' only because Medicare was forced to do so by the ACA. Take that imperative away and we suspect that most hospitals will jump right off the fee-for-value (FFV) bandwagon.

Recall that Medicare set fast goals for achieving 50% of claims tied to FFV by 2018 and is already ahead of pace. CMS can do very little without legislative authority and the authority for this move was from the ACA. MACRA imposes other FFV mandates, particularly for physician services, but the ACA drove the bulk of this. *Take the ACA away, and CMS would not likely have the legislative authority to mandate a tie to FFV in Medicare payments.*

Here's How Repeal is Good for Hospitals…and Bad for Federal Budgets

So here's a perverse outcome: repeal the ACA and save hospitals from emptying out as a result of FFV and patient-centered reforms…or leave it in place and see hospital volumes suffer over time. Of course, taking away these effective cost-reducing tools simply drives per capital health care spending back up to more historic growth rates, which in turn affects the total spending on Medicare, Medicaid and health care in general. In turn, this means that Congress will have to eventually whack reimbursement rates, because no matter who is in charge, the budget equation is hard reality no matter how much post-truth gets spun around:

Total Health Care Spending = Per capita Spend X # of 'capitas'

Per capita spend = Price per unit X # of units of health care consumed.

Making the Hospital Group Call: The Real Risk Looks to Be 'Caid Block Grants & Privatization of Medicare

In other words, in the face of all this, can we buy them? Should we sell them? Or should we just avoid the group altogether until facts, not speculation or belief or unfounded assumptions, can guide us to a proper valuation.

It's pretty clear that this analyst prefers the last. It's also pretty clear that the market wants to have a call on hospitals. So here's ours:

1. It is folly, in our view, to invest based on unfounded beliefs.

2. There is no way to know what will happen as the element of chaos has blown up our pretty little normal distribution.

3. Therefore, we can't even build a range of probabilities around an outcome.

4. But, we can identify the endpoints of the distribution of outcomes and values even if we don't know the midpoint or its shape.

5. **Those endpoints, at the absolute very best, are the status quo and the worst case in which coverage expansions are repealed, but the cuts and regulations stay, Medicare gets fully privatized and Medicaid block grants force states into Medicaid Managed Care arrangements.**

    a. In that case, it appears that the companies have about 2% to 3% of 2016 EBITDA downside (roughly half the upside from reform before the offset from the cuts as roughly half of the patients were previously covered) PLUS they have downside risk from increasing numbers of negative cash flow events when the uninsured roll through the ER again, offset by smaller DSH cuts as the number of uninsured rises again.

    b. If one wants a really worst case scenario, we'll give it – The impact of privatizing Medicare and Medicaid is worse than repeal of the ACA with the cuts remaining.

        i. For 2015 for HCA, the difference between FFS Medicare and MA rates was ($1,880) in revenue per admit (not acuity adjusted), or about a 14% difference. That too would factor into a worst case scenario and it's a bad one.

        ii. For HCA, the hit to revenue and unmitigated hit to EBITDA for 2015 would have been $1.054B or 14% of inpatient revenue and a 13% reduction in EBITDA if ALL Medicare FFS cases were repriced at MA levels.

    c. Then there's the impact of block grants for Medicaid. In the worst case, we'd expect some states to cut eligibility and rates, especially those with provider fee programs (California and Pennsylvania matter here). Both THC and CYH receive such payments and they can be material, even after netting out the tax that is assessed to fund the fee program.

        i. **Shifting FFS Medicaid into Managed Medicaid** also would be a significant hit. Using HCA's data again, for 2015 the difference between FFS revenue per Medicaid admit and managed was a whopping $8,227 per admit.

        ii. Repricing all of those admits at the Managed Medicaid revenue per admit yields another $922mm revenue and EBITDA hit.

Exhibit 9 shows our work on the potential impact of the privatization of Medicare and Medicaid on HCA if ONLY the price changes. We apologize in advance to HCA for making it the focus of this analysis, but it's the only company that provides even close to enough information to do these

calculations. We think the impact on THC would be similar, as its markets are more similar to HCA's than different and its market positioning (number 1 or 2 in the majority of its markets) is also similar to its larger peer. Please note that the revenue percentages are actually given on revenue before bad debt is subtracted and that we apply it to 'cash' inpatient revenue, i.e., after bad debt is subtracted. This is the best data we have: we could allocate bad debt to inpatient revenue, but that would introduce even more potential error. Note that we are consistent in this treatment for all years after 2011.

Exhibit 9: Revenue Per Admit Analysis Suggests Big Hits Under Medicare/Caid Privatization

HCA: Inpatient Revenue Contribution Analysis					Cash Revs Starts					
$ in millions except per unit	2007	2008	2009	2010	2011	2012	2013	2014	2015	3Q16
Consolidated Hospitals										
Inpatient Admissions	1,552,700	1,541,800	1,556,500	1,554,400	1,620,400	1,740,700	1,744,100	1,795,300	1,868,800	467,200
Inpatient Rev/admission	$10,591	$11,336	$11,809	$12,079	$11,329	$11,475	$11,829	$12,327	$12,407	$12,879
All Revenue %are of Revenue before bad debt										
Inpatient Revenue ($ in millions)	**$16,057**	**$17,762**	**$18,692**	**$19,116**	**$20,137**	**$22,327**	**$23,027**	**$24,092**	**$26,355**	**$6,017**
Medicare % Inpatient Revenue	32%	31%	31%	31%	31%	30%	30%	29%	28%	27%
Medicare % Inpatient Admissions	35%	35%	34%	34%	34%	33%	33%	32%	30%	30%
% Change in Admissions YOY		-0.7%	-1.9%	-0.1%	4.2%	4.3%	0.2%	-0.2%	-2.4%	
Medicare Admissions	543,445	539,630	529,210	528,496	550,936	574,431	575,553	574,496	560,640	140,160
Medicare Inpatient Revenue ($ millions)	**$5,138**	**$5,506**	**$5,795**	**$5,926**	**$6,242**	**$6,698**	**$6,908**	**$6,987**	**$7,379**	**$1,625**
Medicare Revenue Per Admission	**$9,455**	**$10,204**	**$10,950**	**$11,213**	**$11,330**	**$11,660**	**$12,002**	**$12,162**	**$13,163**	**$11,591**
% Change YOY	4.2%	7.9%	7.3%	2.4%	1.1%	2.9%	2.9%	1.3%	8.2%	
Managed Care % Inpatient Revenue	44%	44%	44%	44%	45%	45%	45%	47%	47%	49%
Managed Care % Admissions	37%	35%	34%	32%	31%	30%	30%	30%	30%	29%
% Change in Admissions YOY	-0.9%	-6.1%	-1.9%	-6.0%	1.0%	4.0%	0.2%	2.9%	4.1%	
Managed Care Admissions	574,499	539,630	529,210	497,408	502,324	522,210	523,230	538,590	560,640	135,488
Managed Care Inpatient Revenue	**$7,065**	**$7,815**	**$8,225**	**$8,411**	**$9,061**	**$10,047**	**$10,362**	**$11,323**	**$12,387**	**$2,948**
Managed Care Inpatient Rev per Admit	**$12,298**	**$14,483**	**$15,541**	**$16,909**	**$18,039**	**$19,240**	**$19,804**	**$21,024**	**$22,094**	**$21,761**
% Change YOY	**-2.5%**	**17.8%**	**9.6%**	**8.8%**	**6.7%**	**6.7%**	**2.9%**	**6.2%**	**5.1%**	
Uninsured % Revenue	6%	6%	5%	3%	3%	5%	5%	1%	2%	0%
Uninsured % Admissions	6%	6%	6%	7%	7%	8%	8%	7%	7%	8%
% Change in Admissions YOY		**-0.7%**	**1.0%**	**16.5%**	**4.2%**	**22.8%**	**0.2%**	**-9.9%**	**4.1%**	
Uninsured Admissions	93,162	92,508	93,390	108,808	113,428	139,256	139,528	125,671	130,816	37,376
Uninsured Inpatient Rev	**$1,496**	**$1,643**	**$935**	**$573**	**$604**	**$1,116**	**$1,151**	**$241**	**$527**	**$24**
Uninsured Inpatient Rev per Admit	**$16,057**	**$17,762**	**$10,008**	**$5,270**	**$5,326**	**$8,017**	**$8,252**	**$1,917**	**$4,029**	**$644**
% Change YOY		**10.6%**	**-51.1%**	**-47.3%**	**1.1%**	**50.5%**	**2.9%**	**-76.8%**	**110.2%**	
Managed Medicare % Revenue	7%	8%	8%	9%	9%	10%	10%	11%	12%	12%
Managed Medicare % Admissions	7%	9%	10%	10%	11%	12%	12%	14%	15%	15%
% Change in Admissions YOY		27.7%	12.2%	-0.1%	14.7%	17.2%	0.2%	20.1%	11.5%	
Managed Medicare admissions	108,689	138,762	155,650	155,440	178,244	208,884	209,292	251,342	280,320	70,080
Mgd. Medicare Inpatient Revenue ($ millions)	**$1,124**	**$1,421**	**$1,495**	**$1,720**	**$1,812**	**$2,233**	**$2,303**	**$2,650**	**$3,163**	**$722**
Mgd. Medicare Inpatient Rev/admit	**$10,342**	**$10,240**	**$9,607**	**$11,068**	**$10,168**	**$10,689**	**$11,002**	**$10,544**	**$11,282**	**$10,303**
% Change YOY		**-1.0%**	**-3.6%**	**15.2%**	**-8.1%**	**5.1%**	**2.9%**	**-4.2%**	**7.0%**	
Medicaid % Revenue	7%	7%	8%	9%	8%	6%	6%	7%	6%	6%
Medicaid % Admissions	8%	8%	9%	9%	9%	8%	8%	7%	6%	6%
% Change in Admissions YOY		**-0.7%**	**13.6%**	**-0.1%**	**4.2%**	**-4.5%**	**0.2%**	**-9.9%**	**-10.8%**	
Medicaid Admissions	124,216	123,344	140,085	139,896	145,836	139,256	139,528	125,671	112,128	28,032
Medicaid Inpatient Revenue ($ millions)	**$1,124**	**$1,243**	**$1,495**	**$1,720**	**$1,611**	**$1,340**	**$1,382**	**$1,686**	**$1,581**	**$361**
Medicaid Inpatient Rev per Admit	**$9,049**	**$10,080**	**$10,675**	**$12,298**	**$11,046**	**$9,620**	**$9,902**	**$13,420**	**$14,103**	**$12,879**
Medicaid Managed Care % Rev	4%	4%	4%	4%	4%	4%	4%	5%	5%	6%
Medicaid Managed Care % Admissions	7%	7%	7%	8%	8%	9%	9%	10%	12%	12%
% Change in Admissions YOY		-0.7%	1.0%	14.1%	4.2%	20.9%	0.2%	14.4%	24.9%	
Medicaid Managed Care Admissions	108,689	107,926	108,955	124,352	129,632	156,663	156,969	179,530	224,256	56,064
Medicaid MC Inpatient Revenue ($ millions)	**$642**	**$710**	**$748**	**$765**	**$805**	**$893**	**$921**	**$1,205**	**$1,318**	**$361**
Medicaid MC Inpatient Rev per Admit	**$5,909**	**$6,583**	**$6,862**	**$6,149**	**$6,213**	**$5,701**	**$5,868**	**$6,710**	**$5,876**	**$6,440**
% Change YOY		**11.4%**	**4.2%**	**-10.4%**	**1.1%**	**-8.3%**	**2.9%**	**14.3%**	**-12.4%**	
Total Managed Care % Revenue	**55%**	**56%**	**56%**	**57%**	**58%**	**59%**	**59%**	**63%**	**64%**	**67%**
Total Managed Care % Admissions	**51%**	**51%**	**51%**	**50%**	**50%**	**51%**	**51%**	**54%**	**57%**	**56%**
% Change in Admissions YOY		-0.7%	1.0%	-2.1%	4.2%	9.6%	0.2%	9.0%	9.9%	
Total Managed Care Admissions	791,877	786,318	793,815	777,200	810,200	887,757	889,491	969,462	1,065,216	261,632
Total Managed Care Inpatient Revenue	**$8,832**	**$9,947**	**$10,468**	**$10,896**	**$11,679**	**$13,173**	**$13,586**	**$15,178**	**$16,867**	**$4,031**
Total Managed Care Inpatient Revenue per Admit	**$11,153**	**$12,650**	**$13,187**	**$14,019**	**$14,415**	**$14,838**	**$15,274**	**$15,656**	**$15,835**	**$15,409**
% Change YOY		13.4%	4.2%	6.3%	2.8%	2.9%	2.9%	2.5%	1.1%	

Sources: HCA SEC filings and MSUSA estimates

Exhibit 10 shows the running total of potential hits to HCA's EBITDA, again with apologies to HCA for using it as our guinea pig.

Exhibit 10: What Could Happen to HCA's EBITDA in the Worst Case?

HCA as Guinea Pig $ IN MILLIONS	Worst Case 2017E	Middle Case 2017E	ACA Only 2017E
Revenue	**$ 42,710**	**$ 42,710**	**$ 42,710**
Inpatient %	**66%**	**66%**	**66%**
Inpatient Revenue	**$ 28,189**	**$ 28,189**	**$ 28,189**
EBITDA	**$ 8,684**	**$ 8,684**	**$ 8,684**
Medicaid Block Grants			
Medicaid as % of Inpatient Revenue	6%	6%	6%
Implied Medicaid Inpatient Revenue	$ 1,691	$ 1,691	$ 1,691
Managed Medicaid as % of Inpatient	5%	5%	5%
Implied Managed Medicaid Inpatient Revenue	$ 1,409	$ 1,409	$ 1,409
% Difference in Rev/admit from shift to Managed from FFS Medicaid	-48%	-48%	-48%
Implied Reduction in Rev and EBITDA from Block Grants	**$ (810)**	**$ (810)**	**$ (810)**
Phase-in Factor	100%	20%	0%
Mitigated Impact	**$ (810)**	**$ (162)**	**$ -**
ACA Fully Repealed			
2017 E EBITDA	$ 8,684	$ 8,684	$ 8,684
ACA contribution	6%	6%	6%
Assume 6% due to ACA gross	**$ 521.04**	**$ 521**	**$ 521**
Previously Insured + Reduced DSH Cut	-100%	-35%	-40%
Mitigated Impact	**$ (521)**	**$ (182)**	**$ (208)**
Medicare Privatization			
Medicare as % of Inpatient Revenue	28%	28%	28%
Implied Medicare Inpatient Revenue	$ 7,893	$ 7,893	$ 7,893
Medicare Advantage as % of Inpatient Revenue	12%	12%	12%
Implied MA Inpatient Revenue	$ 3,383	$ 3,383	$ 3,383
% Difference in Rev/admit from shift to Managed from FFS Medicare	-17%	-17%	-17%
Implied Reduction in Rev and EBITDA from Medicare Privatization	**$ (1,316)**	**$ (1,316)**	**$ (1,316)**
Phase-in Factor	100%	10%	0%
Mitigated Impact	**$ (1,316)**	**$ (132)**	**$ -**
Total Impact of Price-ONLY on EBITDA	**$ (2,647)**	**$ (476)**	**$ (208)**
Potential EBITDA	$ 6,037	$ 8,208	$ 8,476
% Reduction vs. Estimate	-30.5%	-5.5%	-2.4%
Less NCI	$ 570	$ 570	$ 570
Potential EBITDA less NCI	**$ 5,467**	**$ 7,638**	**$ 7,906**
EV/EBITDA less NCI Multiple	6.5	7.0	7.5
EV	$ 35,533	$ 53,466	$ 59,292
Less Net Debt	30,811	30,811	30,811
Equity Value	$ 4,722	$ 22,655	$ 28,481
Implied Equity Value	**$ 12.26**	**$ 58.84**	**$ 73.98**
Average Shares	385	385	385

Sources: HCA SEC filings and MSUSA estimates

In other words, the answer to the question, "How bad is bad?" is *very bad*, based on these calculations.

As for THC, we don't have the level of detailed information from THC that we do from HCA. But we can make certain extrapolations and certainly can begin to model

what would happen to our 2017 estimates if the ACA is repealed and only 50% of THC's ACA patients become re-insured. See Exhibit 11 below.

Note that we will be happy to make these little models available to our clients. For THC we used reported 3Q16 revenue mix by payer for Medicare and Medicaid, but THC lumps managed care variants of those two into managed care (HCA is nice and splits it out). So the estimates for mix for managed Medicaid/Medicare are our estimates, which is why we only present the ACA repeal case for formal consideration. See below.

Exhibit 11: Estimated Impact on THC from ACA Repeal Only

THC Repeal Only $ IN MILLIONS	ACA Only 2017E
Revenue	**$ 20,356**
Inpatient %	**55%**
Inpatient Revenue	**$ 11,195.80**
EBITDA	**$ 2,522**
Medicaid Block Grants	
Medicaid as % of Inpatient Revenue	9%
Implied Medicaid Inpatient Revenue	$ 985
Managed Medicaid as % of Inpatient	6%
Implied Managed Medicaid Inpatient Revenue	$ 672
% Difference in Rev/admit from shift to Managed from FFS Medicaid	-30%
Implied Reduction in Rev and EBITDA from Block Grants	**$ (296)**
Phase-in Factor	0%
Mitigated Impact	**$ -**
ACA Fully Repealed	
2017 E EBITDA	$ 2,522
ACA contribution	1%
Assume 6% due to ACA gross	**$ 25.22**
Previously Insured + Reduced DSH Cut	-50%
Mitigated Impact	**$ (13)**
Medicare Privatization	
Medicare as % of Inpatient Revenue	20%
Implied Medicare Inpatient Revenue	$ 2,239
Medicare Advantage as % of Inpatient Revenue	15%
Implied MA Inpatient Revenue	$ 1,679
% Difference in Rev/admit from shift to Managed from FFS Medicare	-17%
Implied Reduction in Rev and EBITDA from Medicare Privatization	**$ (373)**
Phase-in Factor	0%
Mitigated Impact	**$ -**
Total Impact of Price-ONLY on EBITDA	**$ (13)**
Potential EBITDA	$ 2,509
% Reduction vs. Estimate	-0.5%
Less NCI	$ 365
Potential EBITDA less NCI	**$ 2,144**
EV/EBITDA less NCI Multiple	7.3
EV	$ 15,654
Less Net Debt	14,358
Equity Value	$ 1,296
Implied Equity Value	**$ 12.83**
Average Shares	101

Sources: HCA and THC company reports and SEC filings and MSUSA estimates

That's Price…What About Volume?

Our work on ER visits and volumes suggests that if the regulations stay and the coverage goes, hospital volumes will remain under pressure, perhaps due to increasing pressure from 'enlightened' primary care practices and supported by managed care. Indeed, we've been concerned about this for some time – not just for hospitals. See our work on the post-acute inpatient business. Bundling affects SNFs today, i.e., when CJR doesn't yet put the hospital at financial risk for the 90 day episode, but it will soon (4/1/17). CMS proposed moving knees off the inpatient-only list, enabling reimbursement for knee replacements on an outpatient basis. Will hospitals under CJR end up having to empty their beds to make money on the bundle just as they have had to do to make money in Medicare ACOs? Maybe.

The real question here is whether, irrespective of what happens to the ACA, the patient-centered value-based care train has left the station.

- If it has, poor quality, expensive hospitals will empty out, leaving the higher quality, cost-effective hospitals to build market share.

- That game could last for a while, but eventually (between technology, pharma and practice changes), we could see where even the best hospitals end up with fewer, higher acuity, patients.

Back in 2006 we called this 'Starvation in the Land of Plenty.' (Lots of old people, no money to pay for them, and so the government would have to find ways to cut spending, which eventually leads to hospitals emptying out). Eleven years later, Starvation is here. Just look at those ER charts in the exhibits above and look at Medicare rates over the last six years. And that's before the repeal of the ACA whacks the hospitals' cash flows.

Valuation Discipline is Especially Important Now – Lowering THC to Underperform, $13 PT.

To conclude, unless and until we see what the GOP plans, we see hospitals as extraordinarily risky investments. We think investors shouldn't pay more than the historic average for HCA 7.5x on 2017 EBITDA less NCI because it's possible that 2018 will be lower than 2016. That's our target of $78.

THC presents a problem because of its high leverage. There, even at $13, the stock trades at 7.8x our 2016 estimate and 7.3x our 2017 estimate of EBITDA less NCI. At its current $17 price, THC trades at 7.6x multiple, i.e., a *premium to HCA and that is not right under any circumstances (HCA has FCF, THC doesn't) in our view.* To be within 10% of the current stock price, i.e., to keep our Neutral rating, THC shares would have to trade at $15, i.e., at a 7.8x multiple, a nearly half-turn premium to our HCA target price. Frankly, with our work in Exhibit 11 showing that a 7.3x multiple on a 2017 year less the ACA impact mitigated by 50% gets to a $13 price target, we're sticking to our guns on valuation work and lowering our rating on THC to Underperform. There's just too much risk to pay a premium in our view.

Exhibit 12: THC Valuation Table

Tenet Healthcare Valuation	At Current Price			EV/EBITDA Less NCI Method At Target Price		
	2015A	2016E	2017E	2015A	2016E	2017E
$ in thousands, except per share						
Revenue	$ 18,634	$ 19,756	$ 20,356	$ 18,634	$ 19,756	$ 20,356
EBITDA margin	12.21%	12.39%	0.00%	12.21%	12.39%	0.00%
EBITDA less NCI	**$ 2,058**	**$ 2,045**	**$ 2,157**	**$ 2,058**	**$ 2,045**	**$ 2,157**
EBITDA less NCI multiple	**7.8 x**	**7.9 x**	**7.6 x**	**7.6 x**	**7.7 x**	**7.4 x**
EBITDA Guidance Basis	**$ 2,276**	**$ 2,421**	**$ 2,522**	**$ 2,276**	**$ 2,421**	**$ 2,522**
EBITDA Multiple Guidance Basis	**7.1 x**	**6.6 x**	**6.5 x**	**6.9 x**	**6.5 x**	**6.3 x**
Enterprise value	**$ 16,084**	**$ 16,059**	**$ 16,290**	**$ 15,687**	**$ 15,659**	**$ 15,884**
Less Debt	$ 14,754	$ 15,257	$ 15,107	$ 14,754	$ 15,257	$ 15,107
Plus Unrestricted Cash	$356	$899	$543	$ 356	$ 899	$ 543
Memo: 2016E Cash and Debt at 12/31/16						
Memo: Net Leverage on EBITDA	**6.3 x**	**5.9 x**	**5.8 x**	**6.3 x**	**5.9 x**	**5.8 x**
Equity value	**$ 1,686**	**$ 1,701**	**$ 1,726**	**$ 1,289**	**$ 1,301**	**$ 1,320**
Equity Value per share	**$17.00**	**$17.00**	**$17.00**	**$13.00**	**$13.00**	**$13.00**
Shares used	**99.2**	**100.0**	**101.5**	**99.2**	**100.0**	**101.5**

Sources: Company reports, MSUSA estimates and Bloomberg

CYH shares are also credit-sensitive equity, in our view, which makes assigning a multiple there quite difficult. Our $3 PT is based on 7.5x our 2017E EBITDA less NCI estimate and includes the expected impact of the $1.2B in potential asset sales.

Finally, for LPNT, our $50 PT assumes a 6.9x 2017E EV/EBITDA multiple as LPNT has the most exposure to the Medicaid expansion and block grants (and we're concerned about its capex commitments for its acquisitions as volumes remain soft). Are those targets reasonable? Maybe. But we think our ratings are reasonable: all are rated Neutral, as in 'go invest somewhere else for the time being, in our view,' except for CYH, which remains rated Underperform.

Price Target Calculation and Key Risks

Community Health Systems, Inc.

Our valuation of $3 is based on 6.7x our 2016E EV/EBITDA and 7.5x our 2017E EBITDA on a guidance basis, including the assumed $1.2B in sale proceeds as cash. We now expect FCF to be negative in 2016, along with further margin compression in 2016 and 2017, which argues for a below peer multiple. However, the high degree of leverage prevents the multiple from going much below 6.5x. These reflect likely volume and mix pressures, coupled with high leverage as well as the remaining CVR risk.

Risks to our rating and price target include, but are not limited to, better than expected asset sale results or the involvement of an activist investor, or the acquisition of shares by deep value investors. Factors weighing on valuation include, but are not limited to, relief of the following: pricing pressure from government and private payers, continued soft volume growth, additional labor cost pressures, further deterioration of bad debt, integration of HMA and turnaround of HMA, physician losses, competition for acquisitions, the pending spin-off and a highly levered balance sheet. However, CYH may be more successful at cost cutting and growing volume than we think and that could cause upside surprise to be reflected in the stock price. CYH has not yet finalized the value of the CVR, which could result in unexpectedly higher settlement and/or legal costs above the reserve level. ACA repeal risk, along with the risks associated with Medicaid block grants and Medicare privatization also exist.

HCA Holdings, Inc.

Our valuation of $78 is based on 7.3x our 2016E EV/EBITDA less NCI.

Risks to valuation include, but are not limited to, repeal/replacement of the ACA, pricing pressure from government and private payors, continued soft volume growth, further deterioration of bad debt, competition for acquisitions, increasing labor costs and labor market shortages, HITECH payment risk, a levered balance sheet and the repeal of all of the provisions of the ACA and the implementation other recent legislation (MACRA and IMPACT), along with the potential for privatization of Medicare and block grants for Medicaid.

LifePoint Health, Inc.

Our valuation of $50 is based on a 6.5x multiple on our 2017E EV/EBITDA less NCI, which rises to 7.5x when we include an estimate of future capex liabilities as 'debt.' We think this multiple is appropriately reflecting likely inpatient volume pressures, the dilutive impact of acquisitions in the near term plus capex commitments associated with them and balanced by its moderately levered balance sheet and smaller, but still positive, FCF. Risks to valuation include pricing pressure from government and private payors, continued soft volume growth, further deterioration of bad debt and competition for acquisitions, excess dilution from acquisitions due to slower than expected improvement in margins and execution risk and the risk of repeal, Medicaid block grants and Medicare privatization.

Quorum Health Corp

With our below-guide $170mm EBITDA estimate and with serious total net leverage of 6.0x our corresponding $233mm LTM CA EBITDA estimate, the EV multiple

explodes in our target price model. At our new target of $3, the stock would trade at 8.2x guidance-basis EBITDA. But if the assets are sold, $3 is only 6.7x our new estimate.

Risks to our rating and price target include, but are not limited to: repeal/replace the ACA, execution, reimbursement, litigation, regulation, investigation and other market and government-based risks. In addition, QHC, formed through a spin-off from CYH, is a very new company just having been formed on 4/29/15. Thus, it has a limited track record and has not laid out its strategic plan. Our estimates, and therefore our rating and price target, are thus based on extremely limited company-specific information. We expect the shares to be very highly volatile given the small float and high degree of leverage, and the risk of repeal of the Medicaid expansion.

Tenet Healthcare Corp.

Our $13.00 PT is based on 7.4x our 2017E EBITDA less NCI of $2.157B, which corresponds to 6.6x our 2016E EBITDA and 6.3x our 2017E EBITDA. Risks to our price target include, but are not limited to, repeal/replace the ACA, pricing pressure from government and private payors, continued soft volume growth, HITECH payment risk, execution risk (including closing transactions in a timely fashion) and further deterioration of bad debt. Risks associated with health policy changes, ACA repeal, Medicaid block grants, privatization of Medicare all factored into our target multiple as well.

IMPORTANT DISCLOSURES

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Ownership Disclosures and Material Conflicts of Interest or Position as Officer or Director

None

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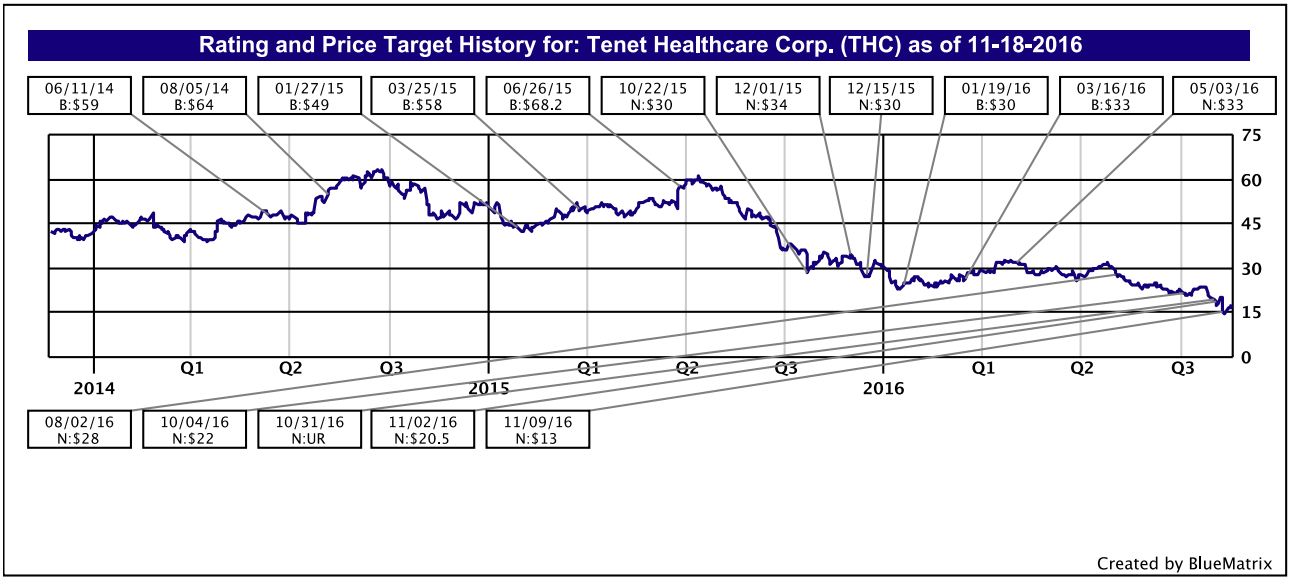
Neutral:	Stocks for which the anticipated share price appreciation is within 10% of the share price.
Underperform:	Stocks for which the anticipated share price falls by 10% or more.
RS:	Rating Suspended - rating and price objective temporarily suspended.
NR:	No Rating - not covered, and therefore not assigned a rating.

Rating Distribution

(As of 11/21)	% of coverage	IB service past 12 mo
Buy (Buy)	41.64%	44.64%
Hold (Neutral)	56.51%	32.89%
Sell (Underperform)	1.86%	20.00%

For disclosure purposes only (NYSE and FINRA ratings distribution requirements), our Buy, Neutral and Underperform ratings are displayed as Buy, Hold and Sell, respectively.


Rating and Price Target History for: Tenet Healthcare Corp. (THC) as of 11-18-2016
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08/05/14 B:$64
01/27/15 B:$49
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06/26/15 B:$68.2
10/22/15 N:$30
12/01/15 N:$34
12/15/15 N:$30
01/19/16 B:$30
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08/02/16 N:$28
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11/02/16 N:$20.5
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Q1 Q2 Q3 Q1 Q2 Q3 Q1 Q2 Q3
2014
2015
2016
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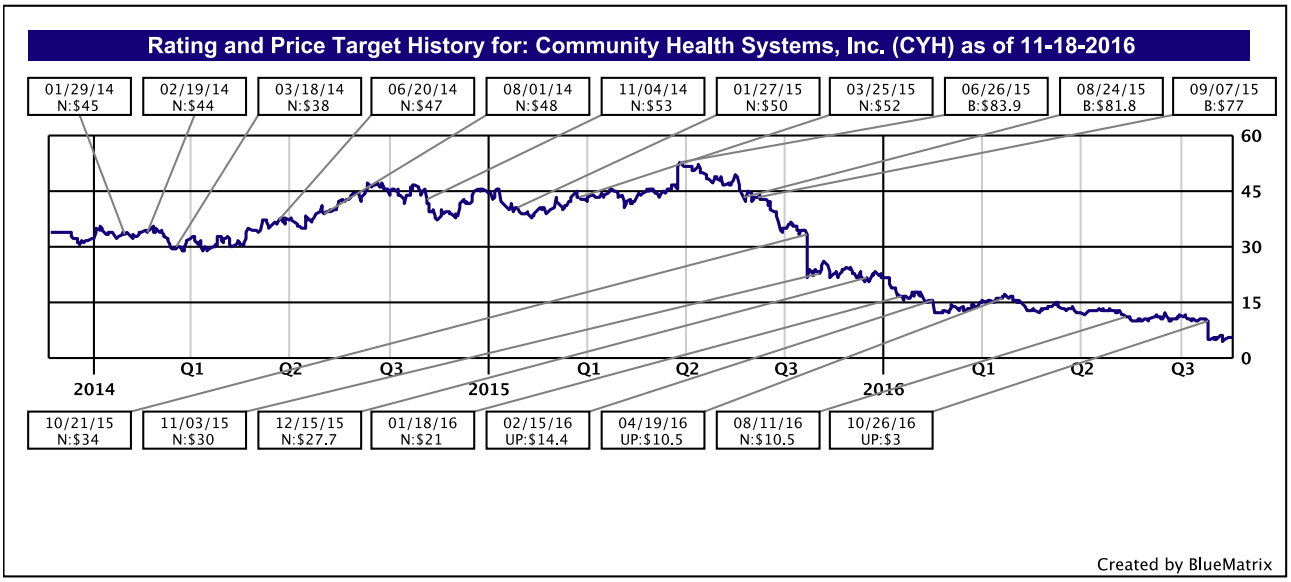
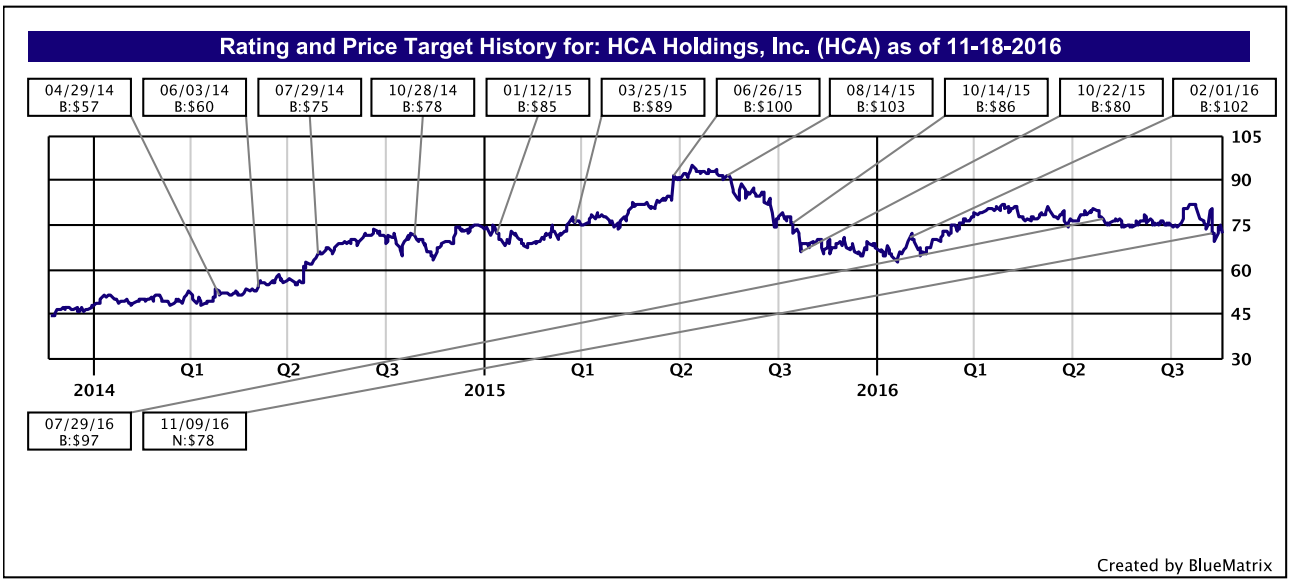
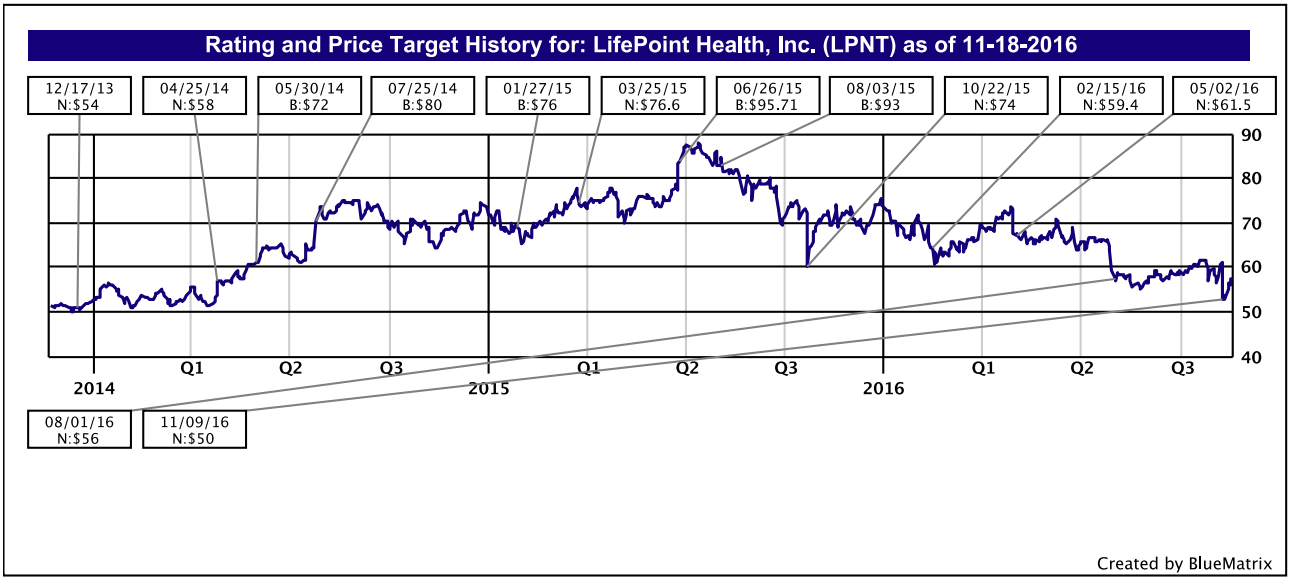
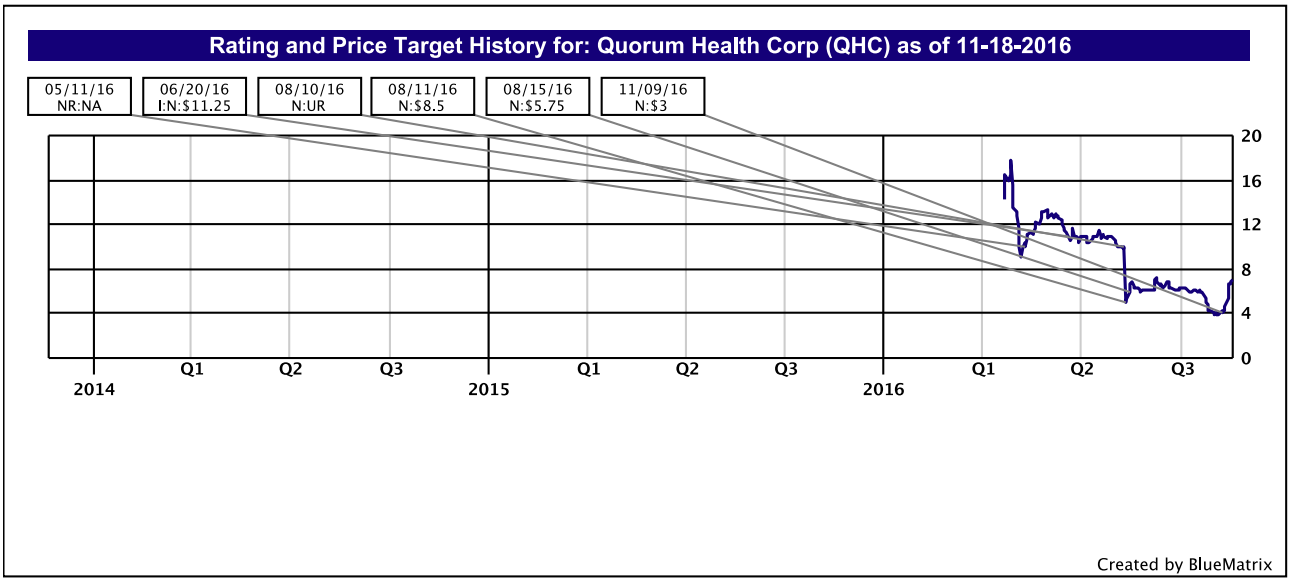

Rating and Price Target History for: Community Health Systems, Inc. (CYH) as of 11-18-2016
01/29/14 N:$45
02/19/14 N:$44
03/18/14 N:$38
06/20/14 N:$47
08/01/14 N:$48
11/04/14 N:$53
01/27/15 N:$50
03/25/15 N:$52
06/26/15 B:$83.9
08/24/15 B:$81.8
09/07/15 B:$77
10/21/15 N:$34
11/03/15 N:$30
12/15/15 N:$27.7
01/18/16 N:$21
02/15/16 UP:$14.4
04/19/16 UP:$10.5
08/11/16 N:$10.5
10/26/16 UP:$3
60
45
30
15
0
Q1 Q2 Q3 Q1 Q2 Q3 Q1 Q2 Q3
2014
2015
2016
Created by BlueMatrix


Rating and Price Target History for: HCA Holdings, Inc. (HCA) as of 11-18-2016
04/29/14 B:$57
06/03/14 B:$60
07/29/14 B:$75
10/28/14 B:$78
01/12/15 B:$85
03/25/15 B:$89
06/26/15 B:$100
08/14/15 B:$103
10/14/15 B:$86
10/22/15 B:$80
02/01/16 B:$102
07/29/16 B:$97
11/09/16 N:$78
105
90
75
60
45
30
Q1 Q2 Q3 Q1 Q2 Q3 Q1 Q2 Q3
2014
2015
2016
Created by BlueMatrix





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