PHILADELPHIA AREA MUNICIPAL ANALYST SOCIETY (PHAMAS)

HEALTHCARE M&A
RECENT ACTIVITY AND POTENTIAL CREDIT IMPLICATIONS
SEPTEMBER 27, 2018

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Tower Health is a nonprofit integrated healthcare system in the Philadelphia area, with six acute-care hospitals and related facilities. The system was formed through the 2017 acquisition of five former for-profit facilities by flagship Reading Hospital. Daniel has been associated with Tower and Reading Hospital since 2014, and previously held a similar position at another health system.

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Christine Doyle has over 30 years of experience in public and healthcare finance. She advises healthcare, senior living and other nonprofit clients on financial and capital planning, development and implementation of balance sheet strategies, financial risk management, evaluation of financing strategies, and optimal financing execution. She also works with a variety of healthcare organizations, including health systems, specialty hospitals, community hospitals, CCRCs, and nursing homes. Prior to joining PFM, Christine was an investment banker at Kidder, Peabody in public finance, and at Donaldson, Lufkin, & Jenrette in corporate finance. Christine holds a BA from Harvard University and a MBA in Finance from Columbia University. In the community Christine is on the Board of Trustees of Lasell Village, a CCRC in Newton, MA, and is board chair of the Friends of Leo J. Martin Skiing. More at https://www.pfm.com/who-we-are/professional?name=cdoyle

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HOSPITAL AFFILIATION STRUCTURES

CLINICAL AFFILIATIONS: Clinical Affiliations span a myriad of arrangements relating solely to the delivery of clinical services. Typically, smaller hospitals which do not have sufficient scale to sustain certain clinical service lines in an economical or quality manner arrange with larger hospitals to share their expertise, sometimes by applying the larger hospital's brand. These arrangements give the larger partners additional referral sources without significant capital investment. Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs) can be considered forms of Clinical Affiliations that include payment components. Clinical Affiliation arrangements vary widely, but all feature neither a governance nor a financial relationship between the partners.
Example: *Columbia Memorial Hospital and Oregon Health & Science University, with respect to the oncology, cardiology, general surgery and emergency medicine service lines*

JOINT OPERATING AGREEMENTS (JOAS): JOAs are not true mergers, or transfers of assets. Instead, most JOAs are carried out by creating a new corporations known as a joint operating companies (JOCs). A JOC, usually a tax-exempt non-profit Section 501(c)(3) organization, serves as the parent organization of two or more affiliating hospitals and represents the main management and financial authority. However, JOAs allow each hospital to retain separate identities and boards.
Example: *ProMedica Health System and Lima (OH) Memorial Hospital*

SELLER JOINT VENTURES (SJVS): SJVs are typically, but not always, formed between community hospitals and investor-owned companies. The investor-owned company acquires a majority interest in the hospital (usually 60-80 percent). However, local control is preserved for the community via 50 percent hospital representation on the joint venture board. In these arrangements, the hospital gains access to needed capital while maintaining a collaborative culture, and the investor reaps returns if and when the hospital partner grows its market share.
Example: *LHP Hospital Group's joint venture with Portneuf Medical Center in Idaho*

BUYER JOINT VENTURES (BJVS): BJVs combine the respective expertise of a clinical partner or a system with a regional presence with an investor-owned system. The clinical partner holds a minority of the equity interest (typically 3-20 percent) and is responsible for overseeing medical safety and quality or providing regional services. The investor-owned partner provides capital (typically 80-97 percent), management capabilities and economies of scale to run the community hospital. BJVs then seek to acquire hospitals and health systems.
Example: *Duke LifePoint's BJV that acquired Conemaugh Health System in Pennsylvania*

MULTI-PARTY JOINT VENTURES: Multi-Party Joint Ventures combine the characteristics of SJVs and BJVs. This model enables the involvement of a clinical partner, capital infusion and preservation of local control. While complex in execution, it has been implemented in a handful of settings around the United States. Multi-Party Joint Ventures lend themselves to an emerging, but yet to be realized, development in the nonprofit hospital industry: the integrated foundation model. This structure allows community hospitals to utilize the financial proceeds of change-of-control transactions to support research, education, training and other academic functions in a community hospital setting. The promise of access to a share of the annual earnings of the foundation created through the transaction are used to lure a preferred academic partner committed to research, academics, quality and clinical growth at the community hospital.

SHELF JOINT VENTURES: In order to be ready to compete effectively for acquisition opportunities, BJVs are sometimes organized before actual acquisition targets become available. Typically, a letter of intent is signed between the prospective joint venture partners, which is then made binding simultaneously with the closing of the acquisition.

CONSOLIDATION TRANSACTIONS: Consolidation Transactions occur when two or more parties combine to create a new parent companies with self-perpetuating governing boards. Consolidation Transactions are difficult to execute but typically multiply the size of the individual partners, quickly achieving scale. This was a very popular structure in the 1990s and has seen a revival more recently.
Example: *Sentara Healthcare in Virginia*

MEMBERSHIP SUBSTITUTIONS: Membership Substitutions are the most common structures between merging non-profit hospitals. One party transfers its corporate membership to the other party, which becomes the new "owner" as the sole corporate member. This structure is commonly used in non-profit transactions where there is an advantage for one party's corporate structure to remain intact post-closing, or the one party wants to assume, rather than retire, the other party's liabilities.
Example: *Meriter Health System joining UnityPoint Health*

ASSET SALES: Asset Sales are the typical structure for an investor-owned companies' acquisitions of non-profit hospitals. Buyers acquire the assets (working capital, fixed assets, intangibles) and excludes most liabilities, which the seller then satisfies via a number of techniques. Because of the change-in-use to a "non-exempt" person, tax-exempt bonds cannot remain outstanding and must be redeemed. Remaining funds are typically used to establish local community foundations that can be used for various charitable purposes, including promotion of healthcare in the community.
Example: *Sale of Marquette (MI) General Health System to Duke LifePoint*

Tower Health

September 2018

TOWER HEALTH
Advancing Health. Transforming Lives.

Community Hospitals

"Independent" but Evolving

Philadelphia Area Municipal Analyst Society

September 27, 2018

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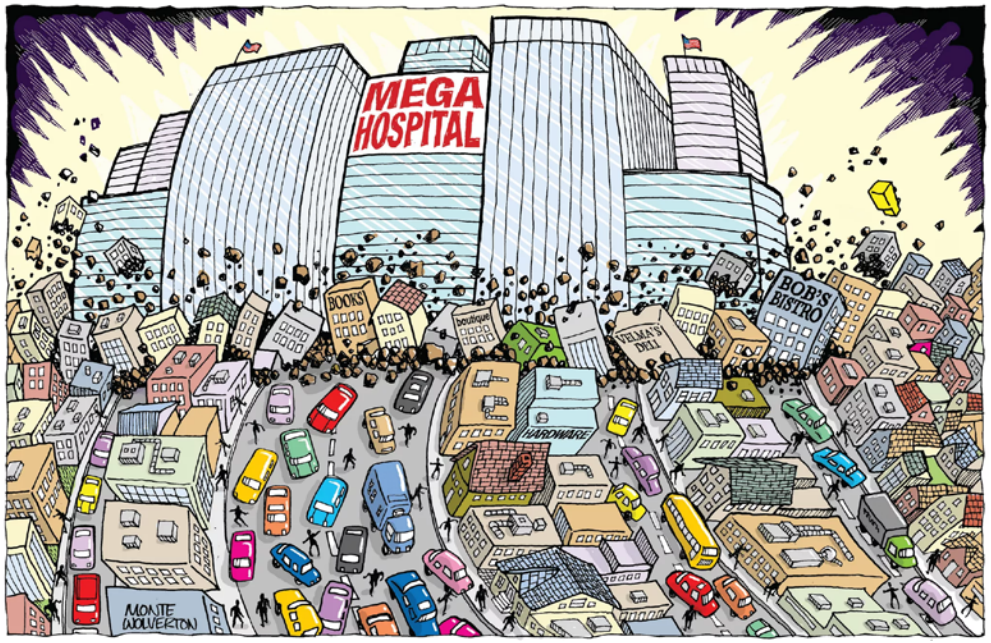
Mission of Community Hospitals

- Community hospitals see themselves as anchors of communities
- Community hospitals provide patient-centered care and overall community health services, including primary care, wellness, behavioral health and prevention
- Major community employers and embedded in community network of social service organizations
- Community hospital Boards typically from the community and strongly committed to it.

Why are Community Hospitals on High Alert?

- Significant consolidation of the past 30 years
- Business model is threatened
- In 1980 ~ 5,900 community hospitals → ~4,800 in 2018



Challenges for Community Hospitals

- Inpatient volumes shrinking and Outpatient environment becoming extremely competitive
  - Non traditional competitors among retailers, insurers, and others
- Provider Recruitment very difficult – physicians, nurses, care extenders
  - Challenges recruiting medical specialists and hard to ensure high quality care for infrequently provided services
- Declining reimbursement
  - Commercial pay squeezed by insurance mergers, large employer efforts, narrow networks
  - Government pay declining as Medicare and Medicaid programs seek to reduce costs

Challenges for Community Hospitals (cont'd)

- Access to, and cost of, advanced technologies, emerging drugs, medical devices, and specialty care
- Investments needed for population health data that is foundation for approaching global payment shift
- Walking a communications tightrope
  - Community hospitals' leadership teams must convey confidence and commitment to their future
  - Simultaneously keeping dialogue open with competitors and other organizations about potential partnerships
- Essentially prepare for potential merger even while pursuing independence

One Potential Response by Community Hospitals

- Pull up the drawbridge and fill up the moat!

"Hey, you wanna talk about ripe for a takeover?"

But Successful Community Hospitals are taking the Opposite Approach – They are engaging with Allies and Competitors

- Successful Community hospitals are surviving - and in some cases thriving – through engagement
- The community hospital of 2018 is not the community hospital of 1980
  - Very few community hospitals are operating completely on their own
- Many community hospitals are building a web of relationships with other organizations throughout their local health and social care continuum
  - Physicians groups
  - Medical Schools
  - Social Service Agencies
  - Specialty Hospitals
  - Schools
  - Housing Organizations
  - Transportation services
  - Post Acute Care
- How are these arrangements working? How are they changing community hospitals?
- **Community hospitals may be creating the networks required for their survival, OR**
  - **They could be creating a glide path for future merger**

Succeeding as Community Hospital by changing the Definition

- Community hospitals seek to preserve the essence of independent community control while gaining targeted benefits of a merger

Arrangements pursued by Community Hospitals short of merger

- Brand name affiliations – co-branding with regional AMC or national brand organization
  - protocol sharing, oversight, consultation
- Alliances / Partnerships – minority stakes, ACOs, shared services
  - Primary care practices, ambulatory surgery, retail location, etc.
- Joint Ventures – with separate governance structures
  - Members with “skin in the game”
- Partnerships to advancing population health through dominant market position and geography

Examples of Community Hospital Arrangements

- Community hospital in western MA provides certain cardiac services in conjunction with larger central state system

- Community hospital in eastern MA
  - Partners with urban AMC in a Medicaid ACO
  - Same hospital partner with a different urban AMC for cancer care in facility developed as joint venture with private financing

- Community hospital in southeast New England
  - Medicaid ACO with an urban AMC
  - National brand-name affiliation for cancer care

Examples of Community Hospital Arrangements (cont'd)

- CT community hospital develops cancer center program with minority investment from urban AMC
- CT community hospital in shared services network of community hospitals
- NH community hospital develops cancer center with minority investment and staffing from national brand program
- Southern New England hospital hosts urban AMC medical students
- MA community hospital manages another community hospital and co-brands

Credit Implications and Funding Approaches

- Arrangements pursued by community hospitals could have credit implications
  - Need aligned vision and culture for the new arrangement
  - Careful contract structures to align incentives and creates clear paths for advancement or exit
  - Clear leadership and governance with ongoing commitment to program, not just launch

- Funding approaches have credit implications
  - Directly funded investment by one or both partners – equity or direct debt
  - Guaranteed debt under permitted buckets of either partners
  - Private funding by developer or third party in conjunction with operating lease or rent
    - Careful treatment for operating leases

Credit Implications and Funding Approaches (cont'd)

- Implications of termination of arrangements
  - Amicable and orderly unwinding
  - Hostile and sudden – expensive, disruptive, poor public relations

SUMMARY

- Community hospitals has found ways to survive and sometimes thrive by evolving from the traditional community hospital model
- Success requires partnership and alliances and open mind to new arrangements
- Current success in evolved community hospital model is not a guarantee of success in the future

2018 Year-to-Date Health Care Transactions

Issue	State	Rating	Sale Date	Underwriter	Par Call	Issue Size	30 Year Maturity	30 Year Coupon	30 Year Spread to Call	30 Year Spread to Maturity
Mayo Clinic	MN	Aa2/AA/NR	09/18/2018	BAML	05/15/2028	200,000	2048	4.000	77	78
St Tammany Parish Hospital	**LA**	**NR/NR/A+**	**09/13/2018**	**Citi Group**	**07/01/2028**	**72,620**	**2048**	**4.125**	**n/a**	**110**
St Tammany Parish Hospital	**LA**	**NR/NR/A+**	**09/13/2018**	**Citi Group**	**07/01/2028**	**72,620**	**2048**	**5.000**	**75**	**131**
U. of Maryland Capital Medical Center	MD	Aa1/AA+/NR	09/12/2018	Barclays Capital	10/01/2028	91,985	2048	5.000	31	109
Sarasota Memorial Hospital	FL	A1/NR/AA-	09/12/2018	JP Morgan	07/01/2028	350,000	2048	4.000	n/a	99
Denver Health	CO	NR/BBB/BBB	08/29/2018	Piper Jaffray, Inc.	12/01/2018	37,815	2048	5.000	90	143
Cabell Huntington Hospital	WV	Baa1/BBB+/NR	08/28/2018	Morgan Stanley	01/01/2029	240,300	2047	4.125	n/a	120
Adventist Health System West	CA	NR/A/A+	08/22/2018	Ziegler Securities, Inc.	03/01/2028	245,660	2048	5.000	35	121
Adventist Health System West	CA	NR/A/A+	08/22/2018	Ziegler Securities, Inc.	03/01/2028	245,660	2048	4.000	74	88
LA Biomedical Research Institute	CA	Baa2/NR/NR	08/16/2018	Wells Fargo	09/01/2018	49,835	2048	5.000	60	130
Allegheny Health Network	PA	NR/A/NR	08/15/2018	Citi Group	04/01/2028	943,365	2047	5.000	87	144
St. Luke Health System	ID	A3/A-/NR	07/25/2018	JP Morgan	09/01/2028	165,506	2048	4.000	n/a	109
Inova Health System	VA	Aa2/AA+/NR	07/18/2018	Morgan Stanley	05/15/2028	206,860	2048	4.000	75	93
Valley Health System	VA	A1/A+/NR	07/17/2018	Ziegler Securities, Inc.	01/01/2028	54,365	2050	4.000	95	97
Maine Medical Center	ME	A1/A+/NR	07/11/2018	Morgan Stanley	07/01/2028	164,330	2048	4.000	98	104
Maine Medical Center	ME	A1/A+/NR	07/11/2018	Morgan Stanley	07/01/2028	164,330	2048	5.000	58	134
West Virginia United Health System	WV	A2/A/NR	6/27/2018	BAML	6/1/2028	218,550	2051	4	n/a	117
Adventist Health System (Sunbelt)	CO	Aa2/AA/AA	6/20/2018	JP Morgan	5/15/2028	257,055	2048	5	45	126
Adventist Health System (Sunbelt)	CO	Aa2/AA/AA	6/20/2018	JP Morgan	5/15/2028	257,055	2048	4	82	94
CareGroup Inc.	MA	Baa1/A-/NR	6/13/2018	Citi Group	7/1/2028	432,725	2048	5	73	136
Evangelical Community Hospital	**PA**	**NR/A-/NR**	**6/12/2018**	**Ziegler Capital**	**8/1/2028**	**50,095**	**2048**	**5**	**66**	**149**
McLeod Health	SC	NR/AA/AA-	6/12/2018	JP Morgan	5/1/2028	144,275	2048	5	48	126
McLeod Health	SC	NR/AA/AA-	6/12/2018	JP Morgan	5/1/2028	144,275	2048	4	85	93
East Alabama Medical Center	**AL**	**NR/A/NR**	**5/17/2018**	**BAML**	**3/1/2028**	**35,080**	**2048**	**4**	**n/a**	**99**
Penn Highlands Healthcare	PA	NR/A-/A-	5/17/2018	BAML	1/15/2028	35,080	2048	5	69	133
Penn Highlands Healthcare	PA	NR/A-/A-	5/17/2018	BAML	1/15/2028	158,000	2048	4	n/a	100

** Denotes transactions where PFM Financial Advisors LLC was the financial advisor.*

2018 Year-to-Date Health Care Transactions (continued)

Issue	State	Rating	Sale Date	Underwriter	Par Call	Issue Size	30 Year Maturity	Coupon	Spread to Call	Spread to Maturity
Lawrence Memorial Hospital	**KS**	**NR/A/NR**	**5/10/2018**	**Piper Jaffray, Inc.**	**7/1/2028**	**77,520**	**2048**	**5**	**68**	**135**
Ballad Health	TN	Baa1/A-/A	5/10/2018	BAML	7/1/2023	535,170	2044	5	80	168
Sentara Healthcare	VA	Aa2/AA/NR	5/3/2018	Barclays Capital	11/1/2028	88,620	2048	4	80	90
SSM Health	MO	A1/A+/AA-	4/25/2018	Citi Group	6/1/2028	73,425	2048	5	67	125
SSM Health	MO	A1/A+/AA-	4/25/2018	Citi Group	6/1/2028	73,425	2048	4	n/a	102
Mason General Hospital	WA	NR/A-/NR	4/11/2018	Piper Jaffray, Inc.	12/1/2027	34,730	2048	5	83	148
Huntington Memorial Hospital	**CA**	**NR/A-/NR**	**4/10/2018**	**Barclays Capital**	**7/1/2028**	**100,000**	**2048**	**5**	**52**	**128**
Huntington Memorial Hospital	**CA**	**NR/A-/NR**	**4/10/2018**	**Barclays Capital**	**7/1/2028**	**100,000**	**2048**	**4**	**97**	**101**
Bozeman Deaconess Health Services	MT	NR/A/NR	4/10/2018	D. A. Davidson	6/1/2028	68,715	2048	5	60	132
Sutter Health*	CA	Aa3/AA-/A+	3/27/2018	Morgan Stanley	11/15/2027	616,790	2048	5	39	124
OU Medicine	OK	Baa3/BB+/NR	3/6/2018	BAML	8/15/2028	911,245	2048	5.25	115	166
Prime Healthcare Foundation	WI	NR/NR/BBB-	1/11/2018	Cain Brothers & Co, Inc.	12/1/2027	133,755	2045	5.35	n/a	272
AdvocateAurora Health	WI	Aa3/AA/NR	8/7/18	JPMorgan / Citi	MWC	409,880	2048	4.272%	n/a	115
West Virginia University Health System	WV	A2/A/NR	7/30/18	BAML / Barclays	MWC	210,405	2048	4.924%	n/a	182
Montefiore	NY	Baa2/BBB/NR	7/25/18	BAML / Citi	MWC	481,950	2048	5.246%	n/a	215
St.Lukes Health System	ID	A3/A-/NR	7/25/18	JPMorgan	MWC	149,910	2048	5.020%	n/a	195
Centra Health	VA	A2/A/NR	7/24/18	Barclays	MWC	101,455	2048	4.700%	n/a	160
McLaren Health Care	MI	Aa3/NR/AA	7/18/18	JPMorgan / PNC	MWC	300,000	2048	4.386%	n/a	140
Valley Children's Hospital	CA	A1/AA-/NR	7/17/18	JPMorgan / MS	MWC	202,272	2048	4.399%	n/a	143
IHC Health Service	IL	Aa1/AA+/NR	6/26/2018	JP Morgan	MWC	227,104	2048	4.131	n/a	111
Marin General Hospital	**CA**	**NR/A-/NR**	**5/23/2018**	**Morgan Stanley**	**MWC**	**66,835**	**2045**	**4.821**	**n/a**	**170**
Saint Luke Health System	MO	A1/A+/NR	5/9/2018	RBC Capital	MWC	98,160	2048	4	n/a	101
El Centro Regional Medical Center	**CA**	**NR/NR/NR**	**4/4/2018**	**Keybanc Capital Market**	**MWC**	**125,000**	**2048**	**5.5**	**n/a**	**309**
Sutter Health	CA	Aa3/AA-/A+	3/27/2018	Morgan Stanley	MWC	683,270	2048	4.091	n/a	103
Mount Nittany Medical Center	PA	NR/A/AA-	2/22/2018	BAML	MWC	18,470	2047	4.35	n/a	114
Ann & Robert Lurie Children's Hospital	IL	NR/AA-/NR	1/10/2018	JP Morgan	MWC	160,275	2047	3.944	n/a	105

Transactions below the line in green are taxable.

Transactions in Bold are community hospitals.

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Bond-Related Aspects of M&A Transactions Involving Nonprofit Hospitals and Health Systems

Presentation to the Philadelphia Area Municipal Analyst Society (PhAMAS)
September 27, 2018
Philadelphia, Pennsylvania

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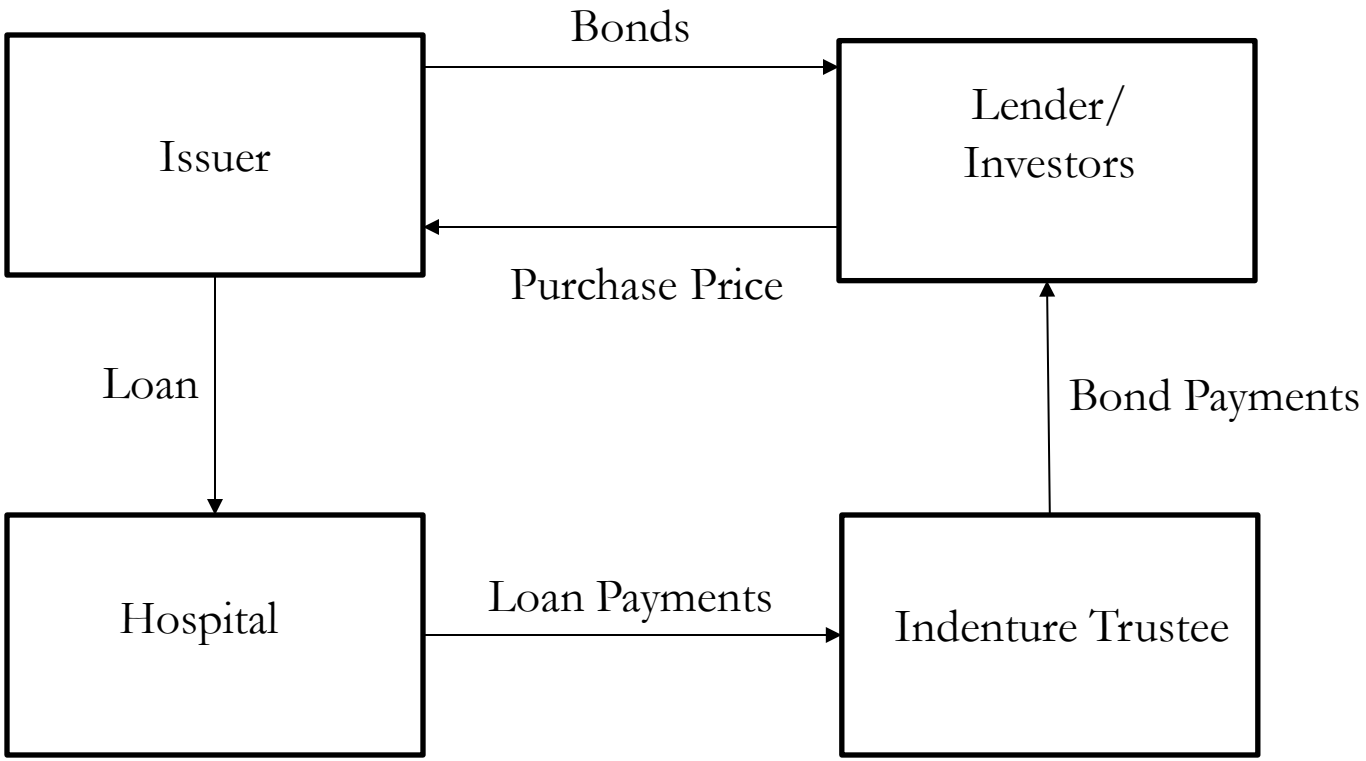
Ballard Spahr LLP

Structure of a Simple Tax-Exempt Hospital Bond Financing



Development of the Obligated Group

- During the 1970's and 1980's, hospitals began reorganizing to put different activities into different but often related entities
- Reasons for this:
  - Regulatory
  - Reimbursement
  - Federal, State and Local Taxes
  - Competitive Factors

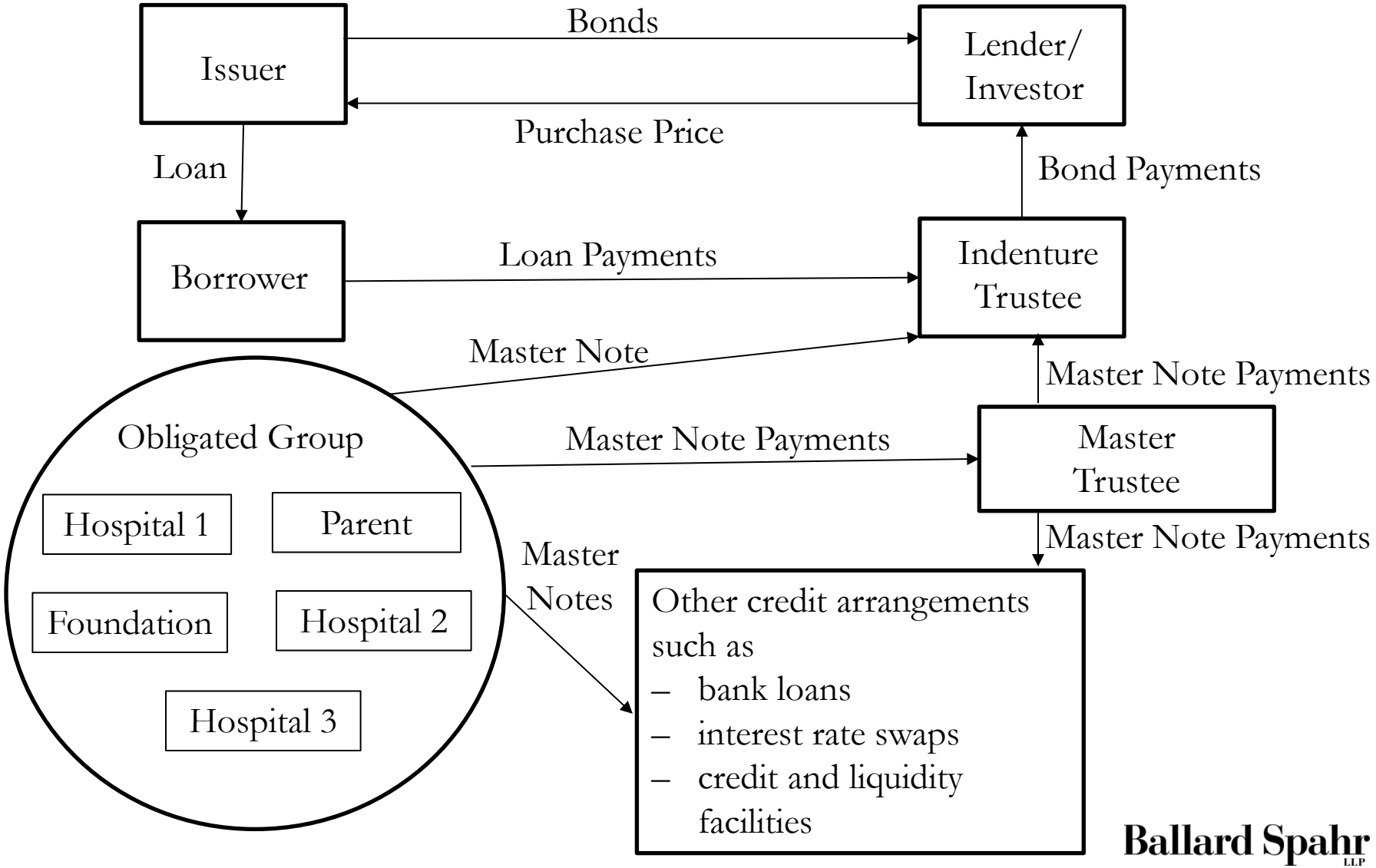
Development of the Obligated Group, cont.

- For example, a single hospital corporation might spin off activities into the following separate entities:
  - Parent
  - Foundation
  - Hospital
  - Physician practice group
  - Real estate holding company

Development of the Obligated Group, cont.

- How to organise some or all of these entities into a single credit group?
- The Master Trust Indenture (MTI)
  - Allows members to join or leave the group upon satisfaction of specified conditions
  - Includes financial tests to be met generally on a combined basis
  - Obligations issued are generally joint and several obligations of the members of the obligated group

Structure of a Master Trust Indenture Tax-Exempt Hospital Bond Financing



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Covenants Typically Found in Master Trust Indentures

- Limitations on
  - Additional debt
  - Liens on property
  - Asset transfers
  - Mergers and acquisitions
  - Entities joining obligated group
  - Entities leaving obligated group
- Transactions within the obligated group are generally permitted

Covenants Typically Found in Master Trust Indentures, cont.

- Typically, however, there are NO limitations on:
  - Governance
  - Management
  - Changes in control
  - Affiliations
- There may be collateral for the obligations secured under the MTI, including
  - Revenue pledge
  - Mortgage of real estate
  - Security interest in equipment

Forms of M&A Transactions and Affiliations

- Asset acquisition
  - Transfers of real and personal property
  - Assignment of contracts
  - Licensing and permitting issues
- Changes in control
  - Membership substitution
  - Acquisition of Board appointment rights
  - Avoids many of the issues associated with asset transfers
  - Typically not constrained by bond covenants

Forms of M&A Transactions and Affiliations, cont.

- Joint Operating Agreement
  - Typically involves establishment of one entity to manage previously unrelated entities
  - Typically not constrained by bond covenants
- Clinical affiliations
  - Typically not constrained by bond covenants

What are the bond-related considerations when hospitals or health systems affiliate?

- Generally depends on the form of affiliation
- There may be none, especially for simple affiliations not involving asset transfers or changes in control
- If there is a change in control, the transaction may result in the consolidation of governance and management
- Pooling of credit and market access may be an intended outcome of a change in control
- Following a change in control, it may be desirable to combine the debt structures of the consolidating organizations to facilitate
  - Pooling of credit
  - Administrative simplicity

Options for Obligated Groups upon Change in Control

- Maintain existence of separate obligated groups
  - May result in multiple and inconsistent bond covenants to be observed
  - May not result in credit pooling
  - May hamper inter-group transactions such as consolidation of services
  - Parties may decide to cross-guaranty each other's MTI obligations
- Example: joint operating agreement with two separate obligated groups
- Terminate one or more of the obligated group structures
  - May require payment or defeasance of debt or related obligations
  - Cost may be prohibitive
- Consolidate obligated groups

Consolidation of Obligated Groups

- Consolidate the debt structures of the combining groups while leaving some or all of the debt obligations outstanding
- Typically involves termination of one or more MTIs and release of related collateral (or pledge of that collateral to the substitute MTI)
- The obligated group members of the terminated MTI join the acquiring entity's obligated group
- Relatively straightforward if the MTI being terminated contemplates substitution of MTIs

Conditions for substitution of MTIs

- MTI being terminated will normally require delivery to the Bond trustee of:
  - New master note from new obligated group
  - Confirmation of ratings
  - Bond counsel opinion
  - Proof that debt incurrence test under terminating MTI could be met by new obligated group on a pro forma basis
- Surviving MTI will normally require:
  - Satisfaction of tests for joinder of new members
  - Satisfaction of tests for incurrence of any additional debt to be issued to refinance obligations issued under the terminating MTI

Conditions for substitution of MTI's, cont.

- Problematic conditions
  - What if surviving MTI is required to contain "substantially equivalent covenants" as the terminating MTI
  - What if ratings maintenance is required when new obligated group does not have ratings from all agencies rating the terminating obligated group (not uncommon)
  - Can one rating be terminated immediately prior to the combination to avoid the ratings maintenance requirement?
- What if terminating MTI is silent on the issue of substitute MTIs?
  - Must all debt under terminating MTI be paid or defeased?
  - Can bondholder and other creditor consents be obtained?
  - Is it ever OK just to terminate an MTI and substitute a new MTI on the rationale that the combination will result in a larger credit group with better ratings?

Continuing Disclosure Considerations

- SEC Rule 15c2-12 requires filing of material event notices for (among other things)
  - Entering into a definitive agreement for a merger, consolidation, acquisition or asset sale
  - Consummation of the transaction or termination of the definitive agreement
  - Modifications to rights of bondholders, if material
  - Release, substitution or sale of collateral, if material
  - Ratings changes
- Consolidation of EMMA filings for the new consolidated group
  - Can inconsistent disclosure undertakings be reconciled?
  - For example, if the entities being acquired have agreed to post quarterly information within 45 days after each calendar quarter, but acquiring entity has 60 days, can the undertaking be changed from 45 days to 60 days?
  - Is bondholder consent required for such a change?
  - Or is the change justified by a change in circumstances – the entity that was formerly the reporting entity no longer exists, since the new obligated group is now the reporting entity?

Continuing Disclosure Considerations, cont.

- Historical Continuing Disclosure Compliance Issues
  - The new obligated group may be required to correct and/or disclose non-compliance with continuing disclosure undertakings by the acquired obligated group

Obligations other than Bonds Secured under the MTI

- Even if bondholder consent is not required, the substitution transaction will ordinarily require the consent of certain creditors that are secured under the MTI being terminated, including
  - Banks holding direct-placed tax-exempt debt
  - Banks and other lenders holding taxable debt, including lines of credit
  - Swap counterparties
  - Bond insurers
  - Banks providing credit and liquidity support for bonds.

Tax Considerations

- Essential to maintain the tax-exempt status of tax-exempt bonds
- Care must be taken that the transaction does not result in change in use of bond-financed facilities (or that remedial action is taken if it does). Example may include
  - Repurposing of financed facilities
  - Sale or lease of financed facilities to a taxable entity.
- Change in control or asset acquisition may present opportunities for "acquisition treatment" for tax purposes of the restructuring of acquired entity's bonds
  - Issuance of tax-exempt bonds by acquiring entity to defease tax-exempt bonds of acquired entity; proceeds are placed in escrow to pay the debt that has been assumed
  - Treated as a "new money" transaction for federal tax purposes
  - Not an advance refunding but the economic equivalent of advance refunding
  - Rules are complex