Assessing the Impact of Health Care Reform for Municipal Investors

July 2010

With the passage of the Health Care Reform Bill into law in March 2010, many investors have expressed interest in the impact that the new legislation will have on the health care sector. The impact of the new law is significant to the U.S. economy as overall health spending currently represents about 17 percent of the U.S. GDP and is projected to increase to about 19 percent by 2019. The Congressional Budget Office (CBO) estimates that the total cost of the reform may reach close to a trillion dollars over the next 10 years.

The not-for-profit (NFP) health care sector is a significant part of the acute care hospital universe with about 85 percent being nonprofits. Tax-Exempt financing is an important source of capital for NFP hospitals. Importantly, the NFP hospital sector represents about 8 percent of the main Barclays Capital Municipal Bond Index and about 13 percent of the Barclays Capital Revenue Index. WellsCap municipal bond portfolios have a significant weighting to the NFP health care sector with our portfolios having hospital exposure at or in excess of the Barclays Capital Municipal Bond Index.

In this paper, we initially discuss our outlook for the NFP health care sector in light of recent economic trends and, where applicable, anticipate how reform legislation will affect the industry. With this backdrop, we discuss various key health care fundamentals that contribute to our stable outlook for the near term. However, our outlook changes longer term, particularly in the second half of 2011 as some of the major provisions of reform begin to be implemented with full implementation in 2014. Finally, we conclude the paper with an overview of our investment strategy for the NFP health care sector. In general, we have found attractive relative value in the short bonds of hospital systems that have seasoned management, dominant market positions, and strong finances, which will likely lead to success in the post-reform environment. Successful providers will also need to adapt and maintain an attractive payor mix, ensure negotiating clout with third-party payors, while also reducing cost to maintain margins in the face of declining government reimbursement.

NFP Health Care Sector Outlook

In summary, the Health Care Reform law will expand insurance coverage and greatly impact how health care providers are reimbursed, resulting in winners and losers among NFP health care providers. Cost and expenditure pressures will escalate for providers, and those entities that are unable to adapt will struggle financially and ultimately may be acquired or cease to exist.

It is important to note that the majority of the Health Care Reform law will not go into effect until 2014 and therefore the full effect of reform legislation will not become reality for at least three years. Between now and then, it is also likely that implementation of many provisions will be difficult for states to execute, and the states may ultimately challenge some provisions. In other words, we expect that there will be catalysts and changes that will unfold and possibly alter the law as it is currently written. However, we expect the broad theme of lower reimbursement, higher volumes, and focus on quality outcomes to remain key parts of the law.

Although providers are preparing for the full implementation of the new law’s provisions by pursuing revenue growth strategies, investing in technology to improve cost structures, and assessing various physician and hospital alignment strategies, our current credit outlook for the NFP health care sector is relatively stable. Third-party payors continue to pay stable contractual rates and governmental payors remain supported by federal stimulus, which ends this calendar year. This, coupled with improved balance sheet metrics, give us providers, but are being more selective in focusing on vertically integrated hospital systems that have seasoned management, dominant market positions, and strong finances, which

Source: Centers for Medicare and Medicaid Services (CMS).
comfort that the sector will remain relatively calm over the next 12 months. Specifically, liquidity for NFP providers is fairly solid with cash and investments representing more than 165 days of expenses and 125 percent of outstanding debt for higher rated entities. Borrowing rates remain favorable for the near term and management teams have trended toward more conservative capital structures.

We see stress in the NFP sector beginning in the second half of 2011 due to declining reimbursement caused in part by large deficits in federal and state budgets. This coupled with anticipated weaker margins in the health insurance sector and health care reform implementation from 2011 through 2014 will lead to uncertainty as NFP providers begin to prepare for the post-reform environment. We are also concerned with the possibility of an inflationary environment and the negative effects of rising costs in borrowing rates. On a positive note, given many improved balance sheets, we believe the sector is better prepared to deal with the uncertainty going forward than in past recessions, or the difficult period following the Balanced Budget Act of 1997. We believe we can mitigate many of these concerns by focusing on NFP providers with strong industry positioning in economically viable markets with positive payor metrics.

While it is difficult to predict the impact of this complicated legislation on the NFP sector, we have analyzed the details and formed views on the providers that we believe will be best positioned to make the transition. Organizations whose physicians, hospitals, and insurance products are aligned to provide cost effective, quality care will be at an advantage as the Centers of Medicare and Medicaid Services (CMS) will encourage efficiency by allowing NFP providers to share in cost savings they achieve as early as 2012. We also believe the more diversified revenue streams of these vertically integrated delivery systems will be beneficial as the full impact of the law becomes realized. NFP providers that have robust information technology capability to track quality, cost, and government reporting will be rewarded as they will be able to share in some of the cost savings. We believe those NFP providers that can demonstrate improved quality-of-care cost efficiently will be reimbursed more favorably.

Other factors will also help determine which providers adapt to the new environment. The stronger providers with dominant market share will likely see opportunities as many smaller providers look to integrate with dominant providers since their ability to compete will be limited. In the intermediate term, we anticipate increased merger and acquisition activity as a result.

**Expanded Discussion of Key Health Care Fundamentals**

**Balance Sheets** As a result of market volatility, we see providers becoming more conservative in their debt structures and investment portfolios, which we view as positive for the sector. Many providers saw audited cash and investments rebound in 2009 as the equity markets bounced back from 2008 lows. This improvement strengthened balance sheets and allowed management to structure investment portfolios more conservatively. We also see a trend to more conservative debt structures as providers have exited variable rate positions, failed auction rate securities, and volatile derivative contracts and refinanced into fixed-rate borrowings at historically low rates. We believe this trend will continue into 2011 as borrowing costs remain historically low. Relative to many corporate and municipal bond sectors, NFP health care providers remain strong with cash positions of 120 percent to 160 percent of debt outstanding in the ‘A’ or higher rating categories.

**Reimbursement** We expect reimbursement to remain stable in 2010 and begin to decline in the intermediate term 2011-2014. The largest payor is Medicare, which represents approximately 42 percent of reimbursement nationwide. Federal fiscal year 2010 began October 1, 2009 and Medicare rates for acute providers improved slightly over 2009 levels with the expectation that rates will decline slightly in the intermediate term. Medicaid, supported by federal stimulus, is a concern in 2011 given reduced stimulus funding and current state budget shortfalls. With managed care payors, many providers remain locked into multi-year contracts that were secured during a stronger economy. We look for this trend to reverse in 2011 as contract renewals will reflect the economic times, including the effects of the reform legislation. We expect these negative effects to be passed on to providers as weaker reimbursement beginning in 2011.

**Utilization Trends** High unemployment and the uninsured population have caused a decrease in demand as many have postponed elective procedures and ambulatory care. We have seen soft volume growth in admissions and surgery volumes. Many providers have seen a shift in payor mix with an increase in self pay and Medicaid-eligible patients at the expense of the more profitable insured populations. We see the effects of this shift in reduced net patient revenue, increased charity care, and bad debt write-offs. While reimbursement rates will likely
remain stable in the near term, the shift in payor mix will continue to be a negative drag on performance. Providers in stronger markets with unemployment rates below state and national averages will fair better than providers in weaker markets. We see this trend continuing through 2010 if unemployment remains high. It is important to note, however, that the negative effect of increases in the Medicaid-eligible and uninsured population has been muted by federal stimulus that remains in effect through 2010. This is a contributing factor to our stable outlook on reimbursement in the near term.

In the intermediate term, payor mixes should improve with a more insured population. This will be complicated by declining reimbursement rates caused by the lingering effects of the recession and health care reform. The end of federal stimulus will likely cause a drop in Medicaid rates. As such, we anticipate the negative effects of declining reimbursement to offset the positive trend of an improving payor mix. Longer term, however, we are optimistic that reform will increase volumes while reducing bad-debt and charity-care write-offs for a positive net benefit for the sector.

**Operating Margins** Moody’s Investors Service showed that sector revenue growth exceeded expense growth in 2009 for the first time in several years (Special Comment, April 2010). While this preliminary review included audited information through June 30, 2009, we see similar trends in our surveillance for subsequent periods enforcing our view that reimbursement rates remained favorable with modest inflationary expense pressure in 2009. We see this trend continuing in 2010 and expect operating margins to remain healthy well into 2011. Medians for operating margin in the ‘A’ to ‘AA’ rating level have averaged 2.5 percent to 3.5 percent during the past year with maximum annual debt service coverage from 4.8x to 6.0x, respectively.

**Capital Expansion** While capital spending as a percentage of depreciation expense has averaged a healthy 140 percent for ‘A’ rated credits, it has slowed from 2008 levels as health care providers have preserved cash in a volatile market. Moody’s medians for 2008 show ‘AZ’ rated health providers averaged 1.5x depreciation expense. This ratio is important for several reasons. Depreciation expense is a measure of historical costs, meaning a facility that does not meet that measure will have an aged facility relative to competition. Average age of plant is a metric that we will follow closely if reimbursement becomes pressured and margins compress. It should be noted that providers who have invested in plant at accelerated levels have the luxury of cutting back, if necessary, to assess the effects of reform and the economy on operations.

**Labor Costs** We believe 2010 labor cost, which is the largest operating expense for providers, will remain comparative to the prior year given the high unemployment levels in many markets. In general, we anticipate nursing and other labor to remain in ample supply for a reasonable cost with low inflation projections in the near term. While this projection is a high level view of the national trend, it is important to view health providers on a local level. We believe a provider’s primary service area is important with factors such as competition, unionized work forces and the local economy having a large impact on a hospital’s largest expense. Each market is unique with respect to employment and competition, and these factors typically drive labor supply and demand. Our research group has several analysts dedicated to this sector in an effort to learn the local markets from which we invest.

**Non-Labor Costs** Given the backdrop of modest economic growth in 2010, we anticipate medical supply and other non-labor costs to remain consistent with 2009 levels. In the intermediate term, we are concerned that inflationary pressures and increasing utilization may cause medical supplies and other operating costs to increase at the exact time reimbursement is projected to decline. On a positive note, we believe many stronger providers with reduced operating costs and improved balance sheet strength are well positioned for the coming stresses in the reform environment, relative to peers. Low-cost, high-volume businesses with well capitalized IT programs will see a competitive advantage over providers that are slower to adapt.

**Physicians** We have noted a national trend where physician groups have sought out affiliations with health providers. This trend has only increased given the pending 21 percent cut in Medicare Part B reimbursement that is scheduled to take effect. The American Medical Association says a reduction will make physicians less likely to accept Medicare patients. Hospitals are not affected by the Medicare Part B reduction making affiliation with health providers more secure for doctors. We believe hospital providers with strong employed physician networks will benefit from increased Medicaid payments to primary care physicians as health care reform will increase the Medicaid eligible population to 133 percent of the Federal Poverty Level (FPL).

**Governmental Payors** The CMS adopted a market basket update of 3.0 percent for 2009 and 2.1 percent for 2010, which increased Medicare reimbursement to hospitals. The Medicare Payment Advisory Commission recommended increasing reimbursement by a market basket update of 2.4 percent in 2011. However, they also recommended reducing the payment rate 2.0 percent for each year
from 2011-2013 to offset the costs of implementing the new Medicare Severity Diagnostic Related Groups, which will give a net basket increase of only 0.4 percent in a period in which we anticipate higher inflation costs. Medicare Advantage payment reductions are estimated to total as much as $132 billion over 10 years, stressing rates going forward. Medicaid rates for 2010 are supplemented by federal stimulus funds. We believe rates will decline materially without additional federal stimulus.

**Managed Care Payors** The reform legislation will tax the managed care industry nearly $70 billion over the next 10 years. This regulation has been delayed until 2014, which will mute the reimbursement effect that was once scheduled to impact 2011. Concerns remain in the near term, however, as private insurers will be required to make some reforms in the next six months. These include ending the practice of revoking a policy holder’s coverage, covering adults younger than 26 on their parent’s policy, as well as insuring children with pre-existing conditions. These immediate revisions, coupled with recent economic concerns, point toward reduced reimbursement for providers starting in 2011. There is also the theory that premiums will rise in the near term as plans will attempt to bank as much capital as possible to offset the more substantive changes in 2014.

**Bad Debt and Charity Write-Offs** The effect of the economy on bad debt and charity is difficult to quantify and is likely much worse than reported given federal stimulus funding and COBRA extensions provided in the America Recovery and Reinvestment Act of 2009. We are concerned these write-offs will accelerate in 2011 as stimulus funding declines from current levels. While this is a concern in the intermediate term, we believe health care reform will materially reduce bad debt and charity as the majority of uninsured residents will be covered in 2014.

The following table is a summary of the key issues that will impact NFP health care performance and, as of the publishing date, our opinions on how these issues will affect the sector over three time frames: the near term (now-2011), ramp-up to implementation of Reform (2011-2014), and post-Reform (2015 forward) when the fully insured model (estimated to be 95 percent of population) is in place.

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<tr>
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<tbody>
<tr>
<td>Balance Sheets</td>
<td>Stable</td>
<td>Stable</td>
<td>Declining</td>
</tr>
<tr>
<td>Operating Margins</td>
<td>Stable</td>
<td>Margin compression due to reimbursement pressure</td>
<td>Lower margins offset by higher utilization trends</td>
</tr>
<tr>
<td>Capital Expansion</td>
<td>Strong due to continued low borrowing rates and favorable margins</td>
<td>Declining if: a) Borrowing costs increase, b) Margins compress, c) Reform concerns</td>
<td>Stabilizing at a lower level if margins compress</td>
</tr>
<tr>
<td>Health Care Costs</td>
<td>Stable due to high unemployment and low inflation. Market specific.</td>
<td>Increasing in inflationary environment.</td>
<td>Low-cost/High Volume systems will have competitive advantage</td>
</tr>
<tr>
<td>Utilization Trends</td>
<td>Weak demand due to economic concerns</td>
<td>Improving as economy emerges from recession</td>
<td>Higher volumes with increased insured population (95%)</td>
</tr>
<tr>
<td>Inpatient Procedures</td>
<td>Stable</td>
<td>Declining</td>
<td>Continual declining with technology and reform</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>Increasing</td>
<td>Increasing</td>
<td>Increasing</td>
</tr>
<tr>
<td>Physicians</td>
<td>Stable</td>
<td>Increased demand</td>
<td>Demand exceeds supply</td>
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<tr>
<td>Nurses and Affiliated Professionals</td>
<td>Stable</td>
<td>Increasing</td>
<td>Demand exceeds supply</td>
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<td>Supply Costs</td>
<td>Reduced</td>
<td>Increasing</td>
<td>Increasing</td>
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<tr>
<td>Information Technology Cost</td>
<td>Increasing</td>
<td>Increasing</td>
<td>Stabilizing</td>
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**Payor Mix**

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<tr>
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<th>Stable</th>
<th>Stable/Increasing</th>
<th>Increasing based on population</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>Increased</td>
<td>Increasing</td>
<td>Increasing</td>
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<tr>
<td>Medicaid</td>
<td>n/a</td>
<td>Ramping up</td>
<td>Increasing</td>
</tr>
<tr>
<td>State Exchanges</td>
<td>Declining</td>
<td>Improving</td>
<td>Accelerated decline</td>
</tr>
<tr>
<td>Commercial</td>
<td>Declining</td>
<td>Improving</td>
<td>Flat</td>
</tr>
<tr>
<td>Managed Care Payors</td>
<td>Increasing</td>
<td>Declining</td>
<td>Declining due to insured population</td>
</tr>
<tr>
<td>Bad Debt and Charity</td>
<td>Increasing</td>
<td>Declining</td>
<td>Lower-than-historical norms</td>
</tr>
<tr>
<td>Self</td>
<td>Increasing</td>
<td>Declining</td>
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Municipal Bond Strategy

While NFP health care has unique risks to consider, we believe that certain opportunities exist where the reward outweighs the risks, and a combination of quality research and relative value purchase decisions can generate favorable risk-adjusted returns for our municipal portfolios.

Over the last two years, our general investment strategy in the NFP health care sector has been to focus on shorter maturities of high investment grade (‘A’ category and higher) large national and regional integrated delivery health care providers. The vast majority of our NFP health care exposure across municipal portfolios has been on the front end of the yield curve with maximum maturities in the five-year range.

During the 2008/09 liquidity crisis, credit spreads widened to trading ranges not seen for over 10 years. Due to the crisis of confidence in the auction rate securities and variable rate demand bond markets, combined with further weakness in the monoline insurance market (insurance companies who provide guarantees to issuers), NFP health care providers refinanced outstanding debt and issued short-term, fixed-rate bonds at relatively wide credit spreads. We were able to identify high-credit-quality health care providers and invest at favorable relative valuations to generate solid risk-adjusted returns.

Over the next couple of years, health care providers will have to refinance a significant amount of short-term debt that was issued utilizing Letter of Credit (LOC) enhancement. Since the LOC market has become prohibitively expensive due to higher fees being charged, it’s likely that there will be solid near-term opportunities to invest in short-term, fixed-rate bonds issued by high-credit-quality NFP health care providers.

Health care bonds of higher investment grade quality (‘A’ category and higher) reached attractive valuations, based on credit spreads, over the last 12 to 18 months relative to ‘BBB’ category bonds as illustrated in Exhibit 1. Bonds of many ‘AA’ category NFP providers were trading in a range that previously only ‘BBB’ category providers reached. We viewed the credit spread widening as a compelling investment opportunity, especially for the bonds of higher investment grade quality NFP providers, which are likely to maintain their public ratings. By investing largely in the bonds of higher investment grade providers, we were able to maintain better liquidity and limit downgrade risk while generating good risk-adjusted returns. Although bonds of ‘BBB’ category NFP providers did perform well, we feel that there is future downgrade risk and credit challenges ahead as most of these companies are not as prepared to navigate the post health care reform environment. There are select BBB-rated bonds of NFP providers that we feel are attractive and appropriately priced to reflect the credit risk, but in general the risk/reward balance is more compelling from an investment perspective for A-category and higher bonds. We continue to favor bonds of higher investment grade NFP providers in the current environment.

Exhibit 1: New Issue Credit Spreads (in bps) over Municipal Market Data (MMD) for Health Care from 1998 to 2009

Average New Issue Health Care Spreads from 1998 to 2009 over MMD for Unenhanced Fixed Income Bonds

Source: B.C. Ziegler and Company (Data as of 7/2/10)
Larger health care providers that benefit from dominant market positions, better negotiating leverage with managed care payors, and economies of scale that generally lead to lower cost structures will be in the best position to navigate the changing health care landscape. Since reimbursement from payors will likely decline in the post-reform environment, those health care providers that are in the best position to drive down costs and improve efficiency will be able to continue to generate good cash flow and maintain credit quality. Bonds issued by these entities will maintain their values and ultimately improve in price as municipal market participants begin to separate the winners from the losers in the NFP health care sector. Conversely, single-site hospitals with only average market share and higher cost structures will likely suffer credit weakness and ultimate downgrades. Bonds issued by these hospitals will likely underperform due to weaker credit performance, rating downgrades, and credit spread widening. However, there have been a few potential acquisitions of NFP providers by for-profit providers and private equity firms which will result in refunding of the NFP providers outstanding municipal debt at par or a premium. Although we acknowledge the potential for further acquisitions of NFP providers and a par or premium refunding of the debt, our investment strategy does not hinge on finding potential acquisition targets, but on targeting well run NFP providers that are expected to be viable in the post-reform environment.

There are three ways our investment strategy is accommodating reform. First, we expect higher patient volumes with an estimated 32 million more insured patients as a result of the new legislation. While reimbursement-per-patient day will be lower in this environment, we anticipate the net benefit to be positive given the higher volumes and lower bad debt than historical norms.

Second, health care providers who successfully adapt to the high volume/low cost environment will have a competitive advantage over providers slower to adapt. We have favored vertically integrated delivery models, which include provider-owned physician groups and insurance health networks that share information technology and enjoy significant cost efficiencies. Successful systems tend to have good market share leverage, a strong balance sheet, and solid operating characteristics in the single ‘A’ to ‘AA’ rating categories.

Finally, our purchase decisions have focused on final legislation that takes effect in 2014. While we believe the sector is resilient and can adapt well to changes with improved balance sheet positions and more efficient cost structures, we anticipate the reimbursement in 2014 to be materially different from 2010. Our current short term positions have allowed us to invest in quality names at attractive yields that, while possibly not as well positioned for reform, mature prior to 2014. Our long term positions will continue to be names we believe are structured to succeed in the new environment. We will continue to evaluate this strategy as conditions warrant.

**Summary**

Despite challenging economic conditions and pending reform legislation, we believe the NFP health care sector is fundamentally sound, demand driven, and well capitalized. NFP providers currently represent 85 percent of all acute care hospitals and will continue to be a relevant part of the overall health care industry. NFP providers have proven to be adaptable in past recessions, leading us to believe they will successfully evolve with pending reform. Management teams in successful systems will continue to trim costs to evolve into the new high-volume, low-cost models with technology and business alignment. Those NFP providers that are able to drive down their costs in preparation for declining reimbursement will be the likely survivors over the longer term. In our opinion, those NFP providers slow to adapt will likely be acquired or dissolved. We remain concerned that reimbursement declines faster than some NFP providers can adapt. By selectively investing in providers that we believe are well positioned, we seek to position our portfolios for upside benefits with limitation on downside risk based on our strategy.
Health Care Reform’s Key Provisions for the NFP Sector

- **Provider Payment Revisions:** There will be some payment reductions that begin well before the benefits of expanded coverage kicks in starting in 2014, such as pay-for-performance programs, bundled payment pilots, revised payments for hospital readmissions, and a productivity factor reduction for hospitals. Given the need to cut costs to justify reform, we anticipate these revisions will be material to the sector. Disproportionate Share Hospital (DSH) reductions in the law are somewhat softened by the House revisions and will not begin until 2014. Total Medicaid DSH cuts would be $14 billion over 10 years (down from $18 billion in Senate version). Medicare DSH cuts would be $22 billion over 10 years. This provision may impact providers with high Medicaid utilization patterns.

- **Medicare Market Basket Inflation Reduction:** The hospital market basket update will be reduced 0.25 percent starting 2010 and 2011, 0.1 percent in 2012 and 2013, and 0.2 percent in 2014 to 2019, accounting for $112 billion over 10 years.

- **Medicare Advantage Payment Reforms:** Medicare Advantage cuts are projected to be $132 billion over 10 years. The law freezes 2011 rates with payment reductions beginning in 2012.

- **Regulatory Moratorium:** The moratorium for long-term acute care hospitals has been extended two years.

- **State Medicaid Matching Rates:** All states receive federal matching at 100 percent 2014-2016 for newly covered populations, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.

- **Independent Payment Advisory Board:** The law includes a provision to expand the scope of the board to include recommendations on the private sector health care costs. It should be noted the Congressional Budget Office (CBO) revised its estimated cost savings from $28 billion to $13 billion over 10 years. This is a concern for many in the industry as both the IPA Board and Congress will then have the ability to affect costs to the sector.

- **Physician Payment Fix:** The law does not addresses the Medicare physician payment issue. Congress will still need to address the looming 21 percent payment cut in the coming months and this has been estimated to cost as much as $200 billion in 10 years.

- **Pharmaceutical Industry Fee:** Delays the $2.5 billion industry fee until 2011. Fees increase to $4.2 billion in 2018 and stabilize to $2.8 billion per year thereafter. Total fees of $28 billion are expected over ten years.

- **Taxes on Wealthy:** Includes a 0.9 percent increase in Medicare payroll taxes for individuals over $200,000 and couples over $250,000 beginning in 2013. The law also adds a 3.8 percent Medicare tax to investment income to include interest, dividends, annuities, royalties, and rents.

- **Medical Device Industry Excise Tax:** 2.9 percent excise tax on the sale of devices, excluding Class I devices (including eye glasses).

- **Coverage Mandates:** Requires all residents to be covered by imposing penalties and fines. Anyone under the 133 percent FPL will be covered by the Medicaid program, and anyone from 133 percent to 400 percent of the FPL will receive subsidies. It allows young adults to remain on their parents plan until 26 years of age, elimination of pre-existing condition qualifications exemptions, and state purchase exchange providers. It is worth noting that we are defining full coverage as an estimated 95 percent of the population of U.S. residents. Uninsured will have a penalty of $750 for individuals and $2,250 for a family or up to 2 percent of income in 2016.

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