RHÖN-KLINIKUM
AKTIENGESELLSCHAFT

28TH ANNUAL GENERAL MEETING

Report of the Supervisory Board

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Chairman of the Supervisory Board
RHÖN-KLINIKUM Aktiengesellschaft

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Note:
Check against delivery

Dear Shareholders and Shareholder Representatives,
Dear Guests, Ladies and Gentlemen,

Following the successful conclusion of the Fresenius/Helios transaction in financial year 2014 with the decisive involvement of the shareholders through the distributions made under the Share Repurchase Programmes 2014 and 2015, our Company has turned its focus towards implementing the new corporate strategy – by way of introduction I will just mention the key points of cutting-edge medicine, campus approach and network medicine.

Before I come to speak in more detail on these subjects and the questions and prospects they raise, please allow me to first cover the usual obligatory points and formalities:

To avoid repetitions in reporting on the work of the Supervisory Board for financial year 2015, I would first of all refer you to the detailed Report of the Supervisory Board in the current Annual Report. This Report has been displayed within the premises of RHÖN-KLINIKUM AG since the convocation to this Annual General Meeting, has been sent to the Shareholders on request and can be accessed at any time online on the Company's website. And of course, the Annual Report is also available here today. You will find the Report of the Supervisory Board on pages 16 to 27.

To fulfil its duties in accordance with the law and the Articles of Association more efficiently, the current Supervisory Board, like its predecessor, established seven standing committees at its constituent meeting on 10 June 2015, i.e. right after last year's Annual General Meeting. In these committees, members of the Supervisory Board dealt with specialised issues and when required adopted resolutions or prepared the same for the plenary meeting. Moreover, specific powers to adopt resolutions were delegated to these committees under the Terms of Reference. We review the efficiency of our work on the Supervisory Board on a continuous basis and make changes to structures and processes without delay by taking appropriate measures whenever we identify the need to do so or any weaknesses. For example, at the beginning of this financial year, for the purpose of escorting the Management in implementing the campus projects and network medicine, we contributed the expertise available in the Supervisory Board so as to help shape this process as much as possible through joint meetings of the Investment, Strategy and Finance Committee held with the Medical Innovation and Quality Committee. From time to time and for specific issues, external experts were involved in these meetings.

As goes without saying, we are closely watching the further development of the German Corporate Governance Code (GCGC) and continue to review which recommendations we find sensible for our Company and consequently may adopt and which one are not – in the latter case giving reasoned arguments for non-adoption. We report jointly with the Board of Management on corporate governance at the Company. Details are provided in the Annual Report on pages 29 to 43.

With effect from 1 January 2016, we adjusted the basic principles of the remuneration system for the members of our Management Board which we presented to you in previous years, which we also submitted for your approval and which you approved by majority vote. The adjustment measures take account of the now changed Company size and economic situation by revising the scheme of management profit sharing and by redefining the limits of guaranteed total annual remuneration as well as the cap. The Supervisory Board adjusted all service contracts of the members of the Board of Management to these aims with effect from 1 January 2016. You can find further details on the remuneration scheme in the Remuneration Report provided as a separate component within the Corporate Governance Report.

In the written Report of the Supervisory Board we also informed on personnel changes within the Board of Management and the introduction of a uniform appointment term. We expanded the Board of Management by the newly created Medical division falling under the responsibility of the newly appointed member of the Board of Management, Prof. Dr. Bernd Griewing, as Chief Medical Officer. With effect from 1 January 2016, the appointment term for the individual members of the Board of Management was harmonised to five years in each case so as to ensure that all critical projects planned and commenced are overseen with the greatest possible continuity in personnel at Management level – with nearly the same term of office existing within the Supervisory Board.

Since this is where I would like to conclude my formal Report on the activity of the Supervisory Board, I would like first to extend my sincere thanks to the Board of Management and my colleagues on the Supervisory Board for the work together with them and their commitment over the past year. I would like especially also to thank all those members of the Supervisory Board who left the body following the last Annual General Meeting. It was not always easy to reach a consensus given the complexity of the issues. Nevertheless, we always succeeded in finding lasting common ground within the Supervisory Board so as to perform our tasks.

Not least, my special thanks goes to those employees who, in their commitment to the interests of patients, have once again shown themselves to be supporting pillar and without whom our Company would be nothing. My thanks also goes to the members of the Supervisory Board whose duties were not always easy in the context of co-determination.

Ladies and Gentlemen,

The speech given by Dr. Siebert has given you an overview of our current plans. I do not wish to elaborate on or refine his statements here. Instead, at this juncture I would like to deal with the fundamental questions facing our sector and with our new business model as a response to them.

Our claim in this regard is clear and unequivocal: we do not wish to merely recognise and acquiesce in the largely identified factors set to bring lasting changes to the industry, but also to become actively involved in helping to shape them. Let me briefly look back at the past so that you can get a

better idea of where, in my view, we are looking to move the focus of our efforts in future: during the first roughly 20 years of the acute inpatient phase of the Company's development, the business model of RHÖN-KLINIKUM AG from 1984–2006 with generalised privatisation and the rationalisation model of the flow principle was controversial, but gradually came to be widely accepted more or less as the **determining factor of the system** for process optimisation**.** This growth model has reached its limits. You see, at the beginning, for every euro of revenue, we had to invest 80–90 cents for investments and purchases. In recent years – at the height of this development – this figure was as much as 1.80 euros for each euro of revenue. That is not economically sustainable, even if it was possible to mitigate the price through public grants. In contrast with our public as well as private competitors, we only hesitatingly took part in this vying for public grants because it was always clear that the money came with strings attached.

At the zenith of the former RHÖN-KLINIKUM AG and the zenith of generalised privatisation, we always demonstrated our courage to reinvent ourselves fundamentally. Change was development. After abandoning the earlier growth model which, as explained above, in its economic thrust was bringing rationalisation pressures to bear in the wrong direction and for that reason met with increasingly stout resistance to privatisation of hospitals – resistance that has persisted everywhere to this day – there was initially a difficulty in coming to terms with what the future of RHÖN-KLINIKUM AG might look like after the departure from the old model. In this regard, we have been composed in acknowledging certain views voiced in the general public referring to the henceforth small RHÖN-KLINIKUM AG, sometimes even disparagingly to the 'leftovers' of RHÖN. However, these voices have now long been silent. And that is because many in this sector recognise that RHÖN-KLINIKUM AG is again a trailblazer of a new system, whereas some providers, with the many pitfalls and burdens this brings, are labouring to squeeze out whatever they still can from the old system, even though, presumably, they have recognised long ago that the old system has run its course.

We, however, are forging new paths and are striving to look ahead: many of us have recognised very early on that the increasing greying of the population, the rapid pace of advances in medical technology, as well as the social consequences of the information age, and not least the mega trend of the digitalisation of the economy will, and indeed must lead to new forms of treating and caring for patients. Full-coverage acute hospitals, which are frequently small with limited service volumes acting as contractors for community-based practitioners and hospital insurance funds pretty much at the end of the performance chain, will lose out under the system unless they summon the strength to change fundamentally. Many will have to fold. As a seasoned provider of specialist medical care at the highest level, but also familiar with small-scale generalised local care delivery, the task set before us was to recast this talent into a new business model which, as a reproduction model, leads to qualitative and then also quantitative growth. We know that nothing makes a more lasting impression on potential patients – **they and they alone are the focus of interest here** –, who sooner or later have to face the question of where they are to turn in an emergency, than the successful rescue of a person or the gift of a virtually new life following a life saving operation. In this context, dynamic information technologies and the new social behaviour of increasingly mobile patients act as leverage when it comes to the question of who we, you, i.e. anyone are to put our trust in as a patient. That is an entrepreneurial opportunity and an entrepreneurial risk at the same time. A glance at reports in traditional and social media will suffice as confirmation that I am right in my predictions.

Almost anybody living in a catchment area with one million inhabitants has an idea of what to do when they need medical care. What desires and wishes does such a person have, what fears, and where are the bottlenecks in performance that we can fill? From this perspective, what has to be done and what has been done? Where are bottlenecks in service volumes and where are they developing under the changed conditions of the information society that we can avail ourselves of? How can we turn the Company RHÖN-KLINIKUM AG for the long term into a provider that prompts modern patients, who today are much more inclined to behave like independent consumers having ample freedom of choice for services, to opt for us above all when they are **not yet sick**, i.e. as healthy persons, when it comes to the question of how they are to orient themselves?

A central aspect in this regard will be the issue of the best possible service: **"I need an appointment." – "Yes, right away"** is the answer. That is the question which, from an entrepreneurial viewpoint, is tantamount to providing more efficient high quality outpatient structures.

To this day, outpatient care is an embodiment of an additive chain organisation, i.e. you go from one doctor to the next until the right one seems to come along. At the Campus with its outpatient centre as the initial point of admission, clinical processes are being fundamentally restructured. Use of electronic patient files as a knowledge platform and computer assisted basic case history coupled with case management makes patients, with their data and needs, the masters of their own processes. In terms of qualitative, humane and economic aspects, this process is optimised by instant access to the necessary performance parameters. Under this new model, the performance parameters are made available on the terms established by the patient, not the other way around. The patient is recommended through the system by the doctor synchronously with the help of the available knowledge base, and not additively or even externally, and then takes a decision after the consultation.

This model is the campus, a place where we – at considerable investment that presumably only RHÖN-KLINIKUM AG can summon for a prototype in the industry – provide high-quality specialist inpatient medical services to high standards, but which are upstream to a broad and comprehensive outpatient structure consisting of in-house practitioners, of practices that have specifically come in from the surrounding regions as well as our own medical care centres. These are operated by particularly dedicated and keenly interested employees in a service friendly environment. At the same time we would like to create for these employees close to the campus and on the campus a living and working atmosphere that promotes the high performance commitment and tends more to bring work and leisure together than to draw them apart.

The rapid pace of advances in medical technology and treatment methods is – at least in part – running contrary to inpatient structures. Since in this selection process medical services with the required quality and range cannot be kept available at each location, centralisation and pooling of specialisation and expertise together with a high mobility of informed patients is the answer. That is why we are on the right path with the project that I call Campus-University +, i.e. a university-based outpatient structure at the Marburg site that is upstream the inpatient system. My recommendation for the faculty and the university is to turn this outpatient structure on a university basis, with separate full professors for each discipline, into the main teaching body for medical training and to base urgently needed care research in this sub-faculty. With this enhancement, also in organisational terms, within both the academic and care delivery fields, both the university and we ourselves are

taking a huge step towards coping with the tasks imposed by an ageing population and integrating the potential of the information society for the future.

At this place I often hear the objection that in our industry too little thought is given to the human dimension and too much to economic aspects and processes. To that I have only one thing in reply: **the human dimension must always be the fundamental and basic position, without chanting this over and over as something self-evident.** This foundation may not be altered. But for me personally, I would not find it comforting if, after a devastating diagnosis that has cast me from one moment to the next into the depths of despair, my head were to be stroked comfortingly as a gesture but I would otherwise be left without hope. Through humanity, patients are to gain trust, but this trust is something that has to be won through medical and nursing expertise – and that time and again. Expertise is skill and knowledge. As is known, that comes from hard work and the uncompromising desire to thus live up to patients and yourself. Let me therefore emphasise clearly: **it is not efficiency and economy that poses a risk to the ethics of medical care, but it is rather the case that medicine threatens ethical principles if it disregards economic principles.**

Network medicine as a future pillar

The greying of society, i.e. more and more patients claiming services of the system, coupled with less and less contribution payers paying for that, and a dearth of specialist staff to treat and care for patients: that is the reality to which society and also our Company have to find an answer, if we do not wish to ration medical services in future, since rationing is the most inhumane of all answers and often a deadly one. The answer is campus!

With the campus approach, we are introducing a solution to selective generalised care by providing accessible centres which in and of themselves are totally networked and within their parameters as a separate entity are highly functional and rational. The expertise available there or better Group-external solutions with other providers become visible on the knowledge platform together with the electronic patient file and the aforementioned computer-based case management system. In an instant they can be located at any level, including regionally and supraregionally, and made available for patients. This concept brings about competition within the entity itself, which is precisely because patients and their data basis result in a transparency which is quality-enhancing in every respect.

Such an approach is premised on many things, including a guaranteed high and verifiable quality of networked physicians internally and externally, but also processes and arrangements at the interfaces that we can shape through the pre-development stage. Establishing networking rules by our pro-competition stance prevents individual network participants from using the scheme for their own solutions offering no other alternatives and always only leading back to their own offerings. Nobody, if they want to make progress like our patients, would constantly take one-way streets leading to dead-ends. Such behaviour would frustrate sustainability. This willingness to compete must be fought out every day because it is the decisive driving force in the permanent development also of our business model, and because at the same time it is a humane act in its orientation.

Campus model as future pillar and digital support from doctors and nurses

Providing and assessing maximum medical knowledge on medical care in general, including patient-related knowledge, will only be possible through use of the electronic patient file and auxiliary functions like IBM Watson Health. Watson Health is being developed at a high pace and probably with the use of a human bridge, meaning e.g. a specially training nurse that is used between the computer and the patient and that performs the anamnesis. In this way, human contact would be promoted with the doctor, with his workload being relieved as far as possible, having time to consult and direct in the knowledge of being backed by the cognitive system knowledge. In the outpatient structure thus having access to all available knowledge, the most important thing that medical care needs arises – a new dimension of diagnosis. By this diagnosis involving the proposal of specific actions – since it is available and transparent before, during and after the treatment – a purely patient-specific knowledge of what "will, might and may happen" is conveyed which serves as a decision aid for patients and doctors, thus making the patient a qualified, informed controller of the processes in place for him. The long outdated barrier between outpatient and inpatient medical care will soon be overcome because there is only the focus on the patient and such focus does not end with outpatient care and does not begin with inpatient care. That is a new era in medical care.

The campus concept is currently already being implemented in full swing in Bad Neustadt, and is in the preparatory phase in Marburg with the involvement of all sceptics and in Frankfurt (Oder) for the special border situation there.

The medical concept initiated by us is anything but already established, neither internally nor externally.

Implementation will take place neither within the Company nor with cooperating affiliates without causing an outburst of protest, e.g. if the University of Marburg and its faculty of medicine have to be convinced that in future it will be better for students of medicine to be trained within the outpatient area. That is because the aspiring doctors will get to know patients 95% of whom they will see again in their career as doctors.

It will hopefully lead to profitable scientific disputes if an equally weighted outpatient sub-faculty with new research models in care research and real science-based outpatient care sets out for new horizons also telemedically.

Of course, everyone can already be heard saying: "With us, the patient is the focus of interest." In future, patients will really force the focus of interest to be put on them, with the hospital or the doctor's practice or the staff or also investment interests being put after that. Despite this, the system will be of sustained benefit for those entities that reorient themselves.

The transformation we face means that within a very short time presumably 20–30% of the procedures, methods and processes will change because with the new insights it will no longer be possible to do things in the same way as in the past. For that reason any preserver of the status quo seeking justification for keeping things the same and not improving them is an economic, qualitative and quality-impeding disaster, not to mention a moral disaster at the human level.

Future pillar of personalisation of medical care and nursing

If personalised nursing takes hold as a part of personalised medical care, patients will send out signals through observation and monitoring systems that will undermine today's abstract plans. Monitoring all patients at a certain time of the day makes no sense since patients, in addition to what we see from outside, are constantly providing us with information on their needs which tend not to be related to a certain time of the day. Observation and technical control will make time for personal contact while at the same time dispensing with the need for mass organisational activities such as distributing tablets or similar.

In other words, reaching an agreement today on how many nursing employees have to be employed to perform e.g. time-controlled services only serves to block change. What people instead should be thinking about is whether the model system at the palliative ward established in Bad Neustadt will become the leading workplace model. For example, a floor is installed that alerts nursing staff if a patient who is not supposed to get up nevertheless does so. That is only one example showing that we should adopt state-of-the-art methods to reinvent the way we provide nursing care. Perhaps it will also come to the point where every nurse will have their own robot working for and assisting them. If the already existing possibilities are considered (Japan), the nurse telling her assistant to lift up the patient, and then to smooth the sheets, is no longer a surreal vision. Then, that will moreover also have an impact on the wage demands of the trade unions. It would be much more creative to think about whether employees have their own robots to work with than to muse about machine controllers as is currently being heard from trade union quarters. Many people are already using the brains of such robot in the form of their mobile phone. The combination of human and technical assistant will make it possible to delegate complex tasks because such a team together can perform far more different tasks than one human or one robot alone can. The robots lifts heavy loads and tells the nurse before she addresses the patient how many children that patient has or when his wife died, but also what parameters of his vital signs are functioning and how. While the nurse is talking with the patient, her assistant might clean up the room.

Today and tomorrow, i.e. still without robots, our campus approach, underpinned by the concept of network medical care, the electronic patient file, as an instrument of organisation and transparency, as well as with intelligent systems such as IBM Watson Health, will ensure our Company's lasting success on the market.

I am firmly convinced that this is the future of our Company. And we, as the Supervisory Board, will continue to ensure that the way in which we oversee this transformative process is not only critical and constructive but also demanding. Given these challenges, we have no time to reminisce nostalgically on the RHÖN-KLINIKUM AG of the past.