INDONESIA HEALTHCARE MARKET REVIEW REPORT

Overview of Jakarta Healthcare Services Market and Assessment of Specialty Hospitals in Indonesia

- Developed for -

First REIT

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Glossary

Terms	Meaning
A&E	Accident and Emergency
ACLS	Advanced Cardiac Life Support
ABFI	Asia Banking and Finance Institute
AGD118	Ambulans Gawat Darurat 118 Or Emergency Ambulance 118, managed by Jakarta Health Department
AIDS	Acquired Immune Deficiency Syndrome
Askeskin	(or Askes for short) Health Insurance for the Poor. This scheme covers basic healthcare in public health clinics and hospital inpatient care.
ATLS	Advanced Trauma Life Support
Bapel	Short for "Badan Pelaksana" or Non-profit administrative bodies or health maintenance organizations
BCLS	Basic Cardiac Life Support
Biopsy	Medical test involving the removal of cells or tissues for examination
BMT	Bone Marrow Transplant
BTLS	Basic Trauma Life Support
Celution800/CRS	Breast Cancer Reconstruction Equipment manufactured by Cytori Therapeutics
CAGR	Compounded Annual Growth Rate
CME	Siloam Continuous Medical Education
COE	Center of Excellence
CRO	Contract Research Organization
CT Scanner	Computed Tomography Scanner

Diagnosis	Process of attempting to determine the identity of a possible disease or disorders
ECG	Electrocardiography
EEG	Electroencephalography
ESWL	Extracorporeal Shock Wave Lithotripsy
ERP	Enterprise Resource Planner
GAKIN	Poor Family Card System, used to identify residents eligible for low-cost or free healthcare and food.
GP	General Practitioner
GDP	Gross Domestic Product
HDR	High dosage rate
HIS	Hospital Information System
HMO	Health Maintenance Organization
IBA	IBA Healthcare, part of IBA Group incorporated in Belgium. The company is among the world's leading manufacturer of radiotherapy solutions and equipments.
ICD2000	International Classification of Disease, the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use.
ICU	Intensive Care Unit
ICCU	Intensive Coronary Care Unit
IGRT	Image Guidance Radiotherapy
IMC	Intermediate care, or a step-down ICU
IMRT	Intensity Modulated Treatment Planning

Jamkesmas	Indonesian government universal insurance scheme for the poor
Jamsostek	Social security through contribution from both the employers and the employees
JCI	Joint Commission International, a US-based organization for healthcare accreditation
Jl.	Indonesian for "jalan" or street
JPKM	Community Medical Services Insurance
LAN	Local Area Netowrk
Medivac	Emergency evacuation service offered by Siloam Hospitals Group
MOH	Ministry of Health
MOU	Memorandum of Understanding
MRCCC	Mochtar Riady Comprehensive Cancer Center
MRI	Magnetic Resonance Imaging
MRIN	Mochtar Riady Institute of Nanotechnology
NGO	Non-government Organization
NICU	Neonatal Intensive Care Unit
NOA	Novartis Oncology Access
Oncology	Branch of medicine that deals with cancer
PACS/RIS	Picture Archiving & Communication System/ Radiology Information System
Payor	A company or agencies that purchases health services
PET-CT	Positron Emission Topography
PICU	Pediatrics Intensive Care Unit

Prevalence	Total number of diseases or cases in the population at a given time
Puskesmas	Pusat Kesehatan Masyarakat, or community health center
Radiotherapy	Medical use of ionic radiation as a form of treatment to control tumor (cancer), other similar terms include radiation oncology, radiation therapy
RSKD	Rumah Sakit Kanker Dharmais, or Dharmais Cancer Center
RSCM	Cipto Mangunkusumo Hospital
RSMKKG	Mitra Keluarga Kelapa Gading Hospital
RSGP	Gading Pluit Hospital
RSPP	Pertamina Central Hospital
SPECT-CT	Single Photon Emission Computed Tomography, combined with advanced multi-slice computed tomography machine
Sub-specialty	A narrow and more complex field of work within a specialty.
Sub-specialist	A specialist of a sub-specialty
Specialist	A physician who completed multiple years of residency to further their medical education in specific specialty after completing medical school
TB	Tuberculosis
TCM	Traditional and Complementary Medicine
Hospital Types :	
Type A	Hospitals with large sub-specialty and specialty services. In Indonesia, these hospitals are regarded as the national referral center, often with more than 400 beds
Type B	Hospitals with limited sub-specialty services but with wide range or specialty offerings. These hospitals are often designated as regional referral hospitals

Type C	Hospital with no sub-specialty services and have the basic 4 specialty services like surgery, obstetrics and gynecology, pediatric and internal medicine. These hospitals are the equivalent general hospitals
Type D	Specialty hospitals with one type of specialty offerings only, examples include mental hospital, and eye hospital
Transplant	Moving of organ from one body to another, or from donor's body to the patient's
Trauma	Critical injury to body tissue by physical or chemical means
UI	University of Indonesia
USAID	United States Agency for International Development
USD	United States Dollar
USG	Ultrasonography, or Ultrasound
WHO	World Health Organization
WIMAX	Worldwide Interoperability for Microwave Access

Executive Summary

Indonesia is the 16th largest country and 4th most populous country in the world. It occupies more than 17,000 islands stretched between Pacific and Indian Oceans south of Equator. The country's economic development is lower than average in the region, but with a steady GDP CAGR of 6%, Indonesia is one of the fastest growing economies with an emerging middle class.

The healthcare system in Indonesia encompasses a close interplay between public and private sectors. While 64% percent of the infrastructure is provided by public sector, the funding is more equally distributed. There is no national insurance scheme, but the government has implemented social healthcare coverage (Jamkesmas & Jaskeskin) to improve healthcare services directed at the less privileged sector of the society. Most of the healthcare services are concentrated in urban areas, especially around major cities. Jakarta has the highest concentration of healthcare infrastructure, especially secondary and tertiary care, which reflects the highest concentration of population in the country, estimated at 9.3 million. It also attracts most of the country's middle class – up to 75%.

The total expenditure on healthcare in Indonesia is one of the lowest in the region and is reflected by the chronic shortage of healthcare resources and work force across the entire country. The situation requires urgent attention as the demand for healthcare services outpaces the growth of healthcare services industry.

Key demand drivers follow closely global trends and include demographic changes: population growth and ageing; change in disease patterns: emergence of life style diseases and higher prevalence of chronic diseases and cancer; and consumerism: demand for better quality care by more affluent population. The emerging demand coupled with insufficient healthcare services provision annually forces as much as 400,000 Indonesians seeking medical help abroad each year.

Oncology services are provided by 5 centers in Jakarta and 22 nationwide. With cancer being the 6th largest mortality cause, the underserved population either seek help from traditional healers or, those more affluent, in the neighboring countries. The existing oncology infrastructure is outdated and overused.

The Accident & Emergency services in Jakarta are in acute shortage. The market is highly fragmented and served by individual hospitals. With no centralized coordination though a central helpline, the existing emergency services are misused by non-emergency patients, which sometimes account up to 70% of all patients turning up at the emergency departments. Profits oriented hospitals very often require proof of payment before attending to emergency cases, however, the situation is expected to change with new regulations making compulsory for private hospitals to treat emergency cases regardless of their ability to pay.

The MRCCC hospital is the first private oncology centre in Indonesia, located in the commercial centre of Jakarta. It offers latest diagnostic and treatment facilities with the services of top oncology specialists within the country and from affiliated foreign centers of excellence. MRCCC is Indonesia's first oncology centre that offers comprehensive services though advanced oncology equipment. Frost & Sullivan believes that MRCCC has a significant potential of becoming a regional centre of excellence.

SHLC is a 75-bed hospital serving the residential and industrial population of East Jakarta. The hospital plans to increase its bed capacity in the near future alongside providing separate ward hosting for higher class patients. The hospital is moving towards provision of full blown emergency and occupational care to meet the increased demand. Frost & Sullivan believes that the lack of coordination of A&E services among other healthcare operators provides a substantial potential for SHLC in the healthcare market in East Jakarta area.

1 General Review of the Indonesian Healthcare Industry and Healthcare Services

INDUSTRY OVERVIEW

1.1.1 Indonesia Healthcare Status

With a population of 232 million in 2009, Indonesia ranks fourth in population size after China, India and the United States. The country with 6,000 inhabited islands covering an area of 5,120 kilometers from east to west and 1,760 kilometers from north to south is rich in culture and diversity.

In the past decade, the significant growth of the public health sector underpinned majority of the healthcare sector development. In response to the financial and economic crisis, new emphasis was placed on pro-poor financing, whereby the public sector was bestowed as the primary sector for delivering accessible and affordable healthcare services to the poor. Universal social health coverage (delivered through the Askeskin/ Jamkesmas programs) established in 2004 was the lynchpin funding platform by enabling substantial geographical and operational growth for the mobile public health centers (Puskesmas) and hospitalization reimbursements in government owned hospitals.

Overall, Indonesia has made steady progress in health outcomes since early 1970s. For instance, infant mortality dropped from 118 deaths per thousand births in 1970 to about 30 in 2009. However, new challenges have emerged in recent years as a result of social economic changes. The fast rising proportion of more complex non communicable diseases, insufficient financing on healthcare and poor accessibility of healthcare are likely to remain as the pertinent issues to be addressed by the policy makers in the next decade. Moreover, Indonesia still falls short in comparison to its regional neighbors in terms of health outcomes, facilities and resource adequacies.

In 2010, the President of Indonesia, Susilo Bambang Yudhoyono, recognized the need for the country to keep pace with the changing healthcare environment and highlighted the need for a reform of community services from medication to prevention. The government had also begun to increase their budget allocation on healthcare programs for disease preventions.

Table 1.1 lists the key indicators of Indonesia's healthcare status in 2009.

Table 1.1: Major Healthcare Indicators in Indonesia, 2007-2009

Healthcare Indicators	2007	2008	2009
Population (mn)	226	229	232
Population Growth Rate (%)	1.3	1.3	1.3
Birth Rate (per 1,000)	19.65	19.24	18.84
Mortality Rate (per 1,000)	6.90	6.85	6.80
Life Expectancy (Female)	72.7	73.1	73.4
Life Expectancy (Male)	67.6	68.0	68.3

Source: IMF, CIA World Fact Book, Indonesian Department of Health, Frost& Sullivan

The constant decline in the various categories of deaths has signaled that the overall healthcare outcomes in Indonesia have improved over time. In 2007, the total number of death in Indonesia was estimated at 1.56 million people. A quick snapshot of the list of causes in table 1.2 depicts a clear picture that non communicable diseases, such as stroke, hypertension, diabetes mellitus, cancer and other heart related diseases have already formed the largest group for mortality causes in the country, collectively accounting for about 43.3 percent of the total deaths.

Out of the total number of mortality, a total of 100,410 deaths occurred in hospitals with a case fatality rate of 3.62 percent.

SNAPSHOTS OF THE HEALTHCARE SYSTEM

1.2.1 Healthcare Expenditures

Despite the compelling need for greater attention to these healthcare issues, commitment has been low, both in the public and private sectors with the percentage of healthcare expenditure to GDP hovering in the region of 2.10 to 2.50 percent since 2004. This has resulted in the present inequitable healthcare system in Indonesia.

Figure 1.1 shows the trend in total healthcare expenditure as a percentage of GDP and total per capita expenditure on healthcare in Indonesia. Figure 1.2 illustrates the change in contribution of the private and government sectors in total healthcare expenditure from the years 2004 to 2009.

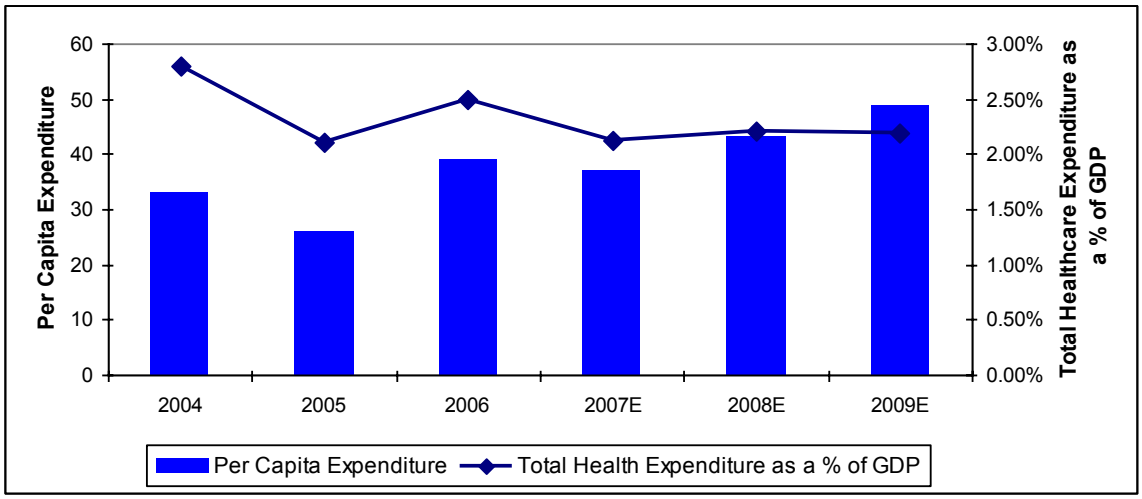
Table 1.2: List of diseases for all causes of mortality, 2007

Causes of Death	Proportion (%)	Estimated Number of Deaths [1]
Stroke	15.4	239,767
Tuberculosis	7.5	116,770
Hypertension	6.8	105,871
Injury	6.5	101,200
Perinatal	6.0	93,416
Diabetes Mellitus	5.7	88,745
Severe Malignant Tumor (Cancer)	5.7	88,745
Liver Diseases	5.1	79,403
Ischemic Heart Diseases	5.1	79,403
Lower Respiratory Diseases	5.1	79,403
Other Heart Diseases	4.6	71,619
Pneumonia	3.8	59,163
Diarrhea	3.5	54,493
Peptic and Duodenal Ulcus	1.7	26,468
Typhoid	1.6	24,911
Malaria	1.3	20,240
Meningitis Encefalitis	0.8	12,455
Congenital Malformation	0.6	9,342
Dengue Fever	0.5	7,785
Tetanus	0.5	7,785
Septicemia	0.3	4,671
Malnutrition	0.2	3,114
Other Causes of Death	11.7	182,161

Source: Indonesian Department of Health, LaporanRiskesdas 2007, Frost& Sullivan

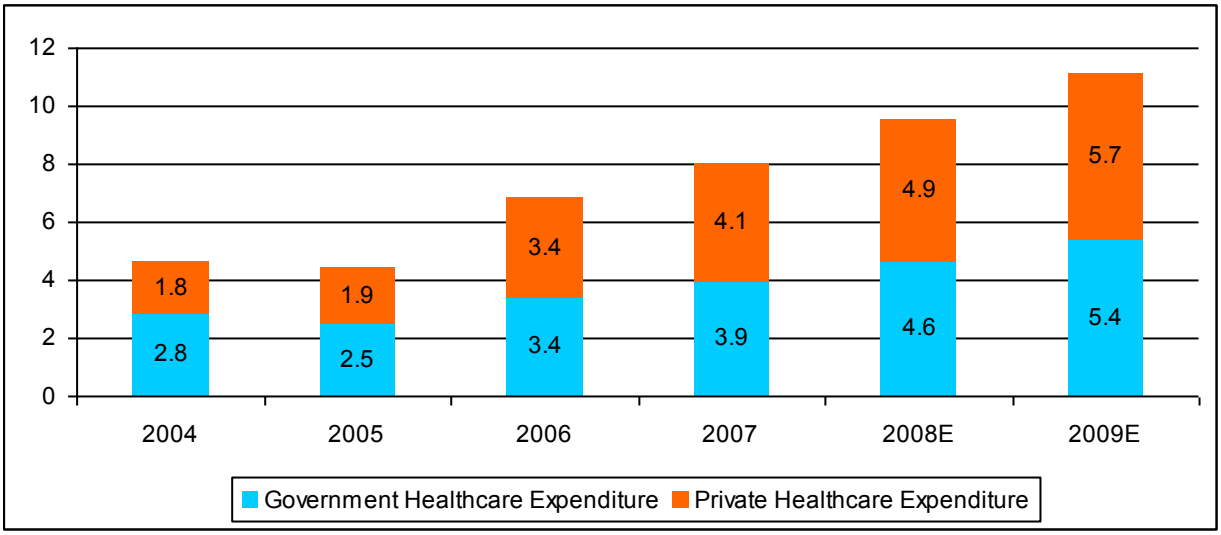
Note: Calculated based crude death rate of 6.9 per 1,000 as reported in Indonesian Health Profile 2008

Figure 1.1: Per Capita Expenditure on Healthcare in Indonesia, 2004-2009



Source: WHO, Frost & Sullivan

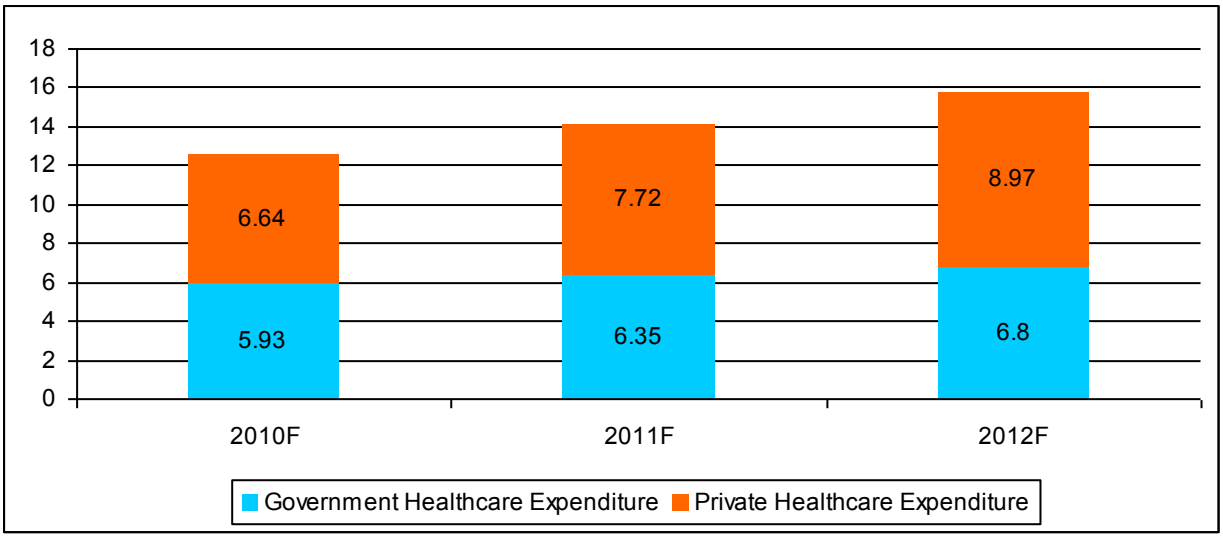
Figure 1.2: Healthcare Expenditure by Private and Government Sectors in Indonesia, 2004-200



Source: WHO, World Bank, Frost & Sullivan

In spite of the credit crunch economic crisis in 2008, the Indonesian healthcare expenditure has continued to grow. The outlook of the healthcare expenditure in the country is likely to continue its positive growth trend, particularly with the growing penetration of the universal public health insurance.

Figure 1.3: Healthcare Expenditure Growth in Indonesia, 2010-2012



Source: Frost & Sullivan

Healthcare expenditures as a percentage of GDP have been steadily growing by 4.3 percent over the past 5 years. This trend is expected to continue as the nation begins to realize the industrial improvements stemmed from the full implementation of Healthy Indonesia 2010. Furthermore, as prescribed in the New Healthcare Strategic Plan 2005-2009, Indonesian's plans to increase healthcare spending in the private sectors and gradual increase of public financing to 15 percent from national and regional state budgets are likely to be extended towards 2012. In a statement made by Indonesian Health Minister in May 2010, the country will increase its healthcare expenditure to 5 percent of GDP in 2011, more than double the percentage between 2005 to 2010.

Traditionally, healthcare financing for the public sector in Indonesia comes from the Ministry of Health, the provincial healthcare budget, the district healthcare budget, military healthcare services, other sector spending on healthcare, social health insurance corporations, and foreign aid and loans

Since 2001, the embarking of the decentralization process in the public healthcare sector and dramatic increase in government investment has resulted in more than three-fold increase of the public healthcare expenditure, from USD 1.7 billion in 2001 to USD 5.7 billion in 2009. The gradual improvement in economic conditions, declining debt repayments and recently reduced fuel subsidies present greater potential for Indonesia to free up more of its resources for healthcare sectoral spending.

Private sector healthcare financing in Indonesia comprises out-of-pocket payments by individuals and households, employers, and private insurance companies. Until 2000, private healthcare expenditure accounted for around 75 percent of the total expenditure on healthcare. Although this has grown

consistently in the past 5 years, due to the decentralization of the healthcare system, growth in government expenditure has resulted in almost equal share of healthcare expenditure among the two sectors in 2009.

According to WHO, it is estimated that over 66.3 percent of the private expenditure on healthcare is sourced from households' out-of-pocket payments, with a small portion of prepaid health insurance plans (9.7 percent), and the remaining were accounted by NGOs and private firms.

1.2.2 Healthcare Infrastructures

Since 2004, the number of hospitals in the public sector had exceeded the number in the private sector, due to the highly accelerated growth of government hospitals stemming from Indonesian government's intention to increasing healthcare accessibility and affordability. During the last five years, the number of public hospitals has grown by 15 percent, while the private sector experienced a slower 10 percent growth.

The assessment on the number of hospital beds, however, reflects a less favorable result. During the period of 2004 to 2009, hospitals in Indonesia merely provided about six beds to every 10,000 population, which is significantly more underdeveloped as compared to its regional neighbors, such as Malaysia, Philippines and Thailand with double digit ratios achieved.

However, despite facing the highest level of restrain in hospital bed capacity, Indonesia offers the most affordable hospitalization cost among the other countries. According to the WHO-Choice program, which consolidates the healthcare costs for its member states, the average patient cost per tertiary hospital bed in Indonesia was estimated at USD 54. Comparatively, similar services in Singapore, Malaysia and Thailand would cost the patient USD 280, USD 122, and USD 107 accordingly.

Table 1.3 gives an overview of the healthcare infrastructure in Indonesia.

Table 1.3: Healthcare Infrastructure in Indonesia, 2007-2009

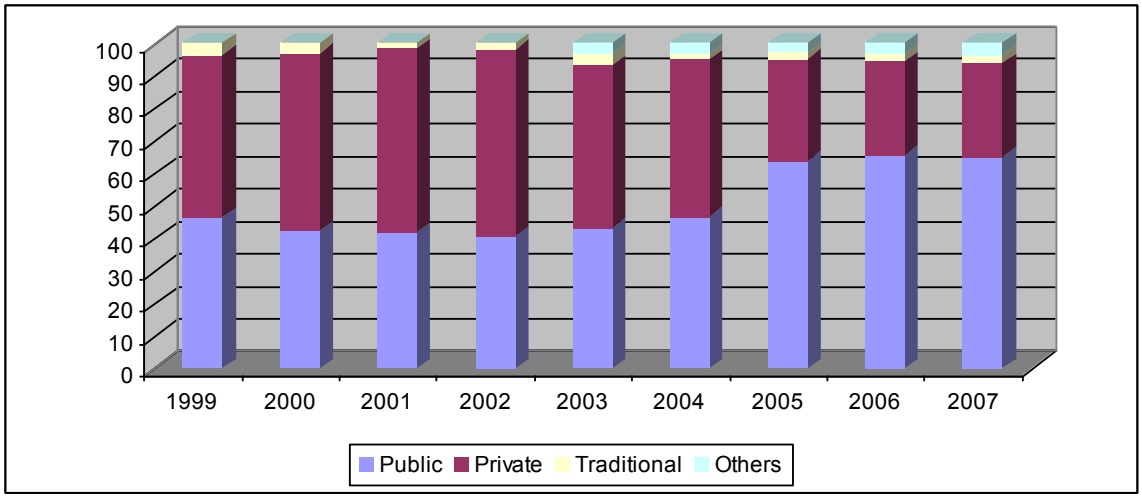
Infrastructure	2007	2008	2009e	CAGR % (2007-2009)
Total Number of Hospitals	1,319	1,372	1,406	3.2%
Private Hospitals	667	673	685	1.3%
Public Hospitals	652	699	721	5.2%
Total Number of Beds	142,707	149,538	153,519	3.7%
Total Specialized Beds	20,412	20,788	21,221	2.0 %
Total General Beds	122,295	128,750	132,298	4.0 %
Private General Beds	45,074	47,226	48,323	3.5 %
Public General Beds	77,221	81,524	83,975	4.3 %
General Doctors	44,378	44,759	47,930	3.9%
Specialized Practitioners	14,599	15,722	16,764	7.2%
Nurses& Midwives	256,290	291,992	327,413	13.0%

Source: Indonesian Department of Health, Frost & Sullivan

The shift of governmental focus towards a community-centric healthcare system since 2004 had drastically changed the way healthcare facilities are utilized in the both public and private sectors. As illustrated from Figure 1.4, the private healthcare service had historically been the more popular option by accounting for more than 50 percent of the healthcare services. However, the rapid increasing of availability and accessibility of the public health centers and the subsidies provided through the establishment of the universal insurance scheme for the poor (Jamkesmas) has caused a gradual decline in the utilization rate of private healthcare services since 2004 to less than 30 percent in 2007. As most of the private services were not reimbursable during the early implementation years of Jamkesmas, patients outflow towards the highly accessible and subsidized public health center and hospitals had increased. Hence public healthcare services had swiftly grown to provide the majority 65 percent of the country's healthcare services by 2007.

Nonetheless, drastic increase of patients has inevitably strained the human capital and facilities at the public health institutions, stimulating an increase of involvement from the private sector in delivering community based healthcare. As of 2008, there are estimated more than 300 private hospitals in contract with Jamkesmas, which helped serving the low income subscribers under the scheme. This growing trend is likely to create a more balanced and efficient sharing of facility and resources among both sectors in the future.

Figure 1.4: Utilization rate of healthcare services by providers, 1999-2007



	Public	Private	Traditional	Others
1999	46.30	50.20	3.50	0.00
2000	42.30	54.70	3.00	0.00
2001	41.70	56.70	1.60	0.00
2002	40.40	57.70	1.90	0.00
2003	43.10	50.10	3.50	3.30
2004	46.50	48.60	1.50	3.40
2005	63.70	31.70	1.80	2.80
2006	65.50	29.00	2.30	3.20
2007	65.00	28.80	2.60	3.60

Source: World Bank staff calculations based on various years of Susenas data (World Bank, 2008)

The number of hospitals in each province, as listed in Table 1.4, clearly shows that the gap in healthcare infrastructure between the developed and under-developed areas that has yet to be effectively addressed.

Table 1.4: Hospitals and General beds per 10,000 population by Province in Indonesia, 2008

Region	Hospitals	General Beds per 10,000 population	Region	Hospitals	General Beds per 10,000 population
JawaTimur	171	4.98	Lampung	22	3.33
Jawa Tengah	162	5.63	Sulawesi Utara	22	11.94
Jawa Barat	144	3.57	Sulawesi Tengah	19	5.45
Sumatera Utara	130	8.57	Maluku	19	11.09
DKI Jakarta	124	15.15	Jambi	18	4.64
Sulawesi Selatan	62	6.59	Papua	18	6.93
Sumatera Barat	41	7.01	Kalimantan Tengah	15	4.74
Aceh	35	5.86	Sulawesi Tengarra	15	4.18
Bali	34	9.03	Nusa Tenggara Barat	13	2.47
Sumatera Selatan	34	5.22	Kepulauan Riau	13	9.15
D.I. Yogyakarta	34	8.17	Bengkulu	11	4.60
Kalimantan Timur	31	9.88	Papua Barat	10	9.40
Riau	28	3.78	Maluku Utara	8	4.99
Kalimantan Barat	28	5.33	Bangka Belitung	7	4.55
Banten	27	2.28	Gorontalo	4	4.11
Nusa TengarraTimur	26	4.83	Sulawesi Barat	1	2.10
Kalimantan Selatan	26	5.86			

Source: Indonesian Department of Health, Frost & Sullivan

Table 1.5 indicates the total number of government hospitals in Indonesia, by different categories of bed size, in 2008.

Table 1.5: Number of Public Hospitals by bed Size, 2008

	Class D <50	Class C 50 – 100	Class B 100-400	Class A >400
Number of Public Hospitals	88	256	79	8

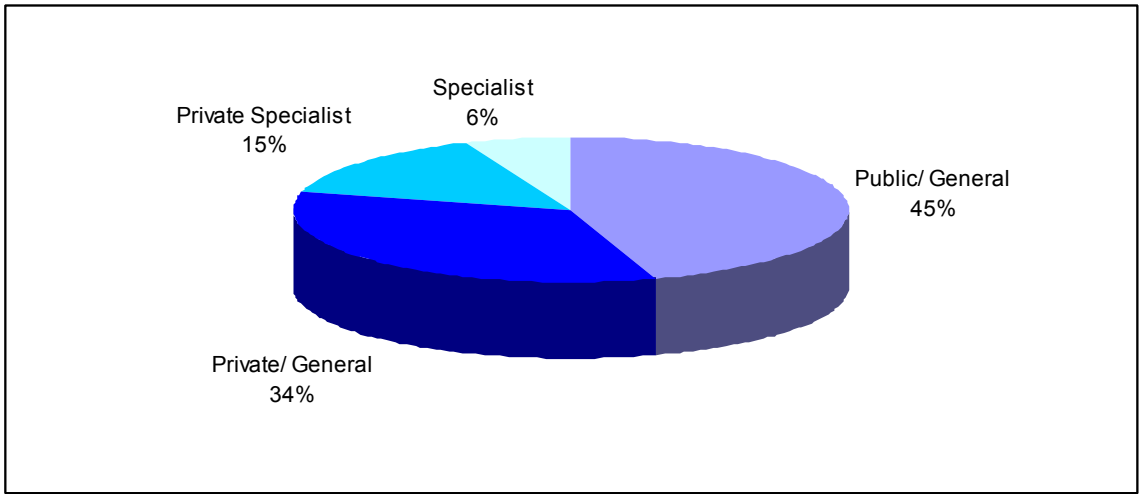
Source: Indonesian Department of Health

The largest number of government hospitals is attributed to the Class C, which generally serve secondary and tertiary care for larger districts. The eight Class A hospitals currently providing top class national

referral care are situated in major provinces of Medan, Jakarta, Bandung, Semarang, Yogyakarta, Surabaya, Denpasar and Makassar.

Predominantly, general hospitals make up more than 78 percent of the total hospitals in the country. Within the public sector, majority of the general hospitals falls within the Class C classification. Despite the rapid increase in non-communicable diseases, it is obvious that the specialist hospitals targeted for diseases, such as cardiac care and cancer is still considerably low at less than one percent. Conversely, hospitals specializing in pediatric care, maternity care and mental treatment are the most commonly found categories in the country.

Figure 1.5: Indonesia Hospital Split by Classifications, 2008



Source: Indonesian Department of Health, Frost & Sullivan

As of 2008, a total of 292 specialist hospitals were established in the country with an increase of 11 hospitals (10 children and maternal care hospitals and 1 tuberculosis specialized hospital) since 2006.

The healthcare system in Indonesia relies heavily on the private sector and this should be given due importance by the government failing which healthcare outcomes will not be improved. More people seek care in the private sector for such critical services as birth delivery, child diarrhea, and acute respiratory infection than in the public sector, and this proportion is rising, even among the poor.

With the intention to boost its healthcare manpower, Indonesia Ministry of Health has prescribed a series of manpower target ratios in the MOH Strategic Plan 2005-2009 for the major categories of healthcare professions by 2010. Based on the total production of healthcare profession in 2008, nursing and midwives are considered as the key categories with significant manpower shortages.

Consequent to the relaxed regulation, the government sanction for health professionals to simultaneously take up jobs in both the public and private sectors. While from the positive end, this human resource distribution trend may be viewed as a form of resource sharing, negative impact such as diminishing service quality and less accountability for less incentivized public healthcare service may arise due to the lack of oversight mechanism for such practices. According to USAID, about 60 to 70 percent of healthcare workers in Indonesia currently hold dual employments in the public and private sectors.

Table 1.6 indicates the targeted manpower ratios by the MOH, by different categories of healthcare professions and the production numbers achieved as of 2008.

Table 1.6: Healthcare manpower targeted and achieved ratios, 2008

Healthcare Profession	Ratio per 100,000 population (2010)	Target Numbers (thousands)	Ratio per 100,000 population (2008)	Achieved Numbers (thousands)	Surplus / Shortage (thousands)
Specialists	9	21.2	6.90	15.7	(5.5)
General Doctor	30	70.8	19.59	44.8	(26.0)
Dentist	11	26.0	3.35	7.7	(18.3)
Nurse	158	372.8	84.80	193.9	(178.9)
Midwife	75	177.0	42.92	98.1	(78.9)

Source: Indonesian Department of Health, Frost & Sullivan

MARKET DYNAMICS, TRENDS AND IMPACTS

1.3.1 Drivers of the Healthcare Services Market and Their Impacts

Table 1.7: Drivers of Healthcare Services Market in Indonesia, 2009

	Driver
1	Longer Life Expectancies and Ageing Population
2	Prevailing Non-communicable and Lifestyle Related Diseases Incidence
3	High Occurrence of Infectious or Communicable Diseases
4	Growing Middle-Class Population
5	Increase Demand for Quality Healthcare
6	National Health Policies and Strategies

Source: Frost & Sullivan

Longer Life Expectancies and Ageing Population

Since 1997, the proportion of the older population to the total population has been increasing. According to the 2006 data found in WHO Indonesia Country Profile, 7.5 percent of the population consists of people above the age of 60. By 2040, it is projected that the proportion of the same population group will grow to 22 percent.

The needs of an increasing older population will add to the existing burden of disease, with prevailing communicable diseases and non-communicable diseases in the country

In 2006, 65.7 percent of the total population is between the age of 15 and 60 years. This group would contribute to the increase number of aged population in the next 2 decades as the life expectancies among Indonesian are improved.

To provide care to such population, greater commitments of care and more personalized services towards the elderly are needed from both the government and the private healthcare providers and the NGOs. The 2 main impacts of this trend are increased demands for healthcare, as well as creation of infrastructures catered to geriatric care.

Prevailing Non-communicable Diseases and Lifestyle Related Diseases

Health problems related to changes in lifestyle have been associated with changing food habits, especially to those living in the cities. Lifestyle choices like smoking, drinking, poor dieting and sedentary lifestyles have been forever been associated with various non-communicable or lifestyle – related diseases like cancer, hypertension and diabetes.

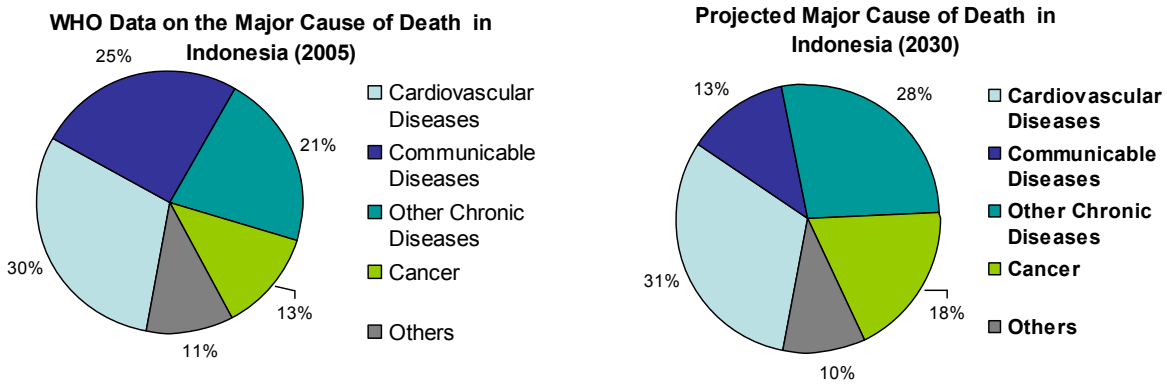
Smoking is among the most notable habit among the local Indonesians. In fact, 11.4 percent or 51.4 million of the people who smoke worldwide live in Indonesia. At present, the age at which the population typically starts to smoke has been getting younger, and young women are almost as likely to smoke as young men. The number of people inhaling second-hand smoke is also high in the country, as 85.4 percent of the smokers smoke regularly at home in the presence of their family members.

A huge 85 percent of Indonesian population aged 15 and above lead sedentary lifestyles compared to only 6 percent of the population who are committed to exercise regularly. Urbanites make the most of these population compared to those who are living out of the cities. Similarly, higher prevalence rate of obesity is found in urban areas compared to rural locations.

According to the 2007 Indonesian National Heath Survey, a total of 29.6 percent of Indonesians above the age of 18 has hypertension. The highest prevalence of hypertension is found to be among the non-working group. Other non-communicable disease, cancer, killed approximately 206,000 people in Indonesia, 135,000 of whom are below the age of 70.

Growing incidences of non-communicable and Lifestyle-related cases caused the shift of focus among healthcare providers to provide curative medicine.

Figure 1.6: WHO Data on the Historical and Forecasted Major Causes of Death in Indonesia (2005, 2030)



Source: World Health Organization, 2009

High Occurrences of Communicable or Infectious Diseases

Although trends showed steady progress for the control of some communicable diseases like tetanus, polio and TB over the past 5 years, other communicable diseases like AIDS and Dengue are still part of the major causes of morbidity and mortality in Indonesia.

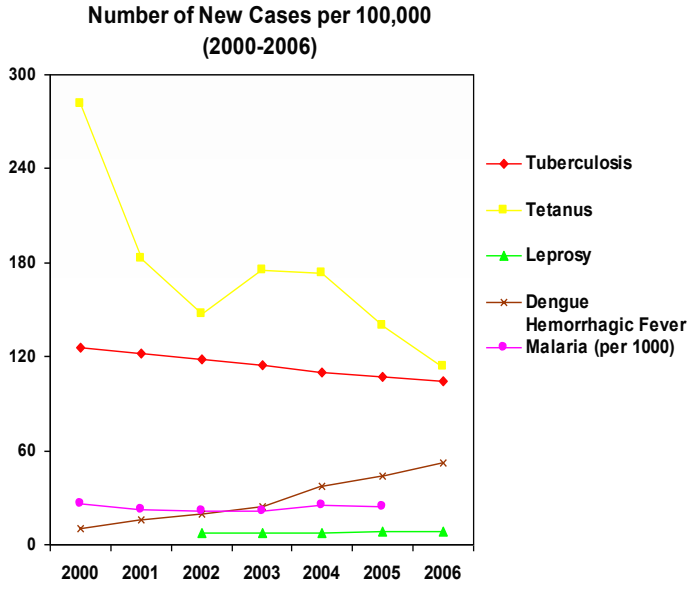
WHO World TB report suggested that the implementation of Pulmonary TB control program by the Indonesian Government had improved TB prevalence in the country. A total of 104 new cases per 100,000 population was recorded in 2006 compared to 130 / 100,000 population in 1995.

However, Indonesia is still ranked third in the world prevalence of the disease. A total of 250 Indonesians died of TB daily in 2006. Similarly, two-thirds of the 576 districts in Indonesia are still classified as malaria endemic areas.

Among the main factor contributing to high prevalence other communicable diseases are high population mobility, especially from disaster struck areas like Aceh in Sumatra to its neighboring cities and provinces, and unsanitary living conditions.

The Indonesian National Aids Commission estimated around 270,000 Indonesians are living with HIV/AIDS in 2007. Majority of the infections are believed to occur through the sharing contaminated drug injecting equipment, unprotected paid sex and sex between men. The same survey showed a worrying trend where the disease has reached both remote highlands and less accessible low lands.

Figure 1.7: Number of New Communicable Diseases per 100,000 population, 2000 to 2006



Source: World Health Organization, 2009

The current trend created an urgent need for communicable and infectious disease management. At present, the services are mainly provided by Ministry of Health and NGOs.

Growing Middle-Class Population

In 2008, the income per capita in Indonesia is at USD 2,271. In the same year, an estimated 22.5 million people belonged to the top 10 percent of the population, each earning above USD 7,000 per year. Another 35 million of the population earned less than USD 4,450, making them part of the middle class population in the country.

ABFI Institute Perbanas, an Institute under the Indonesian Banks Association estimated that by 2010, the average per capita income in the country will grow to USD 3,000, thus creating additional 10 million new middle class population.

These new middle class population in general would have the tendency to switch to more expensive and better quality essentials and services. The same demographic group will also spend more of their income on non-essential categories like fitness, wellness and beauty.

Increase Demand for Quality Healthcare

Among the most frequently cited reason for Indonesian traveling abroad is the lack of quality in the country. Healthcare providers in countries like Singapore, Malaysia, and the Philippines have been receiving approximately 400,000 Indonesian medical tourists seeking quality healthcare annually. Among the indicators of quality as understood by these medical tourists are international accreditation, utilization of latest techniques and equipments, employment of world-renowned specialists, prompt care and excellent patient experience.

However, the services provided by hospital operators abroad are not without any limitation. Treatments done in these countries are often costly, in some cases double or triple the cost of treatments in Indonesia. Aside from the accompanying family members, patients undergoing treatments will also be away from their other friends and relatives during their most critical times.

The rising wealth and population growth will continuously increase the demand for quality healthcare services in Indonesia.

National Healthcare Policies and Strategies

In mid-September 1998, a new healthcare paradigm was introduced as there are still discrepancies in healthcare development among the regions and communities. The "Healthy Indonesia 2010" is a decade long program aiming at 4 main agenda;

- Social mobilization and Society Empowerment for healthy living
- Improvement of quality of healthcare services
- Improvement of healthcare monitoring, surveillance and information systems
- Increasing healthcare financing

As a result, there are marked improvements in several healthcare infrastructures for example 317 percent increase in the number of general physicians and specialists since the launch of "Healthy Indonesia 2010" program in 1998. Other improvements can be found in the table below.

Table 1.8: Comparisons of the Status of Selected Health Infrastructures in Indonesia, 1997 and 2007

Indicator	1997	2007
Number of Hospitals	893	1,318
Number of Physicians	13,633	56,930
Number of Nurses	150,149	308,310

Source: National Health Survey, 1997 and 2007

Indonesia has also long been supporting the growth of private healthcare sector. In 2006, the Ministry of Healthcare began targeting public resources to support priority preventive healthcare services for vulnerable population, leaving the private sector to focus on curative care. Previously in 1990, the zero growth policy for public health institutions allow the private healthcare sector to expand.

Consistent reviews and programs to support healthcare services in Indonesia would help improve the quality of services within the country's healthcare industry.

1.3.2 Restraints of the Healthcare Services Market and Their Impacts

Table 1.9: Restraints of Healthcare Services Market in Indonesia, 2009

	Restraints
1	Restrictive Regulations Governing Healthcare Services
2	Limited Number of Healthcare Professionals
3	Small Number of Private Health Insurance Policy Holders
4	Poor Public Infrastructures in Provinces Outside Jakarta

Source: Frost & Sullivan

Restrictive Regulations Governing Healthcare Services

At present, there are several healthcare regulations that are restricting the operation of healthcare providers in the country.

Foreign ownerships of small health clinics are largely closed to foreign investments, with the exception of up to 65 percent foreign ownership of hospitals located in Medan and Surabaya. The lack of foreign interests in local hospitals limit the size of funds the hospital could use for expansion, and limit the in-bound technology transfers between these foreign institutions and the local hospital operators.

Foreign doctors are not allowed to practice in Indonesia despite the country's poor doctor to patient ratio. These doctors, however, are allowed to supervise and perform procedures in the course of educating Indonesian doctors. Indonesia-born doctors practicing abroad may practice in Indonesia after a 6 month adjustment program. The regulation causes most doctors to be stretched out of their capacity to cater to the overwhelming demand from the local patients.

Current regulation requires all healthcare providers to allocate 10 percent of their total number of beds for 3rd class patients. A new draft regulation, if passed, would require all hospital providers to treat all poor patients for emergency and trauma cases. Hospitals may be heavily fined for cases of death or permanent disability due to their refusal to admit the patients.

These regulations require hospital providers to tread carefully in making their operational decisions.

Limited Number of Healthcare Professionals

According to the Ministry of Health, the shortage of the number of healthcare professionals within Indonesia is critical. The country needs another 5,500 specialist doctors, 26,000 general physicians, 18,300 dentists, 178,900 nurses and 78,900 midwives to provide ideal healthcare services for every single person in the country. The existing number of healthcare professionals is concentrated in the primary and secondary cities, where most of the population are found.

Professionals are often stretched beyond their individual capacity to cope with the domestic healthcare demand.
The monetary incentives for healthcare professionals are low compared to the amount paid in the neighboring countries. The average pay for medical specialists in public services is at USD 824 per month, followed by USD 549 for doctors and dentists. Nurses earn approximately USD 275 monthly. The low incentives paid to these workers caused the shortage of healthcare professionals in the country when many of these healthcare professionals, especially nurses choose to go abroad to places like Singapore, Japan and the Middle East for higher salaries.

To ease the shortage, the vast majority of publicly employed healthcare professionals have second jobs in their own private practices or other private hospitals. Those with second jobs earn nearly 50 percent of their income from private sources. Intense competition exists among private healthcare providers especially for specialists and sub-specialist doctors and nurses.

Many more non-monetary incentives are offered to help retain the existing doctors in the system. The Indonesian government provides housing and transportation benefits for doctors and nurses while several local governments are willing to pay a contracted amount for medical education at University of Indonesia (UI) or even with private medical universities in order to ensure the respective local areas will have medical doctors in the future.

Small Number of Private Health Insurance Policy Holders

Most Indonesians are not 'insurance-minded' or health risk-averse, thus contributing to the low penetration rate of private health insurance in the country. It was recorded to be at only 3 percent in 2005, which grew slightly to 4 percent in 2007.

Excluding approximately 8.6 percent of the population being insured by their employers, and 28.6 percent others being part of the National Health Insurance Program, a hefty 58.1 percent of the population depends on their discretionary incomes for financing their healthcare needs. Most of the healthcare spending by members of this group is done via out-of-pocket payment.

Relying on out-of-pocket payment significantly affect the affordability of healthcare for these population, and help to shape the health utilization among the people. In the past 5 years, the growth of outpatient admission is slowing down as more and more people are opting for cheaper options like self-medication.

The number of policy holders will remain low for the next 5 years, making hospital providers to focus more on targeting the population insured through Jamsostek.

Poor Public Infrastructure in Provinces Outside Jakarta

Public infrastructures in provinces other than Jakarta remain inadequate. Lack of telecommunication infrastructures and poor road conditions and road transport facilities hinder healthcare providers from reaching out to the needs of population beyond Jakarta. Likewise, these factors also hamper the outskirts population from accessing to the better quality healthcare services in Jakarta.

The lack of other infrastructures bars population from obtaining quick medical care. Population may either have to travel far to seek medical care. Public transportation is either not enough or doesn't exists at all. In the village or in very remote areas, people may live without electricity and telephone lines or depends on the few available in some households.

Decentralization makes huge infrastructure projects too expensive for the local government to fund. Frequent occurrences of natural disasters further affect the condition of public infrastructures in these provinces.

At present, although there is a huge opportunity for hospital providers to set up operations in these provinces, the lack of infrastructures may affect the services within the hospital, and the demand for its care.

1.3.3 Challenges of the Healthcare Services Market and Their Impacts

Table 1.10: Challenges of Healthcare Services Market in Indonesia, 2009

	Challenges
1	Negative Perceptions on Domestic Healthcare Quality
2	Huge Number of Private Healthcare Providers
3	Geographical Distribution of Indonesian Population

Source: Frost & Sullivan

Negative Perceptions on Domestic Healthcare Quality

Medical malpractices and adverse events are rampant in Indonesia, undermining the effort of several healthcare providers to push for quality of care. Previous study done by University of Wollonggong found that among the most cited reasons for the negative perceptions on domestic healthcare quality are:

- Low medical reliability ; Doctors' do not provide enough time to deal with patients, Doctors' mistakes during medical treatments, Lack of medical skills among doctors
- Lack of medical facilities and resources
- Poor information ; Difficulties of getting information regarding medical treatments
- Medical treatment errors ; wrong diagnoses, mistakes during medical treatments
- Complaint handling failures

Although there are several specialist institutions in the country, the current services at these centers do not meet international standards.

The lack of quality affects patients' trust in the establishments. The proportion of Indonesians seeking superior healthcare services will continue to travel abroad for their medical needs, if the quality issue is not addressed. Various efforts by both public and private healthcare sector are needed to improve the level of healthcare services in the country and correct these perceptions among the society.

Huge Number of Private Healthcare Providers

At present, there are 685 private hospitals in Indonesia and nearly all are targeting middle to the upper class patients. The hospitals are generally located in major cities across the country, and offer general healthcare services. Several are only offering obstetrics and pediatric care catering to the same population.

Competition for patients is intense and hospitals are fighting to recruit the best doctors, and to collect as many referral doctors and insurance companies to ensure at least consistent number of admissions at their institutions.

Several hospitals are already furnishing their facilities with the most advanced equipments, while others are focusing on offering the most sophisticated techniques. The term "international" is often abused by these hospitals in order to instill trust and to increase the number of patients.

Hospitals may have to look beyond providing healthcare services to the crème de la crème, but also to extend their services to the masses who could afford their care. Focusing on quality of care and building on specialties will help these hospital businesses differentiate themselves from the other players in the market

Geographical Distribution of Indonesian Population

The distribution of Indonesian population is uneven, with 60 percent of the population living in only 7 percent of the nation's land. These population live in major cities like Jakarta, Bandung, Surabaya, Medan, and Palembang.

Java is the most densely populated island in Indonesia, with more than 110 million people, despite having only 7 percent of the land area making it one of the highest in the world today. In contrast, Papua, which has roughly 22 percent of the land area, has only 1 percent of the population.

The transmigration from rural to urban areas further increases the total headcounts in these areas.

As with other countries, the population density in Indonesia is directly related to the concentration of healthcare services. Most hospitals and healthcare institutions are found in major cities across the country. More are expected to be built consistent with the future growth of the population in the locality.

1.3.4 Current Trends of the Healthcare Services Market

Indonesians are taking more active role in the decision making affecting their healthcare. More people are aware of the health risks associated with different lifestyles, and continuously put an effort to stay healthy. Patients are more educated and well informed with knowledge on diseases, treatments and availability of options through various channels like the internet, print media, television and radio.

On the other hand, healthcare providers are continuously pursuing quality of care, claims of international standards and equipping the facilities with the latest and most sophisticated instruments and machines. Several hospital providers are also banking in the wellness services and alternative therapies services demanded by the health conscious consumers.

Equipments and technology vendors are making in-roads towards the healthcare services market in the country. With the emerging few players stressing on 'providing only the best' to its patients, more and more partnerships are formed between these vendors and the healthcare providers.

Bigger coverage of social and private health insurance will help to extend the healthcare services to more people in the country. In June 2010, PT Jamsostek (social security through contributions from both the employers and the employees) announced that it has allocated USD 110 million from its last year's profit to employees post employment benefits. The president earlier announced the increase return rate, death and accident benefits to Jamsostek members. The increase will benefit its members in obtaining better quality of care at both public and private healthcare facilities. The program collects premiums from members and covers payments for accidents, dismissals, layoffs and healthcare treatments as well as pensions

REGULATORY FRAMEWORK AND GOVERNMENT POLICY REVIEW

Indonesia Sehat 2010 ("Healthy Indonesia 2010")

The Ministry of Health has set the vision "Healthy Indonesia 2010" by prioritizing four main elements of healthcare sector development; national development with healthcare focus, professionalism, decentralization and development of managed health insurance. The 'Indonesia Sehat 2010' vision was designed by the government to facilitate the future Indonesia society with improved healthcare standard.

Through several initiatives, Healthy Indonesia 2010 was set to cover 75 percent of the Indonesia population by 2009.

Figure 1.8: Budgetary Overview of "Healthy Indonesia 2010"

Source: Indonesian Health Department

The arrival of 2010 marks the near completion of the "Healthy Indonesia 2010" program implementation. Indonesia has achieved relatively favorable outcome by approaching close to its initial targets.

Certain healthcare indicators have shown a positive turn. Mortality rates have shown a gradual decline, particularly the maternal mortality ratio but the occurrence of communicable diseases remains a public healthcare hazard and the increase in incidence of cardiovascular diseases and other degenerative diseases is another important issue that needs to be addressed.

Guaranteed Health Maintenance Program (JPKM)

Fundamentally, JPKM is a community based managed healthcare program with the intention to ensure public access to good quality and cost-contained healthcare services, and places greater emphasis towards the poor. The scheme is currently managed under Bapels (Non-profit administrative bodies or HMO-like organizations) established at district level, which are responsible for channeling the government disbursements to the public district healthcare centers. Participation of JPKM schemes is voluntary and majority of the population currently serves under the scheme comprises citizens from the informal sector, civil servants, and military for their uncovered dependants. The JPKM structure works towards promoting more preventive and sustainable services over curative and rehabilitative service so as to improve the healthcare of the society as well as the quality of healthcare services it receives. Healthcare centers and third class rooms in public hospitals are the key facilities assigned to deliver healthcare services under this program.

Decentralization

Indonesia is a vast country with large geographical and economical disparities between regions. To ensure healthcare development, arrangement of various healthcare efforts should start from specific problems and potentials of each region. Based on Ordinance No. 32 2004 on Provincial Government, Ordinance No. 33 2004 on Balance Financing between Central and Provincial Government, and Ordinance No. 38 2007 on Affairs Division between Central, Provincial Government, and Municipal Government, planning, budget allocating and drugs provisioning for public sector healthcare had become the responsibility of the Municipal Government. Decentralization is the delegation of more autonomy to the regional governments in regulating their own governance system and local affairs. This is deemed suitable for the management and implementation of future national development programs.

Decentralization requires the necessary resources; human, financial and operational. Determination of roles and activities of the central and regional governments in healthcare sector, analysis of regional capabilities, upgrading of regional human resources, training, repositioning of manpower and other activities have to be carried out before the process of decentralization can be implemented. To date, the development of this initiative has proven to be challenging as each local government has its own authority and every region would have a different regulation on implementing its healthcare program.

Regulations Specific to the Private Healthcare Sector

During the past decades, several healthcare regulations have been implemented by the Indonesian government. Table 1.11 lists the various healthcare regulations that are either targeted to the healthcare delivery sector as a whole or specifically towards the private healthcare sector.

Table 1.11: Healthcare Regulation milestones in Indonesia

Name	Year	Main Function
Ministry of Health Regulation No. 920, subsequently updated in 1990	1986	Quality assurance governance on medical services provided at private hospitals
Health Act 23	1992	Regulates healthcare personnel training and education conducted by government and private sector institutions
Ministry of Health Decree No. 282	1993	Stipulates the tariffs imposed on private hospital services
Ministry of Health Regulation No. 378	1993	Defines and regulates the social function of private hospitals
Ministry of Health Regulation No. 916	1997	Regulates the licensing of medical practitioners
Decision of Director General of Medical Services HK.00.06.3.5.5797, subsequently updated in 1999	1998	Guidelines on private medical specialist services
Ministry of Health Decree No. 1239	2000	Registration requirement for nurses and practice regulations
Ministry of Health Circular No. 725	2004	Updates on regulation of medical services provided by private hospitals
Social Security Law	2004	Mandates the nature of social security contribution and services

Source: Ministry of Health, Indonesia, USAID

A draft of a new regulation was tabled in May 2009 on the issue of patient handling at Accident & Emergency departments. At present, accident and emergency admissions is still based on patient's ability to pay. Private hospitals sometimes do redirect poor patients to another hospital with suitable facilities, together with doctor's medical advice. Once passed, the regulation will impose heavy fines up to USD 110,500 to hospital refusing poor patients. Hospitals also risk similar fine for cases where death and patient permanent disability becomes the consequences of treatment refusals. To date, the draft remains as is and has yet to pass as a regulation.

2 Overview of Jakarta's Oncology and Accident and Emergency (A&E) Space

DEMOGRAPHIC AND HEALTH PROFILE OF JAKARTA POPULATION

The Special Capital Territory of Jakarta is the capital and the largest city in Indonesia. The capital is divided into 5 sub-regions or cities and one regency; Central Jakarta, North Jakarta, West Jakarta, South Jakarta, East Jakarta, and the Thousand Islands, each governed by their own administrative system. The greater Jakarta has its own governor, which is elected on a 5-year term.

The official population of Jakarta is recorded at 9.15 million in 2008. The most densely populated areas in Jakarta are Central Jakarta (18,458 people per km^2) and North Jakarta (17,225 people per km^2)

The following table shows the city population from the year 2006 to 2008.

Table 2.1: Jakarta Population by Age Group, number of persons and percentage (2006 to 2008)

Age Group	2006	2007	2008
0 - 14	2,133,194	2,194,866	2,208,800
15-64	6,632,630	6,550,555	6,639,400
65 & above	197,186	312,572	297,981
Total Population	8,963,010	9,057,993	9,146,181

Age Group	2006	2007	2008
0 - 14	23.8%	24.3%	24.2%
15 - 64	74.0%	72.3%	72.6%
65 & above	2.2%	3.4%	3.2%
Total Population	100%	100%	100%

Source: Department of Health, Ministry of Health Indonesia& Jakarta Health Authority

Declining birth rate, longer life expectancies and inward migration into the cities helped to shape Jakarta demography into an aging population it is today. The proportion of the population aged 0 to 14 years is rapidly declining. In 1990, the group made up 31.9 percent of the entire population, which was reduced to 23.8 percent by 2006. On the other hand, the proportion of the population aged above 65 experienced a growth from 1.5 percent in 1990, to 2.2 percent in 2006.

Life expectancies are improving with the average Jakarta population expected to live up to 72.8 years in 2008 as opposed to only 72.5 years in 2006 and 72.6 years in 2007. The life expectancy of Jakarta population is expected to increase to 74 years by 2012.

Based on the annual household survey done by the Ministry of Health in 2008, 81.75 percent of the total population in Jakarta utilized modern medicine for treating various forms of illnesses. The remaining 18 percent are still using traditional medicine and other form of therapies for the same purpose.

Similarly, in the event of illnesses, most of the Jakarta population will seek medical help from hospitals, while the others will seek first-line medical interventions from non-hospital based institutions like general practitioner's clinics, community clinics or by visiting the midwives. Among those seeking care at hospitals, there is almost an equal split for outpatient visits between public and private providers.

Jakarta population are largely healthy, with only 89.8 percent to get back to their shape within a week following an illness. The following table shows the proportion of Jakarta population and the number of sick days associated with their illness in 2007

Table 2.2: Proportion of Jakarta population and the number of sick days associated with their illnesses (2007)

Year	Less than 3	4 to 7 days	8 to 14 days	15 to 21 days	More than 21
2007	58.74%	31.06%	4.98%	1.90%	3.32%

Source: Department of Health, Ministry of Health Indonesia

The Central Bank of Indonesia estimated that 74 percent of the total population in Jakarta are part of the middle to upper classes, with per capita income exceeding USD 3,600. A different survey by AC Nielsen in 2009 estimated that 13 percent of the Jakarta population an income per capita in excess of USD 10,000.

There are approximately 164,000 poor families or 450,000 poor population in Jakarta, all of which are depending on GAKIN, for financing their medical treatments. Others are depending on Jamsostek, Jamkesmas, private health insurance and out of pocket payments to pay for the medical care.

Illnesses like mental disorders, diabetes mellitus and cancer are more prevalent in Jakarta, with percentages higher than the national average. Heart-related diseases prevalence are at par with other cities in Indonesia.

OVERVIEW OF JAKARTA HEALTHCARE INFRASTRUCTURE

Table 2.3: Types of Healthcare Institution in Jakarta, 2006 to 2009

Type of Institution	Units (2006)	Units (2007)	Units (2008)	Units (2009)
General Hospital	74	76	74	77
Specialist Hospital	44	53	47	50
Community Clinic	341	341	341	341
General Practitioner Clinic	6,700	8,723	10,500	14,000

Source: Jakarta Health Authority 2006 to 2007, published articles, Frost & Sullivan

Although slightly better than the situation in other cities in Indonesia, healthcare services in Jakarta is still inadequate to meet the needs of the fast growing population. Government owned general hospitals are overcrowded and short of state-of-the-art equipments as well as medical staff. Private hospital providers, which generally are well funded, do better in providing high quality care compared to public hospitals. The first and only hospital to receive the world-renowned accreditation from Joint Commissions International (JCI) is a private hospital, Siloam Hospitals Lippo Village.

Jakarta Development Authority previously outlined several issues in the delivery of healthcare services in the city. Among the issues include the lack of quality healthcare facilities and the limited capacity within established medical services institutions. On top of that, society expectations for the services are high but the level of service among healthcare providers remains unsatisfactory. Legal cases involving medical misconducts are rampant and often being highlighted in the printed media. There are no coordination between primary care clinics and both public and private hospitals. Accident & Emergency departments are still struggling with the coordination in providing city-wide comprehensive emergency services.

The city of Jakarta also suffers from a huge gap between the current size of the healthcare workforce and the optimal number outlined by the World Health Organization.

Table 2.4: Jakarta Health Human Resources (2006 to 2009)

Healthcare Professionals	2006	2007	2008
Doctors	8,737	8,993	9,500
Nurses and Midwives	9,664	15,015	22,000
Pharmacists	1,270	1,498	1,740
Nutritionists	680	353	400
Medical Technologists	1,527	1,539	1,540
Community Healthcare Workers	559	339	339

Source: Jakarta Health Authority 2006 to 2007, published articles, Frost & Sullivan

To address these issues, the city healthcare authority had launched a program to review the services provided at 20 percent of the total 127 hospitals around the city by end of 2009. At the same time the authority is promoting accreditation exercise among the healthcare providers. Other programs include:

- Good governance for healthcare services
- Synchronization of healthcare financing, institutions and regulations
- Management and prevention of communicable and non-communicable diseases
- Reduction of maternal and infant mortality
- Healthcare improvements for children 5 years and younger
- Development of healthy environment
- Society healthcare promotion and empowerment
- Healthcare services quality improvements
- Food and drugs monitoring
- Promotion of traditional and complementary medicine
- Improvement of hospitals and community clinics.

JAKARTA ONCOLOGY SERVICES

2.3.1 Background

Cancer is one of the non-communicable diseases that threaten the lives of many Indonesians. WHO Indonesia country report in 2002 estimated there are between 170 to 190 new cancer cases for each 100,000 people in the country. Articles published in Biomedical Imaging Interventional Journal in October 2008 estimated about 200,000 new cancer patients annually. Data from the Ministry of Health shows an estimate of 6 percent or 1.32 million people in Indonesia are living with cancer.

According to the Ministry of Health, cancer is the 6th largest cause of death after tuberculosis, stroke, hypertension, injuries, perinatal and diabetes mellitus. The top 10 types of cancer based on attendance at Indonesian hospitals are as follows.

- Cervical cancer
- Breast cancer
- Lung cancer
- Rectal cancer
- Prostate cancer
- Nasopharynx cancer
- Ovarian cancer
- Non-Hodgkin lymphoma
- Lymph Glands / Node cancer

Hospital Information System 2007 data showed that among all types of cancer, breast cancer is the most prevalent cancer cases requiring in-patient treatment at 16.85 percent, followed by cervical cancer at 11.78 percent. Lung cancer made up 5.7 percent of all cancer in-patient stay.

The same database showed that the most frequent types of cancer found in children between 0 to 17 years old in Jakarta are leukemia (33.7 percent), neuroblastoma (7 percent), retinoblastoma (5.3 percent), osteosarcoma (4.8 percent), and non-Hodgkins Lymphoma (4.8 percent). Indonesia Children Oncology Foundation estimated around 650 children cancer patients are living in Jakarta. Indonesian

Cancer Foundation estimated around 4,000 new children cancer cases are found in the country annually. Only 20 percent of these children obtain the required medical care and treatments.

The disease prevalence in the country is as high as 4.3 cases per 1,000 population. Breast cancer prevalence is 26 cases per 100,000 females, while cervical cancer prevalence is estimated at 16 cases per 100,000 females. Between 60 to 70 percent of cancer patients seek medical treatment when it is already too late. The Indonesian Cancer Foundation reported that the survival rate among cancer patients in the country is only 40 to 50 percent.

Common habits like sedentary lifestyle, smoking, alcohol consumptions and improper dieting are among the factors contributing to the incidence of cancer.

Diagnostic services are provided by a number of hospitals and community clinics, however only a few are well equipped with the latest technology for early cancer detection. Within the capital, or around the country, there is a shortage of advance cancer services. In Jakarta, pediatric oncology is currently available at only 4 hospitals; RSCM, RSKD, Harapan Kita Hospital and Fatmawati Hospital, while stem cell transplant for leukemia patients is only available at RSCM and RSKD. The two hospitals also offer palliative care together with a number of non-governmental organizations. Hospice care is provided only by the Indonesian Cancer Foundation.

There are only 5 radiotherapy centers in Jakarta, all of which are within government owned hospitals. All of these centers are serving as referral centers from all of other parts of Indonesia, primarily for the West Java. Serious overcrowding is present at all of these centers and is reflected by long waiting list, with some exceeding 6 months interval between time of waiting list registration to radiotherapy treatment. Although operating at 10 hours per day, these radiotherapy centers, together with 17 others in the country, are only capable of providing service to approximately 10 percent of the cancer patients in Indonesia.

Surgical oncology is the most commonly found oncology service after imaging services in Jakarta. Tumor removal surgeries are common in both public and private hospitals.

Table 2.5 shows various modalities of therapy for cancer and their proportion of utilizations

Table 2.5 : Modalities for Cancer Therapy in Indonesia

Modalities	Percentage
Radiotherapy	70
Surgery	20-25
Chemotherapy& Oral Medication	5-10

Source: Japanese Journal of Clinical Oncology 2002

Multidisciplinary approach is normally found at large public hospitals, while surgical extraction of tumors is more commonly practiced in smaller institutions.

The number of specialist healthcare workers for cancer services is still small. Director of Nursing at Ministry of Health Indonesia reported that at present, the current ratio for specialist nurse to children cancer patients is 1:15, far from the ideal 1: 6 to 7 patients.

In Jakarta, the city administration had outlined a program to increase cancer detection among the population. The city health authority targeted as many as 50 percent of the community clinics in Jakarta to offer cervical and breast cancer screening services by the end of 2009.

2.3.2 Trends in Patient Movements

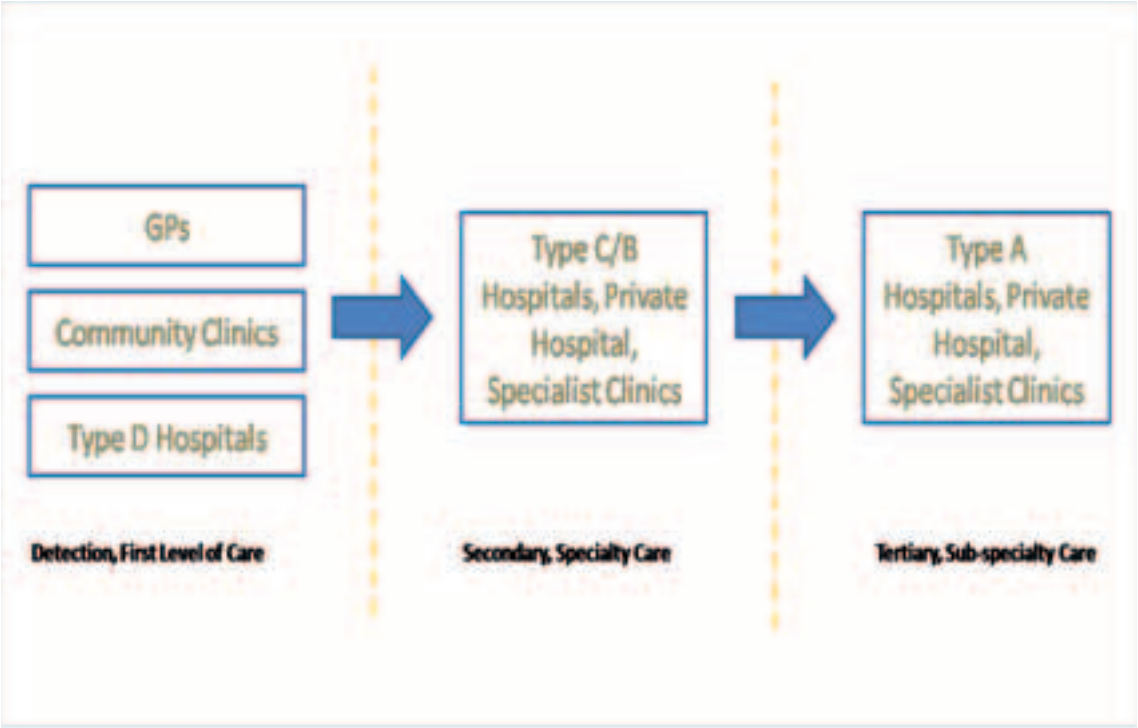
Referral system for cancer care is still not structured in Indonesia, even in Jakarta. The role of community clinics and general practitioners in cancer detection is often being bypassed. The population normally choose to consult with specialists rather than with general doctors.

Poor patients who could not afford the specialist fees would resort to traditional and complementary medicine and other non-medical alternatives.

Ideally, patients would follow 3 levels of referrals, starting with community clinics, general practitioners and doctors at private practice as first level of consultations. These providers would refer patients to specialists at private practice, region-specific Type B and Type C hospitals, and specialist hospitals for cancer treatments. For cases requiring sub-specialist care, or for patients coming from areas without comprehensive cancer center, referrals would be made to the third category; consists of consultant

specialist at private practice, national referral Type A hospitals as well as specialist hospital. The following chart shows the three level of referral for cancer patients in Indonesia.

Figure 2.2 : Oncology Patients Movements



Source: Frost & Sullivan

After confirming that patients have cancer-like symptoms, patients are normally referred to a radiology or imaging center for more accurate cancer imaging. At this stage, multiple factors will affect the type of institutions the patients may choose to go to. Quality, availability of specialists, availability of procedures, procedure fees and waiting time, all play the major aspect in deciding patients' movements.

Next, patient will again be assigned to specific type of treatments. At this stage, only limited numbers of hospitals are offering radiotherapy or sub-specialist services. These are also the two reasons affecting cancer patients' movements in Jakarta.

Long waiting time associated with limited number of specialists at these oncology centers also prompt a group of patients to complete both cancer imaging and their treatments abroad. Although the cost is much higher than the treatment prices in Indonesia, patients are guaranteed a consultation with their oncologist and proceed with the doctor's interventions without having to wait for long.

Indonesian patients make up 60 percent of the total number of overseas oncology patients at National Cancer Center Singapore, Johns Hopkins Cancer Center and National University Hospital Singapore. These oncology centers have an edge over Indonesian oncology providers by being JCI accredited and equipped with state-of-the-art technologies.

In most oncology department, post-therapy patients will be asked to attend follow-up appointments scheduled at the following intervals.

Table 2.6 : Frequency of follow-up appointments for cancer patients in Jakarta

Stage	Frequency
First 6 months	Every month
Next 6 months	Once every 2 months
Second year	Once every 3 months
Third year	Once every 6 months
Fourth year onwards	Once a year

Source: Dharmais Cancer Center, 2009

During follow-ups, doctors will run clinical and cytology tests on the patients. Depending on the test results, a biopsy will be done to assess the condition of the patients. A CT scan will be done on each patient once a year.

2.3.3 Trends in Technology Movements

The technology utilized in cancer center and oncology units in Jakarta includes 64 slices Computed Tomography Scanner (CT-Scanner), 1.5T Magnetic Resonance Imaging (MRI), Angiography, Full field digital mammography, 3D and 4D Ultrasonography and Conventional Fluoroscopy machines. Advanced technologies like 128-slices CT scanner, 3T MRI, Dual-head Gamma-camera, SPECT-CT, Positron Emission Topography (PET-CT), and Cyclotron are currently only available at selected hospitals.

Both the diagnostic imaging and nuclear medicine equipments require trained professional to operate. They are also very expensive to buy. Per unit price is estimated to be between USD 1 to 3 million, while the annual maintenance often cost between 10 to 15 percent of the purchase price per year. Radiotherapy equipments calibrations are generally done between 3 to 5 years apart, and performed by qualified personnel from vendor companies in Singapore. Siemens, Varian, GE Healthcare and Phillips are four most popular manufacturer for diagnostic and therapeutic equipments used in these centers.

Most hospitals do not have a preferred vendor, and commissioned each purchase solely on the equipment prices and needs.

The 5 radiotherapy centers in Jakarta are equipped with the highest number of linear accelerators compared to all the other centers outside Jakarta combined. One Jakarta-based center is equipped with Intensity Modulated Radiation Therapy (IMRT), while others in the city are still using 3D Conformal CT simulators. 3 Tele-cobalt machines are available catering to 9.2 million people in the city. Brachytherapy devices are available in selected few centers, all of which are performing HDR after loading and intracavitary insertion techniques. The most popular brands for linear accelerator are Siemens, Varian and Elekta, while Victorean and Capintec are most popular for dose calibrators.

With a few hospitals starting to utilize more sophisticated technology for cancer diagnostic, others are expected to follow. Many hospitals are expected to upgrade their 16-slice CT scanner to 64-slices or higher resolution CT scanner. A few key hospitals are also looking into or already have commissioned the purchase of more advanced PET-CT for improved and more accurate cancer diagnosis.

2.3.4 Key Service Providers

Cipto Mangunkusumo Hospital (RSCM)

Cipto Mangunkusumo Hospital (RSCM) is a Type A teaching hospital in Indonesia. Being a national referral hospital, RSCM has been the benchmark for many hospitals across the country.

The oncology services at RSCM cover all four stages of care; preventive, diagnosis, treatment and continuing care, all of which are provided by several departments within the hospital. The figure below shows all of the services available at RSCM under its oncology care.

Figure 2.3: Four stages of oncology care at Cipto Mangunkusumo Hospital

Source: CiptoMangunkusumo Hospital, 2010

The hospital treats between 3,000 to 4,500 cancer patients annually. Pediatric oncology unit admits an average of 100 patients per year. In 2007, it is reported that cancer patients made up nearly 50 percent of the in-patients beds in the hospital. Compared to other hospitals in Jakarta, the oncology unit at RSCM is the first choice among patients for cancer management.

The radiology department supporting oncology services are equipped with 6 conventional x-rays, a 64 slices CT scanner, an MRI, 4 ultrasonography machines, mammography units, and angiography machines. The department is currently looking to purchase one more 64-slice CT scanner, a 1.5T MRI and a PET/CT. Cancer detection service at RSCM is also supported by its anatomical and clinical pathology laboratories.

The country's first linear accelerator, simulator and treatment planning system were installed in RSCM. To date, RSCM radiotherapy department is equipped with 2 linear accelerators, tele-cobalt machines, brachytherapy device, 1 single head gamma camera, 1 double-head with SPECT and 2 dose calibrators. It is the only hospital in Indonesia performing Intensity Modulated Radiation Therapy (IMRT) and stereotactic radiosurgery to its cancer patients. Radiotherapy department management and services at RSCM is ISO 9001:2008 certified since January 2010.

RSCM oncology unit is also one of the referral centers to Mount Elizabeth hospital and Singapore General Hospital.

In beginning of May 2010, RSCM Kencana, the new private wing at RSCM has offered oncology care. The facilities at the new wing include VIP wards, which are already regarded as among best found in Jakarta.

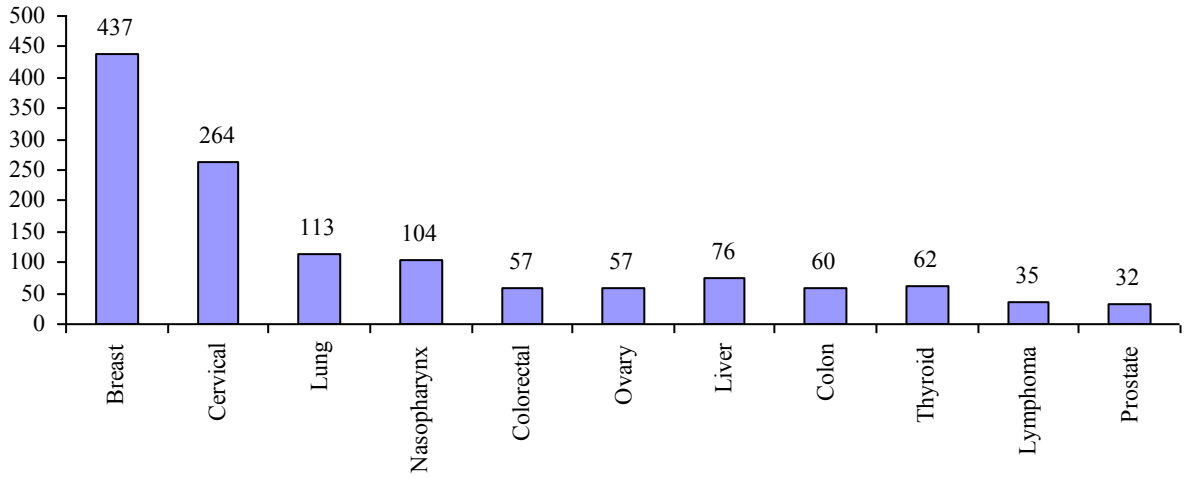
Dharmais Cancer Center (RSKD)

Dharmais Cancer Center (RSKD) was set up in 1988 with clear focus on oncology care and research. The hospital located in West Jakarta is also functioning as teaching hospital for postgraduate students at University of Indonesia (UI). Apart from the total of 3,000 current patients, the hospital admits an average 400 new breast cancer patients, 270 cervical cancer patients, 100 lung cancer patients and 60 new pediatric oncology patients annually.

Oncology care and therapies at RSKD are managed by a number of working groups. Each working group is made up of specialists of various types of cancer as well as several consultative members from any of the 10 other disciplines like anesthesiology, psychiatry, nutrition, cardiology, nephrology, gastroenterology, oral and maxillofacial, immunology and psychology. Each group handles each assigned case from diagnosis to therapy and rehabilitation stage. Specialists within each working group exchange opinions and plan for therapies together to achieve accurate diagnosis, and to provide only the best treatments with the hope to ultimately to cure the illness or to improve patient outcomes. At present, 81 specialists and resident medical officers makes up the medical team at this cancer center.

The following chart shows the top 10 new cancer cases treated at Dharmais Cancer Center in 2007.

Figure 2.4: Top 10 new cancer cases treated at Dharmais Cancer Center, 2007



Source: Dharmais Cancer Center, 2009

The in-patient facilities at RSKD cost between USD 140 per day for VVIP room, complete with separate area for accompanying family members with sofa bed, kitchenette and dining area, to USD 15.70 per day for third class facilities. Jamkesmas patients are charged USD 10.50 per one night stay.

RSKD is equipped with 2 linear accelerators and tele-cobalt machines. It also possess Celution800/CRS system, an equipment used for breast reconstruction therapy

To date, the laboratories at RSKD cancer research wing still do not have enough facilities and equipments to support its purpose. Since 1993, the limited resources and equipments have continuously hindered the cancer research at RSKD to take off as planned. To date, each cancer research at RSKD is sponsored individually by different medical specialty groups.

Future plans at RSKD include the purchase of equipments for cancer diagnostic, therapy and research. The management also has some plans for renovating the current hospital premise to improve its service area and building esthetics.

Gading Pluit Hospital (RSGP)

One of the few private players tapping into oncology services is Gading Pluit Hospital (RSGP). The hospital is located in Pluit area in North Jakarta. RSGP is built on 1.3 hectares of land, and houses 187 in-patient beds.

At present the hospital is only concentrating on providing diagnostic service in its cancer center. For this purpose, the hospital is equipping its cancer center with 64-slices CT scanner, 1.5T MRI, Ultrasonography, Angiography, conventional x-ray and mammography machines. It is the first hospital in the country to have a PET/CT and cyclotron facility. Since the equipments arrival, many cancer patients requiring PET/CT imaging have been referred to RSGP instead of to Singapore.

RSGP is also looking at expanding the services offered at its own cancer center. The cancer will provide services like chemotherapy, cryosurgery, fine needle biopsy, clinical pathology and anatomical pathology laboratory tests. Future services also include radiotherapy and transplant.

2.3.5 Alliances and Partnerships

Novartis Oncology Access

Novartis Oncology Access or NOA is a program to increase patients' access by subsidizing some of the treatment costs to patients requiring financial support. The program is targeting 1,000 chronic myeloid leukemia and gastrointestinal cancer patients by end of 2010.

Novartis, the manufacturer of drug Glivec, the commercial name for Imatinibmesylate, are working with 2 hospitals in Jakarta for the program; RSCM and RSKD. Both of the hospital will be the center for NOA services in the city.

Hospital-based Cancer Registry

In 2004, Oncology Society of Indonesia, Indonesian Cancer Foundation and Pathologist Society of Indonesia launched the country's first hospital-based cancer registry. The reporting system is based on records from 20 hospitals across the country and the ICD2000, the unified medical language system thesaurus. The registry is used to estimate burden of cancer and its risk factors in different provinces across the country. In also provides other information such as capacity programs and specialties at specific facilities.

Today, the application is merged with Ministry of Health programs tracking other communicable and non-communicable diseases across Indonesia. Accurate data on cancer incidence is still unattainable due to administrative, financial and geographical constraints.

Siloam Hospitals and Equipment Vendors

Siloam Hospitals, a premier healthcare group in Indonesia and Varian Medical Systems, a world-leading manufacturer of medical device and software for oncology, signed a memorandum of understanding (MOU) in October 2008 to pursue a collaborative relationship to explore opportunities for developing innovative healthcare solutions for providing world-class cancer care in Indonesia. The hospital signed another MOU with IBA Molecular Equipment of Belgium in December 2008. Through the collaborations, all parties are giving their full commitment to furnish Mochtar Riady Comprehensive Cancer Center (MRCCC), the country's first private cancer center with sophisticated radiotherapy equipments.

Similar ties are formed with Phillips for diagnostic equipments for use at MRCCC and other Siloam Hospitals branches.

JAKARTA ACCIDENT & EMERGENCY (A&E) SERVICES

2.4.1 Background

Accident & Emergency (A&E) department is the most common entry point for any hospital. Patients arriving at the department may present themselves with various ailments like sudden unexpected illnesses, major injuries and other life threatening conditions. A&E departments across the city are also dealing with primary care and social problems. The increasing number of cases requiring quick, accurate treatments increases the importance of these departments to the society they serve.

In Indonesia, a 24 hours A&E is one of the major criteria for any prospective hospital operator needs to fulfill to be able to receive the license from the Ministry of Health. The following Table 2.7 shows the proportion of Accident & Emergency unit compared to the total number of institution by type in Jakarta

Table 2.7: Percentage of Accident & Emergency Unit in Jakarta by types of Institution, 2006 to 2007

Type of Institution	Number of Units (2006)	Number of Units (2007)
General Hospital	92%	92%
Specialist Hospital	62%	62%
Community Clinic	13%	7%

Source: Jakarta Health Authority, 2006 to 2007

The number of Emergency Specialists in the country is still very limited. This prompted most hospitals and all of the community clinics in the city including Jakarta to assign general practitioners to work the shifts in 24-hour Accident & Emergency departments. According to Brawijaya University Head of Emergency Specialist program, there are less than 20 Emergency specialists working in Indonesia today. Other healthcare professionals like the nurses and the paramedics, although limited, serve both the department and the patient pre-hospitalization care. Emergency care professionals would typically be trained and receive specific emergency and trauma certifications like ATLS, ACLS, BTLS and BCLS.

Most of the A&E department in the city is running on two to three different staff shifts.

Patients' overcrowding is common, and has become one of the major problems at many hospitals in the city. High proportions of semi-urgent and non-urgent cases contributed to excessive patient volumes at these hospitals, threatening both the quality of care and efficiencies

The top four emergency conditions in Jakarta are excessive bleeding, stroke, cardiac arrest and asthma attack.

Pre-hospitalization phase

Despite the focus on providing hospital-based emergency care, there is an absence of citywide pre-hospital emergency medical service in Jakarta. Each of the city's district emergency service is independent of each other, and there is no central hotline that provides comprehensive emergency services to the society.

The ambulance service provided by the Jakarta Administrative Office, the AGD118, is not able to match their total number of fleet to the city population. With only 32 vehicles to serve a 66,152 square kilometers city of 9.2 million, the AGD118 is struggling to meet its target response time of below 10 minutes. The current average response time for AGD118 ambulance is 30 minutes, and in some cases may be extended to 1 hour depending on the availability of ambulance, traffic conditions and the caller location. To improve the pre-hospital service in the city, the office had commissioned the purchase of 15 more ambulance which will be ready by August 2010. All of AGD118 fleets remain basic and are rarely sent for annual maintenance service due to the lack of funds.

Apart from the limited number of ambulances, efficiency of pre-hospitalization service in Jakarta is also hindered by the massive traffic jams around the city and limited number of other ambulance service providers.

Some hospitals with A&E department and several non-governmental organizations (NGOs) are equipped with their own ambulance. Only small numbers of these ambulances are fitted with complete facilities matching those found in ambulance in developed countries. Several hospital groups have taken the initiatives to improve their pre-hospitalization care for their patients. Central emergency hotlines, international grade ambulances and air evacuation services are among the services currently available in Jakarta.

Siloam Hospitals Lippo Village and Siloam Hospitals Lippo Cikarang are at the forefront of providing pre-hospital emergency care to patients around the city. The Medivac air ambulance service by Silom Hospitals Group allows patients located a distance as far as 322 km away from hospitals to obtain intensive care and be transported to the nearest Accident & Emergency department much quicker. The service also includes other medical evacuation services via ambulance, private jets and commercial planes, previously chartered for evacuation within Jakarta to as far as the Philippines and Australia. A team of specially trained doctors and nurses will be accompanying the patients throughout the journey.

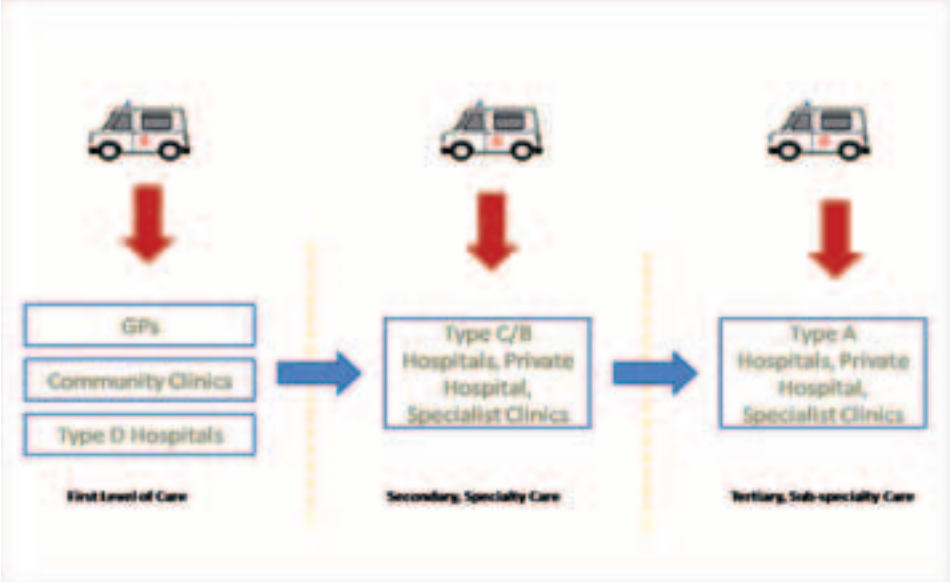
Another pre-hospitalization medical emergency care service is provided by a company called the Medic One. The membership-based service caters to middle to upper class population in Central, South and West Jakarta. Medic One service is provided by a team of 2 Emergency Specialist doctors, 21 paramedics, and Emergency Medical Operators. At USD 155.30 to 820.90 (Rp1.4 million to Rp7.4 million) a year, corporate or individual members are entitled to paramedical ambulance and motorcycle service, air ambulance, pre-hospital hospital arrangement service, hospital monitoring, medical escort service and for Platinum members, the 24 hours priority top specialist appointment in Singapore, and a guarantee for nationwide hospital admissions. At present, more than 700 families have signed up to the service.

Most of the emergency assistances in Jakarta are not bilingual. English speaking emergency care services are limited to small number of providers, primarily the private hospital players.

2.4.2 Trends in Patient Movements

There are 2 different pathways for patients to get to A&E department. The first category includes patients going straight to the hospital to receive treatments. In this category, as depicted in red in Figure 2.5, patients may choose to go to any healthcare providers for emergency care. Depending on the healthcare providers A&E and services capabilities, patients may be treated right away or redirected to other hospitals. The second pathway, depicted in blue, shows the order of referral by healthcare providers for emergency cases in Jakarta. In the latter category, patients will be examined by referring doctor and result of the doctor's assessment will accompany the patients to speed up care at the receiving A&E unit.

Figure 2.5 : Patient Movements in Receiving A&E Care



Source: Frost & Sullivan

Upon arriving at the A&E department, patients will be put in a triage, where nurses or doctor will assess the conditions and assign priorities to the most critical cases. Depending on the patient condition, some may be directed to resuscitation room, operation theatre or placed in observation and followed by treatments. Extremely critical patients will be placed in ICU while non-critical others will be given out-patient treatment before being discharged.

Time taken between patient's arrival at hospitals and receiving treatments depends largely on his conditions and hospital's capability to treat the patients. Patients may be redirected to another hospital if the current hospital does not have the capability to provide treatments, either due to the absence of specialist or the lack of manpower to handle emergency cases. In some circumstances, insurance

verification process or patient's ability to pay for the treatment may also contribute to the delay of treatments.

A community clinic typically receives between 60 to 80 emergency and trauma patients per day, while hospital-based A&E may receive between 100 to 200 patients daily. The proportion of A&E patients forwarded to inpatient services differs between providers. At hospitals like Atma Jaya Hospital, it was reported in 2002 that 75 percent of their inpatient patients are from the hospital's A&E department, while others may admit between 30 to 45 percent of the total A&E attendees.

Food poisoning and road accident cases are highest during holiday seasons, while heart attack, stroke and obstetric cases remain consistent throughout the year.

2.4.3 Trends in Technology Movements

Equipments found in Accident & Emergency departments are arranged by the type of intervention planned for the area. Trauma room, operation theatres, radiology, laboratory and intensive care rooms are all equipped with different equipments. Table 2.8 lists the different equipment most commonly found in Accident & Emergency department in Jakarta

Infrastructures and technologies in Accident & Emergency departments across Jakarta are still poor and far from the international standards. Most of the equipments are between 5 to 10 years old and replacements are made only when existing machines are no longer working. Only limited numbers of hospitals are committed to equipping their A&E department with the latest or the most advanced technologies.

Table 2.8: Space and corresponding equipments found at Accident & Emergency Department in Jakarta

Space	Equipments
Trauma Area	Defibrillator, ECG, Patient Monitor, Centralized Oxygen, Syringe Pump, Infusion Pump, Short Wave Diathermy, Transcutaneous Electrical Nerve Stimulation
Operation Rooms	Clean room with HEPA filters, C-arm, ventilator, compact anesthesia monitor
Radiology	CT scanner, mobile x-ray, 3D or 4D ultrasonography, C-arm
Laboratory	Hematology analyzer, Blood gas analyzer, Electrolyte analyzer
PICU	Incubator, UV light

Source: Frost & Sullivan

Equipment purchases for A&E departments at government hospitals must start with a written request from the head of department to the hospital administration. Decision will be made by the hospital director based on the price and the availability of funding at the time of request.

2.4.4 Key Service Providers

Cipto Mangunkusumo Hospital (RSCM)

Cipto Mangunkusumo Hospital (RSCM) is a teaching hospital of University of Indonesia (UI), which is one of the national referral hospitals for various provinces in the country. Its very own Accident & Emergency unit, located in the left wing of the hospital received no less than 120 patients every day. Accident victims with critical conditions make up nearly 500 of the total number of admissions to the department annually. Obstetric cases made up only 5 percent of the total number of cases.

Together with the annual turn-up at its A&E department, this Type A hospital has been continuously improving its service by deploying more paramedics, assigning additional number of specialized doctors and nurses, and adding the number of ambulances. To extend the coverage to more people, the department is also working hand in hand with the AGD118.

The A&E department is open 24-hour per day, and equipped with treatment area, resuscitation room, 5 operation rooms, laboratory, radiology services and a pharmacy. At present, the equipments used in A&E department of RSCM are between 5 to 10 years. Future plan as per March 2010, include refurbishing all the equipment in the department and commissioning the purchase of few others. The department will also undergo a renovation in July 2010 which is scheduled to finish by December of the same year. Once completed, the department will have more space to cater additional number of patients.

Being the teaching hospital to the best medical school in the country, the department is staffed with specialized doctors and nurses on every shift. For example, 3 resident ophthalmologists are assigned to the A&E with one consultant on on-call basis. Other staffs manning the A&E department include 10 surgeons, 8 internal medicine specialists, 2 pediatric specialists, 2 ENT specialists, 2 neurology specialist, 2 psychiatrists and 11 anesthetists.

Among the key service at RSCM A&E department is the comprehensive crisis center for women and children, located at level 3 on the same wing. The center treats approximately 600 patients per year, and 5,200 since its inception. Other strengths of RSCM A&E departments are as shown in below

- Surgery
- Neurosurgery
- Neurology
- Internal Medicine

- Pediatric
- Obstetrics & Gynecology
- Anesthesiology
- Ophthalmology
- Radiology
- Psychiatry
- Dermatology and andrology

75 percent of the patients admitted to RCSM are from the lower middle and lower class population.

Pertamina Central Hospital

Pertamina Central Hospital (RSPP) is among the many hospitals owned by PT Pertamina Bina Medika, a subsidiary of the country's own oil & gas company. It is conveniently located at Kebayoran business area and is highly accessible from all parts of Jakarta by both private and public transportation.

The Accident & Emergency department at RSPP is manned by 8 doctors and supported by an ambulance, 24 hour anatomical and clinical laboratories, ICU and ICCU, in-house blood bank, 9 operation theatres, radiology services and a pharmacy. The hospital also provides helipad facility to accommodate emergency case evacuation.

The department is known for its specialties in handling serious burn patients, heart patients and stroke patients. Its burn unit features a treatment room with 360 degrees access to patients, and regarded as the best burn facility in Indonesia. Between 2005 to 2009, the department has successfully treated more than 50 second- and third- degree burn cases.

Majority of the patients at RSPP are Pertamina employees, followed by patients under government's social security schemes. The third biggest group of patients at RSPP A&E is the self-paying patients. Main contributors to A&E revenue are sales of medicine, doctor consultation fees and A&E activity charges.

Mitra Keluarga Kelapa Gading Hospital (RSMKKG)

Mitra Keluarga Kelapa Gading Hospital (RSMKKG) is a private hospital serving the neighborhood of Kelapa Gading and Jakarta. The hospital's management received its ISO 9001:2000 in 2006 and has 16 of its services accredited by the Ministry of Health in the same year.

The Accident and emergency services at RSMKKG is open 24 hours per day and is supported by ICU /ICCU, a step down ICU (IMC), NICU and perinatology as well as other services like 24 hour pharmacy, an ambulance and diagnostic radiology equipped with 1.5T MRI, Multislice CT scanner, 3D and 4D USG, Panoramic Mammography and Flouroscopy. Doctors' stationed at RSMKKG A&E unit handles all emergency cases with the help of on-call consultants from various specialties.

Among key services at RSMKKG A&E is its tie with the hospital's vascular unit. The clinic, Jakarta Heart and Vascular Clinic performs procedures like coronary & peripheral angiography, heart catheterization, coronary & peripheral angioplasty, open heart surgery as well as pacemaker implantation. The primary target patient for this clinic is the 10,000 heart patients in Jakarta.

2.4.5 Alliances and Partnerships

"Operasi Citra Pelayanan Lalulintas 2010"

In March 1st 2010, the Jakarta traffic authority partnered with 5 hospitals in the city as referrals for accident and emergency cases. The tie-ups are parts of a program that combines transportation, communication, information, and healthcare services while incorporating technologies like smart camera for real time monitoring of traffic conditions in Jakarta. The partnership also involves other institutions like PT Jasa Raharja, the Health Authority, the Agency for the Assessment and Application of Technology, and the Telecommunication Authority.

The five referral hospitals are RS Islam (Central Jakarta), RS Fatmawati (South Jakarta), RS Sumber Waras (West Jakarta), RS Koja (North Jakarta) and RS Universitas Kristen Indonesia (East Jakarta). Under this program, treatments received by victims at any of these 5 hospitals will be paid by PT Jasa Raharja, a government-owned life insurance company.

"Yayasan Rumah Hati and AGD118"

In 2009, Yayasan Rumah Hati, a foundation interest in social issues and humanities signed an MOU with the AGD118 to create "safe community" starting with the city of Jakarta. The partnership aims to improve emergency care in the city center by organizing fundraising events to collect as much money for purchasing additional 50 ambulances, 30 high-powered motorbikes, hiring enough healthcare workers, preparing 3 years operational funds and upgrading or setting up AGD118 bases in all 5 sub-districts in Jakarta.

The fund raising events include gala dinners, fundraising nights, seminars as well as partnerships with corporate communities.

Banks and Healthcare Providers Partnerships

Several partnerships have been formed between local banks and several healthcare providers in Indonesia and from abroad. Most of these partnerships are part of the strategies taken by these financial institutions to increase the type of benefits they could offer for their credit card holders. BCA Bank Prioritas Card Holder may now be discounted for emergency care received in any of the Parkway Healthcare Group's hospitals in Singapore. Similarly, Mandiri Bank credit card holders will be enjoying discounted fees for several diagnostic radiology services at any one of the Husada Hospitals Group branches.

3 Overview of Mochtar Riady Comprehensive Cancer Center (MRCCC) and Siloam Hospitals Lippo Cikarang (SHLC)

Mochtar Riady Comprehensive Cancer Center (MRCCC)

3.1.1 Background

Mochtar Riady Comprehensive Cancer Center (MRCCC) will be the first private cancer center and treatment facilities with the most complete state-of-the-art equipments and the latest generation of smart IT-systems in Indonesia. Situated in Central Jakarta, MRCCC is highly accessible via public and private transportation and is surrounded by major 5-star international hotels, allowing the hospital to cater to both local and international cancer patients.

The 29 storey's cancer center with 2 basement levels will house 160 in-patient beds on the first year of operation. By 2011, the cancer center will increase its capacity to 220 beds and to 375 beds by 2012. The 52,702 m^2 (including car parking spaces) "Building of Hope" will also have 78 outpatient consultation rooms, 5 operation theaters, a Japanese clinic, an emergency unit, as well as diagnostic, medical, alternative therapy and radiotherapy services under one roof.

On completion around October 2010, MRCCC will offer international standard private oncology care for the population of Jakarta and the whole of Indonesia. Among the firsts for MRCCC will include its palliative care and oncology wellness center, high dose brachytherapy service, radio-immunotherapy (RIT) service, radiopeptide therapy and the most complete radiation therapy equipments in the country.

3.1.2 Key Focus Area of Diseases

Key cancer focus would be the top 10 types of cancer most frequently affecting the lives of Indonesians. MRCCC will provide access to screening for breast cancer, colorectal cancer, cervical cancer, lung cancer, head and neck cancer and many others.

3.1.3 Service Profile

MRCCC will provide diagnostic radiology services, medical oncology services including chemotheraphy, surgical oncology, complementary therapy, and radiation therapy, in-house clinical trials and cancer research.

Table 3.1 Services to be offered at MRCCC

Category	Services
Diagnostic Radiology	MRI scan, CT Scan, Mammography, Ultrasonography, Fluoroscopy, Angiography, PET-CT Scan, SPECT-CT Scan
Laboratory	Genetic screening, biopsy, clinical pathology
Medical Oncology	Surgery, Chemotherapy, Oral medication
Complementary Therapy and Wellness Services	TCM; acupuncture, herbal medicine and anti-aging clinic
Radiation therapy	Branchytherapy, linear accelerator with rapid arc

Source: Frost & Sullivan

Emergency and Medical evacuation to and from the hospital is available via designated ambulances and Medivac services. At the hospital, its Accident & Emergency department will be supported by PICU/NICU and ICU units serving any cancer or non-cancer emergency cases in Central Jakarta.

Apart from oncology care and emergency services, MRCCC will also provide training on medical oncology, radiation therapy, cancer imaging and surgical oncology to produce more highly qualified personnel for oncology care in Indonesia.

On-site retail will be available to provide comfort to the patients and visitors to MRCCC, such as Starbucks Coffee, Kenko Reflexology, a Pharmacy, Times Bookstore and restaurants. Ample capacity in-house parking area will be available for visitors to the center.

3.1.4 MRCCC Operations

Workforce

The medical team at MRCCC will consist of 99 contract specialists and 30 resident doctors, of which 18 are medical professors and sub-specialists, while others are 42 PhD holders and specialist doctors. Over the past years, MRCCC has been successful in recruiting top Indonesian sub-specialist and specialist doctors from 2 of the country's premier medical schools; Medical school of University of Indonesia and the Medical school of Gajah Mada University. Joining the team are other top performing doctors in Indonesia with excellent academic qualifications, track records and with national and international visibility and collaboration networks. The hospital has also been successful in bringing several overseas practicing specialists home to Indonesia to work exclusively for the cancer center.

Key opinion leaders to join MRCCC and Siloam Hospitals Semanggi are Prof. Dr. LA. Lesmana, PhD, Sp.PD-KGEH, FACP, FACG (Professor at the Faculty of Medicine, University of Indonesia and the former president of Indonesian Association for the Study of Liver), Dr Samuel Haryono SpB K Onk (Chief Surgical Oncology Specialists at Dharmais Cancer Center)and Dr Aru Sudoyo (Internal Medicine Specialist at RSCM, Lecturer at the University of Indonesia's School of Medicine, and the Head of Indonesian Internists Association)

MRCCC will be staffed by a total of 260 nurses, 15 percent of which possesses a nursing degree. 30 radiographers and 15 biomedical engineers will also be part of the hospital's 300 allied healthcare professionals and non-medical staff.

Technology

The cancer center will be equipped with latest and most comprehensive therapeutic equipments like the 1 Clinacs iX Linear accelerator complete with image-guidance radiotherapy (IGRT), the most advanced simulator technology currently available in the market. IGRT, or rapid arc is an extremely precise form of treatment that utilizes multiple imaging and motion management techniques to target tumor precisely, thus significantly improve treatment margin for cancer patients. IGRT is an upgrade from IMRT treatment planning technology, which is currently only available at RSCM radiotherapy department.

MRCCCC will also house advanced diagnostic equipments like SPECT-CT, PET-CT and a cyclotron. The latter two equipments will be the second of such technologies to be brought into Indonesia and the biggest in the country as yet. Other technologies supporting the diagnostic capabilities at MRCCC are a multi-slice CT scanner, a 3T MRI, high dose brachytherapy, mammography, endoscopy, conventional x-rays and angiography machine – all to be integrated with PACS/RIS by end of 2010.

Hospital information system (HIS) and Electronic Resource Planning (ERP) will be available at the hospital once opened. The technology is provided by WIPRO, one of the world's IT solution providers, thus making MRCCC one of the first in the Indonesia to run an integrated computerized and digital information system linking imaging (RIS/PACS), pathology, pharmacy and hospital IT services. The hospital will also be equipped with video conferencing capabilities and telehealth hub supported with 100Mbps LAN, linking the hospital with other Siloam Hospitals. Within the hospital building, teleconferencing facilities will be installed to link the 5 operating theaters with the conference room on the top floor. These facilities are designed to speed up the efficiency and accuracy of services, which not only will improve the experience for patients but also will facilitate faster diagnoses and improved patient outcomes at MRCCC.

Capacity Assessment

The 29-storey cancer center with 2 basement levels will house 160 in-patient beds, and 5 operating theaters in the first year of its operation. According to plan, the in-patient beds will be increased annually to 220 beds by 2011 and to 375 beds by 2012.

It will also house the biggest outpatient department in the country, with 99 consultation rooms to serve both oncology and non-oncology patients.

The following table lists the targeted number of runs per equipment per day in 2010 and in 2016.

Table 3.2: Targeted number of runs per equipment per day (2010 and 2016)

Equipments	2010	2016
PET/CT	4	10
Linear Accelerator	25	45
CT	25	45
MRI	15	20

Source: Siloam Hospitals

Affiliations and Partnerships

In June 2009, MRCCC signed a memorandum of understanding (MOU) with SingHealth, Singapore's largest healthcare group, to allow the two premier institutions to work together on joint training, patient referral, medical exchange and hospital management. The collaboration with SingHealth, is indeed a statement of recognition of the quality of medical care provided by Siloam Hospitals group.

The hospital also collaborates with several advanced technology medical device manufacturers such as, Varian Medical Systems for oncology equipments, as well as IBA Molecular and Philips Healthcare for diagnostic devices. The ties allow all parties to work together in equipping the hospital with the latest and most sophisticated healthcare technology at par with other top hospitals around the world. The partnerships will result in greater access to advanced cancer diagnostics and therapies for Indonesian and the population of the surrounding countries.

Locally, MRCCC will also work hand-in-hand with Lippo's own Mochtar Riady Institute of Nanotechnology (MRIN) and Universitas Pelita Harapan in pursuit of creating synergy within the group and providing comprehensive healthcare services by combining medical care, research and education.

Demand Side Analysis

Although aiming to be the national referral center for oncology, MRCCC will still target most of its patients from 2 main catchment areas.

Catchment area 1: Areas within 20 kilometers away from the hospital

The areas within 20 kilometers away from the hospital include all of the 5 major cities in the Special Capital Territory of Jakarta. The total population of Jakarta is 9,146,181 in 2008, with an estimated 16,463 people living with various types of cancer.

The following table shows the total population and the estimated number of cancer patients within the city of Jakarta from 2006 to 2008.

Table 3.3: Total Population and the Estimated Number of Cancer Patients within Jakarta (2006 to 2008)

Year	Population	Estimated Number of Cancer Patients
2006	8,963,010	16,133
2007	9,057,993	16,304
2008	9,146,181	16,463

Source: Department of Health, Ministry of Health Indonesia& Jakarta Health Authority, Frost & Sullivan

By end of 2009, around half of the total number of community clinics around Jakarta are equipped with breast cancer and cervical cancer detection facilities. At the same time, 14,000 general practitioner clinics around the city may serve as the first level detection and screening centers for cancer cases. All of these small healthcare institutions, together with 77 general hospitals play an important role in

cancer referrals to specialist hospitals. With high number of primary care centers and general hospitals, more cancer patients in Jakarta is expected to seek medical care from professionals before it is too late.

The two oncology specialist centers, Dharmais Cancer Center and RSCM, may only serve up to 7,500 cancer patients annually. However, despite having the capacity to serve only 45 percent of the total cancer patients in the city, these two national referral centers for oncology cases, must also receive patients from other parts of the country.

Catchment area 2: Depok, Tangerang and Bekasi

Depok, Tangerang and Bekasi are the three biggest suburbs surrounding Jakarta. The total population and the estimated number of cancer patients in living in these three areas are listed in table 3.3.

Table 3.4: Total Population and the Estimated Number of Cancer Patients in Depok, Tangerang and Bekasi (2008)

Suburbs	Population	Estimated Number of Cancer Patients
Depok	1,412,772	2,543
Tangerang	1,783,881	3,211
Bekasi	2 076 146	3,737

Source: Department of Statistics, Indonesia, Tangerang Admistrative Office, Depok Administrative Office, Frost & Sullivan

There are no cancer specialist hospitals located in these suburbs. The nearest cancer center catering to these areas are Dharmais Cancer Center and RSCM, both of which are located in Jakarta.

107 community clinics, 57 hospitals and approximately more than 2,000 general practitioners in these three suburbs may act as the screening and referring institutions to the specialist centers like MRCCC.

Supply Side Analysis

Table 3.5: SWOT analysis of MRCCC

Strengths ▪ Strong Siloam Hospitals Branding ▪ Siloam's flagship hospital, ie Siloam Hospitals Lippo Village is a JCI-accredited hospital ▪ Medical staff at MRCCC will be sub-specialists / specialist doctors with excellent track record ▪ Ability to leverage on the strengths and network of Siloam Hospital's parent company, ie PT Lippo Karawaci Tbk. ▪ MRCCC having the first mover advantage in private cancer care in Indonesia	Weakness ▪ Access to MRCCC during peak hours may be hampered due to traffic congestion in central Jakarta
Opportunity ▪ High cancer incidence in Indonesia ▪ Huge unmet oncology needs in the country ▪ Possibility of receiving cancer patients from countries around the region through cancer center collaborations, self-referral or from medical concierge recommendations	Threat ▪ Strict regulation on hospital operations ▪ Possibility of competition from other private hospital players

The hospital will provide advanced oncology therapy at a fraction of the price in the neighboring countries. It will also provide access to the treatments through 2 different types of pricing, catering to both the affluent and the non-affluent population in Indonesia.

Unlike any other oncology department, or cancer hospital in the country, MRCCC's operation is backed by a parent company that is committed to equipping each of its many hospitals only with the most advanced technology available. It is also the only oncology care provider in Indonesia with long term partnerships with a few leading oncology devices manufacturers.

In the midst of shortage of human resources in oncology services in the country, oncology departments across Indonesia need to source and factor in the availability of personnel prior to any expansion activity. On the other hand, MRCCC will have direct access to trained professionals through its training

programs in medical oncology, surgical oncology, radiotherapy and cancer imaging and through its collaborations with other healthcare and education institutions.

MRCCC will pursue JCI accreditation to allow itself to be the 3rd in Asia, and the 13th JCI recognized cancer center outside United States. The accreditation will automatically sets MRCCC apart from all the other cancer centers in the region, and raise its standard as a model for world-class and premier cancer center in South East Asia.

Current Development Stage

In early July 2010, the major construction activities were completed, except for minor cosmetic re-touch at the external reception and the interiors. Almost half of the major equipments like 3T MRI, CT scanner, CT simulator, SPECT-CT, Digital X-ray, Fluoroscopy and Angiography machine were installed. During Frost & Sullivan's visit to the hospital site, it is in the process of installing a few more equipments like cyclotron, PET-CT and the linear accelerator. Installing each of these equipments will take 2 weeks.

In August, the equipment vendors met with the radiation therapy oncologists, the radiologists, biomedical engineers and the technologists for a series equipment familiarization and training sessions.

Simultaneously, the fixtures for the consultation rooms, wards, treatment rooms and the common area will be installed starting August. Retail area operators are scheduled to move in within the same month. The final beautification of the interiors and inspection will take place around the middle of September 2010.

If all activities are progressing as planned, MRCCC will be completed and ready for its grand opening ceremony on October 20th, 2010.

Future Outlook

Upon completion, MRCCC will prepare for JCI accreditation. In the same year, it will build its capacity by increasing its in-patient beds from 220 beds in 2011, to 375 beds by 2012. Together with the increase of capacity, the hospital will introduce more services to its patients. Among the programs planned for the future include bone marrow transplant for leukemia patients. MRCCC will also provide kidney and liver transplant services.

Plans for 2011 to 2014 include installing the second linear accelerator, CT scanner and MRI machine depending on the utilization volume. Remote patient monitoring will be available in the first half of 2011. In the second quarter of the same year, MRCCC will roll out oncology research and education programs for nurses, medical technology and specialist doctors, especially in the subject of nuclear medicine.

Through partnerships with multiple technology vendors, the hospital will continue to employ the latest and most sophisticated equipments and to incorporate the most advanced techniques into its range of oncology services. With the success of a pilot remote patient monitoring project in Siloam Hospitals Lippo Village, MRCCC plans to employ the same technology for its patients. The cancer center is also planning to adopt Wimax in the future.

Siloam Hospitals Lippo Cikarang (SHLC)

3.2.1 Background

Siloam Hospitals Lippo Cikarang caters to the growing residential and industrial area in East Jakarta. The hospital located near Jakarta-Cikampek toll road has 75 beds, 8 of which are in ICU and A&E area. The hospital is currently served by a team of 61 specialist doctors, 12 general practitioners, 110 nurses and 63 allied healthcare professionals.

SHLC is entirely connected with Hospital Information Systems (HIS), which will be replaced with a new systems by WIPRO by end of 2010. The new system supports all of SHLC clinical and administration functions, and provide real-time management of processes like bed booking, doctor's appointment scheduling to laboratory or radiology test ordering. It also hosts electronic patient medical records, case sheets, test results and doctor prescriptions in the hospital server.

The hospital is committed to provide quality medical care to its patients, and to continuously improve its services. In 2008, the hospital received ISO9001:2000 certification from the United Registrar of Systems (USR).

3.2.2 Key Focus Area of Diseases

The three centers of excellences at SHLC are Center of Excellence in Urology, Center of Excellence in Internal Medicine and Center of Excellence in Trauma. Other focus areas are obstetrics, neurology and digestive health with the incorporation of laparoscopic surgery in the lines of treatments.

Urology Center at SHLC was conceived in response to growing needs of patients with kidney stones in the area of Cikarang and Bekasi. The center is equipped with Extracorporeal Shock Wave Lithotripsy or ESWL machines, a non-surgical and painless procedure to break kidney stones using shock waves. Other services available at the center are prostate enlargement, sexual dysfunction, infertility, incontinence, pediatric urology and andro-urology. New addition to the center is a Uroflowmetry Laboratory.

Trauma center at SHLC is built on its capability in managing occupational emergency and road emergency cases.

3.2.3 Service Profile

Key services found at SHLC includes Executive Medical Check Up facilities catering to corporate clients in Cikarang and Bekasi Area, a Micro-biology Laboratory and Maternity & Labor suite.

The Executive medical check-up area is equipped with a multi-slice CT scanner, and designed to provide seamless registration process and comfort for the patients.

The hospital has improved its accident & emergency services by combining Pediatric / Neonatal Intensive Care Unit (PICU/NICU), Adult Intensive Care Unit (ICU) and A&E department in the same area for improved patient safety and increasing service efficiency. Total beds allocated for these units are 8, and is big enough to cater for any the future expansion plan for the hospital.

Apart from its own ambulances, emergency evacuation service at SHLC is also provided by Siloam Medivac. A helipad for the use of the hospital is located 500 meters away from the hospital building.

3.2.4 SHLC Accident & Emergency Department

Workforce

Like any other Siloam Hospitals branches, SHLC is dedicating its time and money for all of their A&E staff to undergo specialized emergency training. The hospital, together with all the other Siloam Hospitals branches plan to have the first formal specialized medical training for resident medical officers working in their A&E and ICU departments.

Training is one of the core activities for staff development and competency building at Siloam Hospitals, and staff are given 4 to 5 months e-learning program to prepare A&E staff (EMT training). All staff at

SHLC A&E are also given access to Siloam Continuous Medical Education (CME) program in topics like handling patients with critical conditions, hemodynamics and airway management. The program used a curriculum based on US standards and partly delivered by a specialist brought in from Johns Hopkins University.

Key opinion leaders at SHLC include Dr. Indra SM Manullang (Internal Medicine Specialist), Dr. Okto Dewantoro (Internal Medicine Specialist), Dr Naomi Esthernita Dewanto (Pediatric Specialist) and Dr Sugianto Wiriadinata (Pediatric Specialist).

Technology

Major diagnostic equipments found at SHLC are Multi-slice Computed Tomography Scanner, 4 Ultrasonography, Electrocardiography (ECG) machine, Stress ECG, Echocardiography, Electroencephalography (EEG) and conventional x-ray machine.

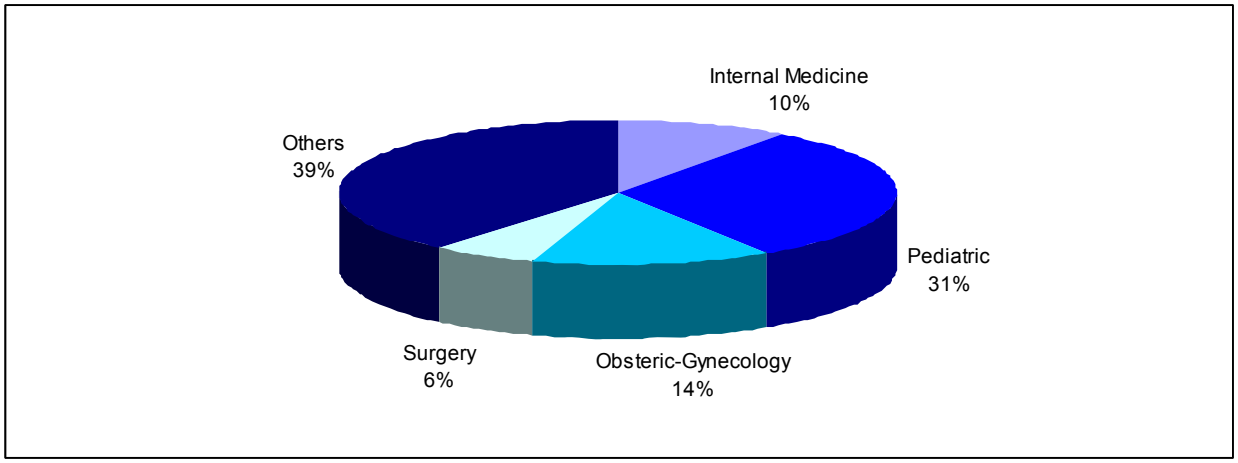
SHLC clinical units like the A&E department, ICU, PICU/NICU and operating theaters are backed by 24-hours emergency power generators.

Capacity Assessment

In 2009, SHLC received 6,300 patients requiring emergency care. 30 percent or 320 patients at the Accident & Emergency department are admitted to receive in-patients treatments. 15 percent of all cases treated at the Accident & Emergency department were classified as trauma cases.

The following are the breakdowns of case-mix at the outpatient department in SHLC in 2009

Figure 3.1: Case-mix at outpatient department in SHLC, 2009



Source: Siloam Hospitals

Affiliations and Partnerships

At present, SHLC management is in the process of forming a partnership with outside parties for its Accident & Emergency unit. Details of the discussion will be announced by March 2011.

Demand Side Analysis

SHLC targets 3 catchment areas;

1. Primary : Lippo Cikarang, Jakarta-Cikampek Toll Road and Cikarang
2. Secondary : Bekasi
3. Tertiary : Karawang

Lippo Cikarang

Lippo Cikarang is a township located 35 kilometers east of Central Jakarta. The fully functional township has a full array of urban facilities integrating residential, commercial, industrial, educational, healthcare, social and recreation amenities. The combined residential and industrial area of Lippo Cikarang spans across 2,940 hectares.

SHLC is located within Lippo Cikarang, giving it access to 9,000 households and more than 30,000 people. As of December 2009, there are 632 international manufacturing facilities providing jobs for

approximately 250,000 workers during the day. The developer of Lippo Cikarang is expecting the population to grow to 1 million people by 2020.

Nearly all of Lippo Cikarang residents are categorized into the middle to upper middle class population.

Jakarta-Cikampek Toll Road

Jakarta-Cikampek Toll Road is a road connecting Jakarta and the third largest city in Indonesia, Bandung via Cipularang Toll Road. The road stretches over 83 kilometers and passes through Bekasi, Cikarang and Cikampek. The toll road which is managed by PT Jasa Marga has traffic volume at 342,670 vehicles per day or more than 121 million vehicles in 2009.

The following table shows daily and annual traffic volume at Jakarta-Cikampek toll road between 2007 to 2009

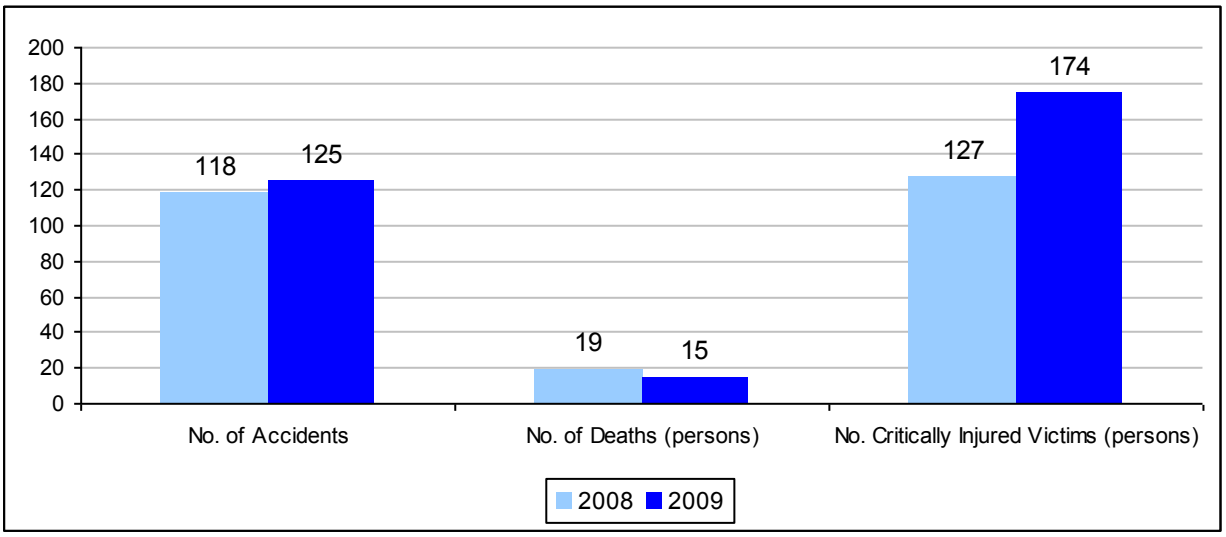
Table 3.6: Daily and Annual Traffic Volume at Jakarta-Cikampek Toll Road (2007 to 2009)

	2007	2008	2009
Daily Traffic Volume	330,711	331,317	342,670
Annual Traffic Volume	117,733,116	117,948,852	121,990,520

Source: PT Jasa Marga

In 2009, 125 accidents happened along the toll road and killing 15 people. 174 victims were critically injured and were referred to the nearest accident & emergency departments. The following figure shows the number of accidents, deaths and critically injured victim in the years 2008 and 2009.

Figure 3.2: Number of Accidents, Deaths and Critically Injured Victim at Jakarta-Cikampek Toll Road (2008 and 2009)



Source: Jakarta Police Department, 2008 and 2009

SHLC is located only 3.5 kilometers away from the Cikarang exit on Jakarta-Cikampek Toll Road.

Cikarang

Cikarang is the capital of Bekasi Regency, which has several large residential and industrial townships like Lippo Cikarang, Kota Deltamas, Cikarang Baru and Kota, MM2100 and Jababeka. Today, the population of Cikarang is estimated at 1.8 milion people.

The three main townships are home to approximately 1 million people. The following table shows the demographic information of Kota Deltamas and Kota Jababeka.

Table 3.7: Demographic Information of Two of the Biggest Townships in Cikarang.

Townships	Demographic Information
Kota Deltamas	- Size : 3,000 hectares - No. of Households : 4,000 - Population : 12,000 people - Other types of establishments : ▪ Bekasi Administrative offices
Kota Jababeka	- Size : 5,600 hectares - No. of Households : 30,000 - Population : 958,000 people (600,000 workers) - No. of Industries : 1,500 - Other types of establishments : ▪ 24 malls ▪ 8 hotels / apartments ▪ 36 educational institutions

Source: PT JababekaTbk, Published Articles

A total of 389 road accidents happened in Cikarang in 2009, causing 49 deaths and 554 victims to be hospitalized due to critical injuries.

SHLC is located 10 kilometers away from Kota Jababeka, and is accessible via Jl. Raya Cibarusah-Cikarang. On the other hand, the hospital is only 15 kilometers away from Kota Deltamas and is reachable via Jakarta-Cikampek Toll Road.

Bekasi

The suburb of Bekasi is the main access to Jakarta from other provinces in West and Central Java. The two main access roads to the Indonesian capital via Bekasi are the Jakarta-Cikampek Toll Road, and the Jakarta Outer Ring Road.

The economy in this area is driven largely by industrial activities followed by others like commence and agriculture. An estimated 4,000 large scale industries are operating in this area.

Several townships have been developed in Bekasi including Harapan Indah, Kemang Pratama, Taman Galaxy, and Grand Wisata. The estimated population of Bekasi is 2,076,146 in 2008, where 50 percent of the total population are of lower income.

At present, the only access to SHLC is via Jakarta-Cikampek Toll Road.

Supply Side Analysis

Table 3.8 SWOT analysis of SHLC

Strengths ▪ Siloam Hospitals brand name is a trusted brand in quality healthcare services ▪ Ability to leverage on the strengths of the parent company's other business and networks ▪ Strong referral networks and increasing number patients from medical check-up service ▪ SHLC will be the hospital with the most advanced diagnostic equipments in the stretch between Bekasi and Bandung	Weakness ▪ Lack of awareness among the public on the hospital, and its range of services
Opportunity ▪ New road will provide direct access from Bekasi to SHLC Lippo Cikarang, bypassing the traffic between the toll road exit to the hospital ▪ More development in Lippo Cikarang will increase the number of residents in the township	Threat ▪ Possibility of competition from other private hospital players

All of Siloam Hospitals facilities are connected through one emergency call center, 500-911 that will instruct ambulance from the nearest Siloam Hospitals to pick up the patients. This emergency call center will provide emergency advices to the caller and arranges for emergency or trauma care prior to arrival at the hospital. Seen as among the few providers that offer such emergency care in Jakarta, the number of calls received by the center has been steadily increasing since it was launched in 2009. Siloam Hospitals are committed to improve its response rate to only 3 minutes, compared to 1 hour at other healthcare providers.

Prior to arrival at the hospital, patients are pre-classified into groups requiring emergency care or non-emergency. The system allows the department to focus only on critically ill patients and freeing up their space and resource capacity for other emergency cases. Non-emergency patients will be brought directly to outpatient department for treatments.

SHLC A&E is connected to its ICU and PICU unit, and served by 2 operating theatres next door. Radiology is located within the same floor providing easy access to equipments and maximizing patients' safety.

SHLC A&E as well as the other emergency departments within Siloam Hospitals group are operating based on several standard clinical pathways. Each of these pathways is tailored to treat different emergency conditions to ensure high quality care is given to all of its patients.

At SHLC, the A&E department is supported by an in-house blood bank, allowing emergency patients requiring blood transfusion to wait only for the preparation that lasts less than an hour. Other hospitals in Cikarang and Bekasi typically would source for blood from the Indonesian Red Cross office in Kramat or Bekasi, wasting up to 5 valuable hours being trapped in the traffic.

Performance

The A&E department has been receiving a lot of emergency & trauma patients, primarily from the surrounding industrial area. Through their medical check-up facilities, the hospital has been able to raise themselves to be the preferred healthcare providers for the employers within the area.

The department had also been receiving road accident victims from the Jakarta-Cikampek toll road and from within Bekasi, Cikarang and Karawang.

Future Outlook

Future plans for the hospital would include a renovation to improve the building layout, equipping new a dedicated VIP floor, and to offer 2 clinics catering solely to Japanese and Korean patients. The reception area of the hospital will be renovated to reflect more welcoming and professional appearance. The current restaurant located at the reception will be moved to the back of the building to give extra space for the pharmacy.

The hospital's bed capacity of 75 is able to cater to the additional number of patients that will be admitted once the new and improved road access from Bekasi direct to Lippo Cikarang is completed.

Similarly, the hospital will add 2 more outpatient clinics by end of 2010, A 24-hour GP service will be available on site by October 2010.

With the hope of becoming the best emergency & trauma center in the East of Jakarta, SHLC will be equipping its current ambulance with international class facilities, provide EMT training for its nurses, and continuous medical education for the resident medical officers.

The current hospital information system will be replaced with WIPRO HIS in the first quarter of 2011, to streamline the service with other hospitals within Siloam Hospitals group. Major equipments like the current 16-slice CT scanner will be replaced by a 64-slice CT scanner, which will be able to provide better image resolution for diagnostic purposes. The hospital will also add an MRI, a panoramic x-ray and endoscopy machine. The MRI will be the first of such equipment to be available within the area from Bekasi to Cikampek.

SHLC plans to start applying for the coveted JCI accreditation by the end of 2011.

4 Strategic Recommendations for MRCCC and SHLC

4.1 Strategic Recommendation for MRCCC

Competitive Landscape Assessment

With increasing cancer incidence in the city and around the country, there are already more demand for oncology care than services available. Hospitals and comprehensive oncology care units around the city are already running at maximum capacity. However, the small number of cancer hospitals and their non-profit nature keeps competition at the minimum. Common objectives allow collaborative relationships to form between these providers. A few private players recently tapped into oncology care, almost all focusing only on diagnostic radiology and surgical oncology services. As with the public hospitals, competition among these players is low.

Despite government support for private sector to invest in local specialist hospital industry, oncology care still posseses extremely high barriers of entry. Highly specialized medical professionals are limited, and the possibility of contracting foreign professionals is not likely due to stringent local laws. Total investment cost for new hospital is high. Key technologies and equipments used in oncology care are expensive; each costs more than USD 2 mil to acquire and around USD 400,000 per year to maintain. The management of cancer hospital is complex and issues like public acceptance and trust are crucial for the business.

Complements to oncology care include the use of Traditional and Complementary Medicine (TCM) as well as supplements for preventive measures and for post treatment care. No real substitute for the oncology diagnostic and therapeutic is available in the country as yet. Alternative sites to Indonesian cancer services are found in cancer departments located in neighbouring countries. Switching to overseas cancer center is common practices among the affluent in Indonesia, while the underprivileged remains in queue for treatments at local facilities.

Limited number of suppliers increases their bargaining power of these cancer hospitals. Oncology specialists, nuclear medicine specialists, oncology nurses and allied healthcare professionals are currently working for various number of healthcare providers and are utilized beyond their capacity. Similarly, there is only a small number of specialized oncology care equipment and niche drug manufacturers for use in the current cancer treatment protocol.

The lack of balance between the demand and the supply of oncology care services resulted in patients having relatively low control over the providers and their services.

Table 4.1: Brief Profiles of MRCCC and Other Oncology Care Providers in Jakarta

	MRCCC	**RSCM**	**RSKD**	**RS Gading Pluit**	**RS Gatot Subroto**	**RS Pertamina**
Distance from MRCCC	-	12km	10km	17km	8km	4km
Primary Catchment Areas	Jakarta Indonesia	Jakarta Indonesia	Jakarta Indonesia	Jakarta Indonesia	Jakarta Indonesia	Jakarta Indonesia
Est. No. of oncology patients (persons)	3,000	5,500	5,800	950	2,800	2,200
Types of Service						
Diagnostic						
Laboratory	√	√	√	√	√	√
Radiology	√	√	√	√	√	√
Therapeutics						
Surgical	√	√	√	√	√	√
Chemotherapy	√	√	√	√	√	√
Radiotherapy	√	√	√		√	√
BMT Transplant		√	√			
Other Transplant						
Others						
Wellness / TCM	√					
Palliative Care		√	√			
Modalities						
Diagnostic						
X-ray	√	√	√	√	√	√
USG	√	√	√	√	√	√
Mammograpy	√	√	√	√	√	√
CT-Scanner	64 slice	64-slice	32-slice	64-slice	64-slice	64-slice
MRI	3T	3T	1.5T	1.5T	1.5T	1.5T
Angiography	√	√	√	√	√	√
Nuclear Medicine						
SPECT-CT	√	√				
PET-CT	√			√		
Cyclotron	√			√		
Linear Accelerator	1**	2	2		2	1

Treatment Planning	IGRT	IMRT	3D-CT	3D-CT	3D-CT
Branchytherapy	√	√	√	√	√

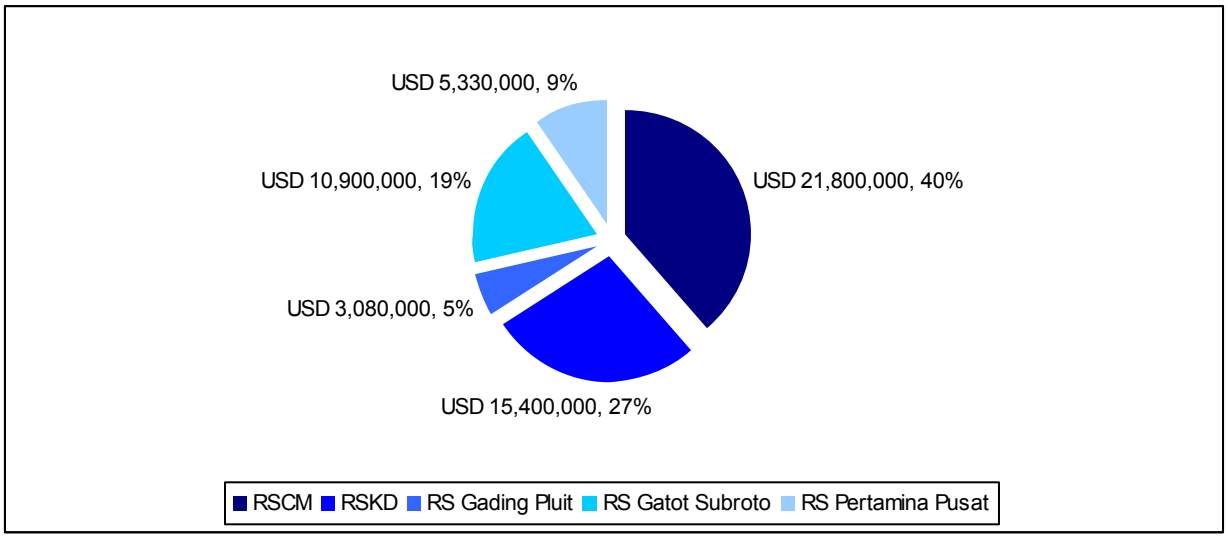
**Siloam Hospitals estimates*

***The second linear accelerator will be installed at MRCCC depending on utilization volume*

Sources: Hospital Websites and official publications, published articles and Frost & Sullivan

Waiting time is long and patients' comfort is often sacrificed for keeping cost low and to provide treatments for more people.

Figure 4.1: Oncology Hospital and Department Revenues (2009) and Potential Growth for 2010 to 2013



CAGR (2010 to 2013)	
MRCCC	23.42%
RSCM	5.35%
RSKD	1.15%
RS Gading Pluit	21.40%
RS Gatot Subroto	3.50%
RS Pertamina Pusat	6.40%

Source: Siloam Hospitals, Published Articles, Frost & Sullivan

1 dedicated cancer hospital, Dharmais Cancer Center and hospital-based oncology departments at RSCM and RS Gatot Subroto are currently running at maximum capacity The non-profit nature of these hospitals require them to charge only at the minimum, just enough to cover the cost of treatments. Money collected from 30 percent of the patients who pay for VIP care is used to subsidize the cost of

treatments for the underprivileged. Future revenue growth for these hospitals would depend a lot on additional capacity from new equipments and the increase in fees for services.

Aside from the type of cancer center available in the country, there lies a huge potential for newcomers to reap the profits from unfulfilled demands. Premier cancer care is previously not available locally and is only made available recently by one public provider. Patients at VIP class could now enjoy 5-star facilities and services for inpatient care.

Most of these players are looking to purchase new equipments in place of the existing technology they have installed at the hospitals. Others will work on refurbishing their buildings and its other facilities to provide better environment for their patients.

Positioning of MRCCC as National Hospital

National hospitals provide specialist and subspecialist care covering promotive, preventive, curative and rehabilitation services to its patients. The hospital is a comprehensive and one-stop center for specific types of care and receives referral cases from every corner of the country. The facility is usually equipped with the most advanced equipments and boasts enough capacity to provide high quality care for the patients. A national hospital is also involved beyond providing patient care, but also as a specialist education, training and research hub.

MRCCC is a private comprehensive cancer center in Indonesia, equipped with the most advanced technology and housing the best names in regional oncology care. Benefits of MRCCC to the Indonesian society mimic those of the other existing national hospitals, including:

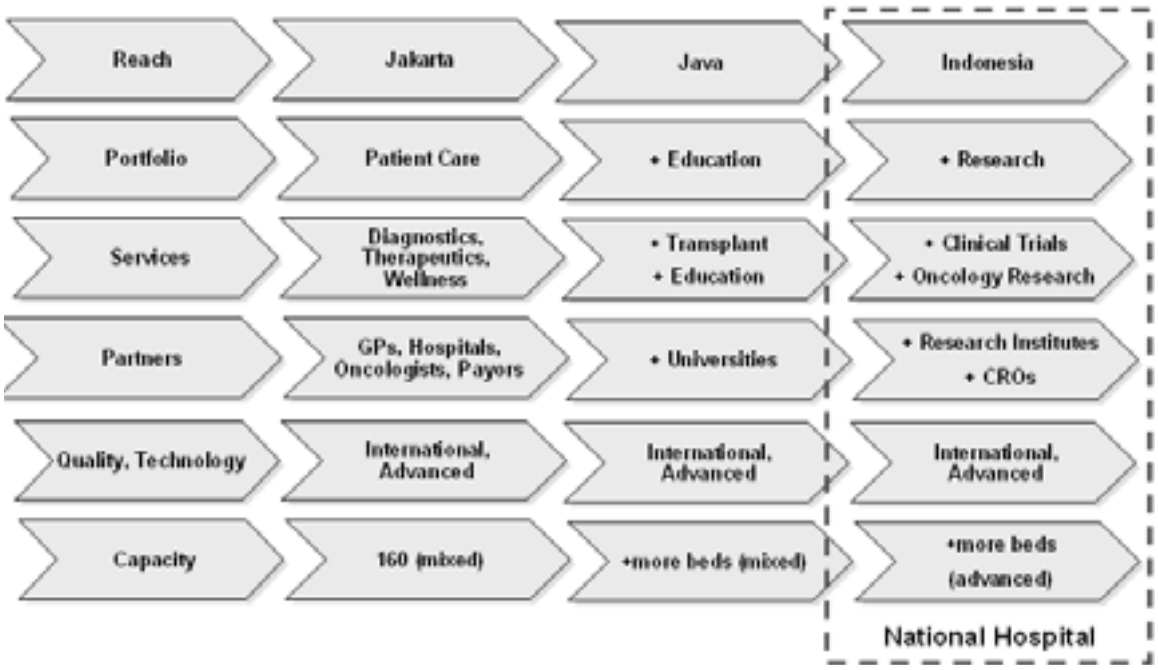
1. Access to the latest and the most comprehensive oncology care technologies, techniques and protocols
2. Access to the service of the best names in the region for oncology care
3. World's best practices and quality of care in oncology
4. Access to international network of oncology specialists through MRCCC collaborations
5. Care by a team of highly qualified and specialized nurses, and other allied health sciences specialists
6. Services for all levels of population

7. The comfort of going through all phases of oncology care under one roof and closer to home

At present MRCCC is competing in a green turf, previously not served by any oncology hospitals in Jakarta and Indonesia. At inception, MRCCC will compete with overseas cancer center for affluent Indonesian patients until any newcomer set up operations in the city center. Middle to lower income population will remain the focus of existing hospitals.

The following figure indicates the steps necessary for MRCCC to become the National Hospital for Oncology.

Figure 4.2: MRCCC towards becoming a National Hospital for Oncology



Hospital capacity is based on mixed-class patient beds, indicated in the table as mixed

Sources: Siloam Hospitals, Frost & Sullivan

Future Outlook – Tapping Into Oncology Patient Flow

Apart from inviting the oncologists to familiarize themselves with MRCCC, other channels to increase the inwards traffic to the hospital include the general practitioners (GPs), primarily those practicing in the city of Jakarta. These groups of physicians could play a central role for first line detection of cancer and to provide MRCCC with access to the market. The huge patient base from the GPs makes them one of the biggest referring units to MRCCC.

The next group to target would be the local hospital management teams, especially those from towns and cities outside Jakarta. MRCCC may benefit from strategic relationship with these hospitals by receiving oncology referrals from them, and outsourcing step-down care back to each of the partners' facilities.

Other ways to increase the visibility of MRCCC and create awareness of the range of service and specialties available within the hospital include onsite educational and training programs for various types of healthcare professionals, on-site tour, public awareness campaigns, and participation in cancer and healthcare services-related events like conferences and cancer relay.

To tap onto international cancer patient flow, MRCCC will have to do various types of public relations moves including partnering with various medical tourism concierges and to appear on as many medical tourism-related publications and at conventions. Invitation for MRCCC tour to oncology societies from around the region is necessary to introduce the types of services available at the hospital. Collaborations between providers as well as down to specialists' level are crucial for channeling international cancer patients to Jakarta.

Key Success Factors

Being a new cancer hospital, visibility is the utmost important key to the success of the business. MRCCC should be visible and recognized not only among local and international oncology societies, but also to general healthcare fraternities and the public. Creating awareness and buzz among these population is crucial especially in the first few years of operations. MRCCC must also continuously build and maintain relationships with all of its referring organizations, be it the GPs, hospitals, medical tourism concierges to mass media.

Changing people's perceptions on the quality of care available at MRCCC is the next step to gaining market acceptance in Indonesia. Local and international population alike have been fed with stereotypes that the quality of care in Indonesia is worse compared to what their neighbors could offer. Obtaining world class accreditation, like those from JCI will help to change these thoughts and may help to reverse the affluent cancer patient flow back into the country.

The next key success factor for MRCCC lies in its ability to secure the right specialists and sub-specialists doctors to enhance the superiority of its service and to ensure sustainability of its business.

The fifth key success factor is the availability of funds to finance the hospital's future investments in technology and other resources.

4.2 Strategic Recommendation for SHLC

Competitive Landscape Assessment

The demand for medical care in Bekasi Regency is largely driven by population growth and demographics. Poor public healthcare infrastructures and services redirected most of the population to private hospitals for medical care. Inpatient and outpatient visits at these hospitals, however, are largely determined by healthcare providers' relationship with insurance companies, corporate clients and third party administrators.

Private hospitals in Bekasi Regency are intensely battling each other to be the provider of choice among the population. Most of these hospitals have between 30 to 40 percent excess capacity and targeting primarily the middle to upper income population in the regency. Only a few private hospitals are targeting lower to middle income population. Hospitals, primarily those catering to the affluent population, differentiate themselves from the others by building on their strength in specific area of care and equipping their facilities with advanced equipments to prevent patients from switching to other healthcare providers. Several private hospitals are relying on their brand names to gain competitive advantage over the rest of the providers.

While Bekasi Administrative Office is supporting the idea for more specialized hospital to be built in the regency, the other aspects of setting up hospital are not too favorable to potential operators. Healthcare is a capital intensive industry where operators need to have enough funds to acquire both the technologies and specialized human resources prior to opening a hospital. The operators must also have the capabilities and the experience to manage the business. Patient loyalty and brand preference, among the other important aspect for the hospital business continuity, is costly and may take years to establish.

Only a few of the inpatient care and procedures could be substituted by outpatient clinics, private practice or even home care. Advancement in technology gave birth to innovations of new techniques and instruments and thus making medical care away from hospital possible. The large part of the inpatient care, especially those depending on the constant specialist monitoring or the use of advanced and often expensive equipments, are still done within the hospital's premises.

Medical professionals have the upper hand over the hospitals in Bekasi. They often come with their own group of patients and will dictate the type of specialty and the level of care each hospital may provide for their patients. Due to the limited number of specialist doctors and nurses in the country, as well as the location of hospitals, finding the appropriate mix and the required number of medical staff is challenging for hospital operators in Bekasi Regency. Hospital equipments, medical devices manufacturers and

pharmaceutical item suppliers have moderate power over these hospitals. To reduce the influence of these suppliers, some hospitals resort to using economies of scale by buying supplies centrally in big bulk for themselves and each of their sister hospitals.

Depending on hospitals, patient or payers includes the patient themselves, corporations, third party administrators and insurance providers. While the actual patient may switch to other providers for reasons such as distance, type of services or their loyalty, the remaining clients are cost – conscious. These patients will look at cost as one of the main reasons for switching to other providers or sticking to the current ones. They generally have strong negotiation power over the hospitals, especially when managed care contracts are prepared.

5 hospitals in Bekasi Regency have been identified as the main competitors to Siloam Hospitals Lippo Cikarang. All of these hospitals are Type B and Type C private healthcare institutions with bed capacity of more than 50, located between 10 to 30 km away from Lippo Cikarang and targeting the same population served by SHLC. Type B and Type C are secondary hospitals, each differentiated by size and target service configurations. Type C hospitals offer specialty services in 4 major areas; internal medicine, surgery, obstetrics and gynecology and pediatric, while Type B hospital offer more specialty services than the former.

Table 4.2 lists SHLC and 5 other competitors and brief profile of their operations.

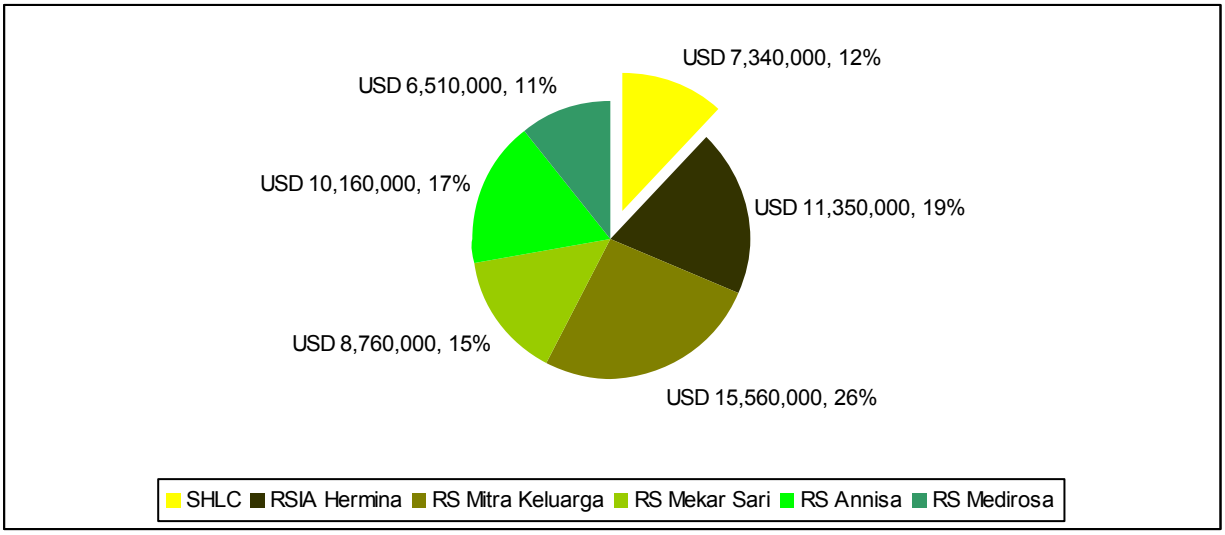
Table 4.2: Brief profiles of SHLC and 5 other hospital operators in Bekasi

	SHLC	RSIA Hermina	RS Mitra Keluarga	RS Mekar Sari	RS Annisa	RS Medirosa
Distance from SHLC	-	24km	24km	28km	10km	8km
Primary Catchment Areas	Cikarang Jababeka	Bekasi	Bekasi	Bekasi	Jababeka Cikarang	Jababeka Cikarang
Number of Doctors	133	60	67	50	77	40
Number of Nurses	94	160	180	71	187	101
Number of Beds	75	138	165	120	132	86
Beds Occupancy Rate (%)	60.8	66.9	88.9	66.8	66.0	75.1
Est. No. of inpatients (persons)	6,293	9,965	13,214	8,238	11,513	4,414
Types of Beds						
VVIP	√	√	√			
VIP	√	√	√	√	√	√
Class 1	√	√	√	√	√	√
Class 2	√	√	√	√	√	√
Class 3	√	√	√	√	√	√
ICU	√	√	√	√	√	√
ICCU			√			
NICU	√	√	√		soon	
PICU	√					
Key Specialties	Urology Internal Medicine Occupational Medicine	Ob-gyn Pediatric	Ob-gyn Pediatric Internal Medicine	Ob-gyn Pediatric Surgery	Diabetes care Ob-gyn Urology	Internal Medicine Surgery A&E
Modalities						
X-ray	√	√	√	√	√	√
USG	√	√	√	√	√	√
EEG	√	√	√			
ECG	√		√	√	√	√
ESWL	√					
CT-Scanner	√		√		√	
MRI	soon		√			
Mammography			√			

Sources: West Java in Numbers (2007, 2008), Hospital Websites and official publications, published articles and Frost & Sullivan

Each of these 6 hospitals targets the middle to upper middle class population in Bekasi. These hospitals are building their expertise in specific areas like obstetrics, emergency and trauma, diabetes care and urology as well as equipping the facilities with advanced equipments to differentiate themselves from their competitors.

Figure 4.3: Hospitals Revenues (2009) and Potential Growth for 2010 to 2013



CAGR (2010 to 2013)	
SHLC	15.80%
RSIA Hermina	9.50%
RS Mitra Keluarga	2%
RS Mekar Sari	10.10%
RS Annisa	8.50%
RS Medirosa	3.40%

Source: Siloam Hospitals, West Java in Numbers (2007, 2008), Published Articles, Frost & Sullivan

In 2009, only 3 of these 5 hospitals made over the USD 10 million mark, while the others earn between USD 6.51 to USD 8.76 million. Growth potential are high for RSIA Hermina, RS Mekar Sari and RS Annisa, each with extra beds capacities in 2009 and with plans to provide additional services to capture more patients in the future. These hospitals are expected to continue with their marketing campaign to increase hospital visibility. RS Mitra Keluarga which is already running at more than 80 percent occupancy may need to conduct more outpatient procedures or to build on complex and most sought after procedures to increase its revenues. Projects to improve building environment and to create more

space and capacity at SHLC will result in better outcomes for patients, which will translate additional growth in revenue as seen in figure 4.3.

Positioning of SHLC as a Regional Hospital

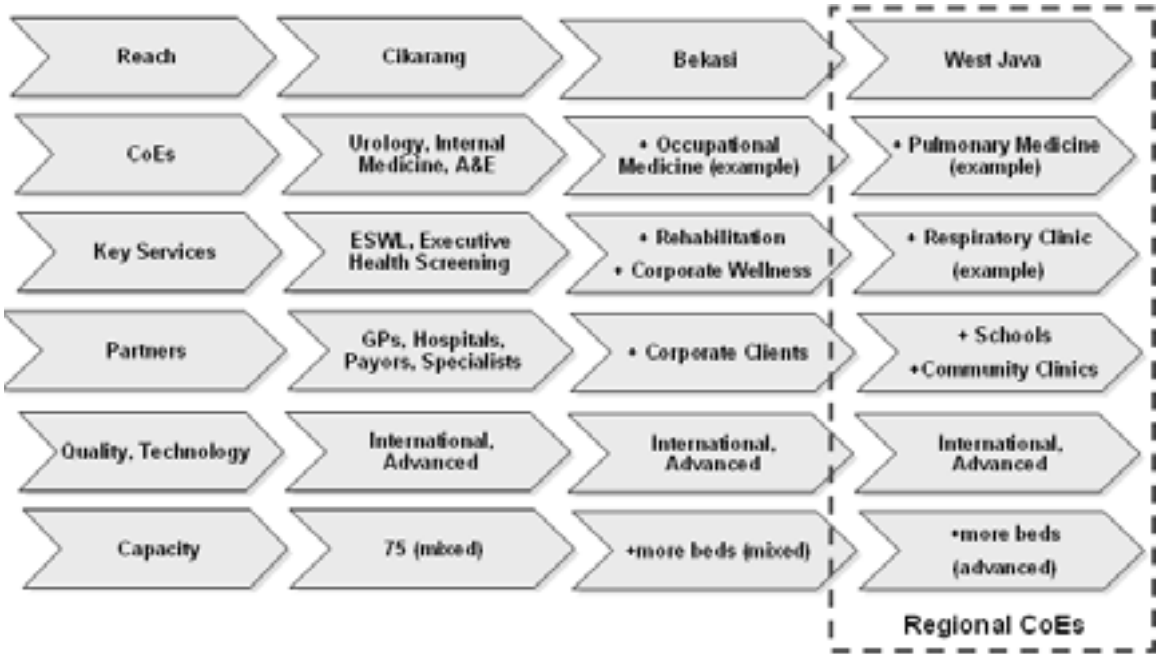
Regional hospital provides secondary or tertiary care for selected disciplines to patients referred by primary care and private hospitals within the province. These hospitals are mostly owned by local district or provincial governments and provide social functions aside from its specialty medical care. Hospitals in this category are heavily utilized by poor and lower income population due to its affordable fees.

Private hospitals aiming to become regional hospitals will have to change its business model including their fee structure to fit into the objectives of such public institutions. SHLC, a profit oriented hospital, should instead focus on being a premier specialist hospital and position each of its Center of Excellences (CoEs) as the referral unit for other hospitals in the region.

Bekasi District Hospital have recently been nominated as the Bekasi area referral hospitals, which will see it expanding its specialist services, capacity as well as improving their facilities in the next 12 months. Other hospitals, which currently are concentrating only on general medical care and limited specialist care (obstetrics & gynecology and pediatrics), have not indicated any signs that they will pursue the same direction as SHLC in the near future.

The following figure list the necessary steps for SHLC for becoming the referral hospitals for specific types of care while fulfilling its objective as one of Siloam Hospitals' profit-making entities.

Figure 4.4: SHLC Towards Becoming Specialty-based Regional Referral Center



**** Hospital capacity is based on mixed-class patient beds, indicated in the table as mixed***

Source: Siloam Hospitals, Frost & Sullivan

Future Outlook

Apart from urology and internal medicine, there are other areas that could help to increase SHLC's future revenue.

SHLC may also tap into respiratory or pulmonology-related illnesses care, as cases like respiratory infection is highly prevalent in the Cikarang and the whole of Bekasi. An estimated 100,000 cases and high number of deaths occurred per month affecting all age groups in Bekasi. Current care for respiratory illnesses is only provided by 1 district hospital.

Building on its Accident & Emergency care, Occupational Medicine expertise and the countless experience in managing executive health screening services, SHLC should also move into providing comprehensive employee health management or corporate wellness services to its existing patient base. The service will create another stream of revenues for the hospital without the necessity to go beyond SHLC's existing corporate clients in Lippo Cikarang and MNCs in the surrounding areas.

Additionally, the current rehabilitation care may also be marketed separately as a product to the adult and working population in the surrounding Cikarang neighborhood.

These three products resonate well with SHLC internal capabilities, patient base, and the demography of its surrounding area.

Key Success Factors

SHLC's success depends largely in the hospital's ability to secure the right manpower. The hospital needs to overcome problem of limited number of professionals and their unwillingness to work in Cikarang. The Siloam Doctor's Partnership & Development Program (SDPDP) which is widely used within Siloam Hospitals Group will help to bring in more specialists to the hospital.

The next important key to success is to gain and to maintain the trust from the population. Strict quality monitoring, adherence to the standard operating procedures and pursuant of international recognition would help to secure SHLC position as the leader of quality medical care provider in the area.

Becoming the preferred provider for the population served is the next key success factor for SHLC. With many hospitals surrounding the area starting to build their specialty capabilities and pursuing quality medical care, securing a large group of loyal patients would be very important for the hospital's future performance. Loyalty programs, discounts, and words of mouth marketing play central role in making this to happen.

Offering specialized and advanced medical services often comes with huge capital requirement. SHLC should be able to secure enough funds to finance its future investments.

FIRST REIT

FIRST REAL ESTATE INVESTMENT TRUST

(Constituted in the Republic of Singapore
pursuant to a trust deed dated 19 October 2006 (as amended))

MANAGED BY

BOWSPRIT CAPITAL CORPORATION LIMITED

LETTER TO THE INDEPENDENT DIRECTORS AND THE TRUSTEE

&

SUMMARY OF SUPPORTING ANALYSIS

10 November 2010

STIRLING COLEMAN

(Incorporated in the Republic of Singapore)
(Company Registration Number: 200105040N)
www.stirlingcoleman.com

Independent Financial Adviser in respect of the proposed SHLC Acquisition, the Master Leases and the proposed Whitewash Resolution

STIRLING COLEMAN CAPITAL LIMITED

(Company registration no.:200105040N)
4 Shenton Way #07-03
SGX Centre 2
Singapore 068807

10 November 2010

To: The Independent Directors of
Bowsprit Capital Corporation Limited
(as Manager of First Real Estate Investment Trust) and

HSBC Institutional Trust Services (Singapore) Limited
(in its capacity as trustee of First Real Estate Investment Trust) (the "**Trustee**"):

Dear Sirs

INDEPENDENT FINANCIAL ADVISER'S ADVICE IN RESPECT OF:

(1) THE PROPOSED ACQUISITION OF SILOAM HOSPITALS LIPPO CIKARANG;

(2) THE MRCCC MASTER LEASE AND THE SHLC MASTER LEASE;

(COLLECTIVELY THE "IPT TRANSACTIONS"); AND

(3) THE PROPOSED WHITEWASH RESOLUTION

*For the purpose of this letter, capitalised terms not otherwise defined shall have the meaning given to them in the circular dated 10 November 2010 to the Unitholders of First Real Estate Investment Trust (the "**Circular**").*

1. INTRODUCTION

First REIT was established with the principal investment objective of owning and investing in a diversified portfolio of income-producing real estate and/or real estate-related assets in Asia that are primarily used for healthcare and/or healthcare-related purposes including, but not limited to, hospitals, nursing homes, medical clinics, pharmacies, laboratories, diagnostic/imaging facilities and real estate and/or real estate related assets used in connection with healthcare research, education, lifestyle and wellness management, manufacture, distribution or storage of pharmaceuticals, drugs, medicine and other healthcare goods and devices and such other ancillary activities relating to the primary objective, whether wholly or partially owned, and whether directly or indirectly held through the ownership of special purpose vehicles whose primary purpose is to hold or own real estate.

As part of First REIT's growth strategy, the Manager is committed to pursuing acquisition opportunities that will enhance First REIT's asset base and maintain an attractive cash flow and yield profile.

1.1 THE ACQUISITION OF SILOAM HOSPITALS LIPPO CIKARANG ("SHLC")

Siloam Hospitals Lippo Cikarang is located at Jalan Mohammad Husni Thamrin Kav.105, Lippo Cikarang, Bekasi 17550, Indonesia. SHLC, which began operations in 2002 is a six storey hospital (with a basement and a covered roof space) which will accommodate 75 beds by the end of 2010. It is situated in the growing residential and industrial areas of East Jakarta and is committed to providing a broad range of quality general and specialist services, including Accident and Emergency services with Centres of Excellence in Urology, Internal Medicine and Trauma.

The Manager is seeking to acquire SHLC for a purchase consideration of approximately S$35.0 million) (the "**SHLC Purchase Consideration**") from PT East Jakarta Medika ("**EJM**"), which is 90.8% owned by PT Lippo Karawaci Tbk ("**Lippo**"). First REIT will acquire SHLC through its indirect wholly-owned subsidiary, PT Graha Pilar Sejahtera ("**GPS**") which is 95.0% and 5.0% held by Platinum Strategic Investments Pte. Ltd. ("**Platinum**") and Ultra Investments Pte. Ltd. ("**Ultra**") (Platinum's wholly-owned subsidiary) respectively. Platinum is wholly-owned by First REIT.

As at the Latest Practicable Date, Lippo directly and/or through its subsidiaries and through its interest in the Manager, has deemed interests of (i) 90.8% in EJM (being the vendor of SHLC), (ii) 21.74% in First REIT and (iii) 80.0% in the Manager, and is therefore regarded as a "controlling unitholder/shareholder" of EJM, First REIT as well as the Manager, under both the Listing Manual and the Property Funds Appendix.

For the purposes of Chapter 9 of the Listing Manual, EJM, being a subsidiary of (i) a controlling Unitholder of First REIT and (ii) a controlling shareholder of the Manager, is an Interested Person and an Interested Party (as defined in the Property Funds Appendix) of First REIT.

As such, the SHLC Acquisition will constitute an Interested Person Transaction under Chapter 9 of the Listing Manual and also an Interested Party Transaction under paragraph 5 of the Property Funds Appendix for which Unitholders' approval is required.

1.2 THE MRCCC MASTER LEASE AND THE SHLC MASTER LEASE

In relation to the MRCCC Acquisition, the MRCCC Master Lease Agreement has been entered into between PC and Lippo (as the MRCCC master lessee) on 8 November 2010 pursuant to which the MRCCC Master Lease will be granted to Lippo for a lease term of 15 years (subject to renewal of MRCCC's HGB title), with an option to renew for a further term of 15 years.

As at the Latest Practicable Date, Lippo directly and/or through its subsidiaries and through its interest in the Manager, has deemed interests of (i) 21.74% in First REIT and (ii) 80.0% in the Manager, and is therefore regarded as a "controlling unitholder/shareholder" of First REIT as well as the Manager, under the Listing Manual.

For the purposes of Chapter 9 of the Listing Manual, Lippo, being a controlling Unitholder of First REIT and a controlling shareholder of the Manager is an Interested Person of First REIT.

Given that the value of the MRCCC Master Lease will exceed 5.0% of First REIT's latest audited NTA, the MRCCC Master Lease will constitute an Interested Person Transaction under Chapter 9 of the Listing Manual for which Unitholders' approval is required. In compliance with the requirements of the Listing Manual, therefore, the approval of Unitholders is sought for the MRCCC Master Lease.

In relation to the SHLC Acquisition, the SHLC Master Lease Agreement has been entered into between GPS and Lippo (as the SHLC master lessee) on 8 November 2010 pursuant to which the SHLC Master Lease will be granted to Lippo for a lease term of 15 years (subject to renewal of SHLC's HGB title), with an option to renew for a further term of 15 years.

As the SHLC Master Lease will constitute an Interested Person Transaction under Chapter 9 of the Listing Manual for which Unitholders' approval is required, the approval of Unitholders is sought for the SHLC Master Lease.

1.3 THE WHITEWASH RESOLUTION

In the event that Lippo and parties acting in concert with it acquire sufficient number of Units as a result of:

(i) the receipt by the Manager in its own capacity of the MRCCC Acquisition Fee Units; and/or

(ii) the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units; and/or

(iii) the Lippo Entities taking up the Proportionate Rights Units allotted and issued to them pursuant to the Irrevocable Undertaking; and/or

(iv) the Lippo Entities subscribing for the Commitment Rights Units pursuant to the Commitment Agreement; and/or

(v) the Lippo Entities acquiring Rights Units through, if applicable:

(a) applying for the Lippo Excess Rights Units pursuant to the Lippo Excess Application; and/or

(b) acquiring any Lippo Nil-Paid Rights Units under the Rights Issue,

Lippo and parties acting in concert with it may incur a mandatory bid obligation pursuant to Rule 14 of the Code.

Rule 14.1(a) of the Code states that Lippo and parties acting in concert with it would be required to make a Mandatory Offer if the Lippo Entities acquire additional Units which increases their aggregate unitholding in First REIT to 30.0% or more.

The Manager is seeking approval from Independent Unitholders for a waiver of their rights to receive a mandatory offer from Lippo and parties acting in concert with it for all the remaining issued Units not owned or controlled by Lippo and parties acting in concert with it, in the event that the Lippo Entities incur a mandatory bid obligation pursuant to Rule 14 of the Code (the **"Whitewash Resolution"**).

The Whitewash Resolution is to enable Lippo to, either by itself and/or through one or more of the Subscribing Subsidiaries to, (i) subscribe for the Proportionate Rights Units and the Commitment Rights Units, (ii) apply for the Excess Rights Units and/or (iii) acquire "nil-paid" rights.

2. TERMS OF REFERENCE

Stirling Coleman has been appointed to advise the Independent Directors on whether (i) the IPT Transactions are on normal commercial terms and are prejudicial to the interests of First REIT and its Independent Unitholders; and (ii) the Whitewash Resolution in relation to the Rights Issue is prejudicial to the interest of Independent Unitholders.

Our opinion, by way of this Letter, will be limited solely to the IPT Transactions and the Whitewash Resolution, as of the date of this Letter. Neither our opinion nor its related analysis constitutes a recommendation of the IPT Transactions and the Whitewash Resolution to the Independent Unitholders. Our opinion will be rendered solely for the use and benefit of the Independent Directors for their deliberations on the IPT Transactions and the Whitewash Resolution, before arriving at a decision based on the merits or demerits of the IPT Transactions and the Whitewash Resolution and in making any recommendation, and the Trustee.

We were not involved in any aspect of the negotiations in relation to the Transactions (as defined in the Circular), nor were we involved in the deliberations leading up to the decision by the Board of Directors to enter into the Transactions, and we do not, by this Letter or otherwise, advise or form any judgment on the merits of the Transactions other than to form an opinion, as to whether the IPT Transactions are based on normal commercial terms and prejudicial to the interests of First REIT and its Independent Unitholders and whether the Whitewash Resolution is prejudicial to the interests of the Independent Unitholders. We have confined our evaluation to the financial terms of

the IPT Transactions and the Whitewash Resolution and our terms of reference do not require us to evaluate or comment on the risks and/or merits of the Transactions or the future prospects of First REIT, including whether the Transactions are commercially desirable or justifiable, and we have not made such evaluation or comment. Such evaluation or comment, if any, remains the responsibility of the Directors and the management of the Manager, although we may draw upon their views or make such comments in respect thereof (to the extent deemed necessary or appropriate by us) in arriving at our opinion as set out in this Letter. Accordingly, it is not within our scope to conduct a comprehensive independent review of the business, operations or financial condition of First REIT. Neither are we required to provide opinion on the adequacy of the working capital or sufficiency of the Rights Issue in meeting the requirements of First REIT in relation to the Transactions and after the Transactions.

It is not within our terms of reference to compare the relative merits of the Transactions vis-à-vis any alternative transaction previously considered by the Manager or transactions that the Manager may consider in the future, and such comparison and consideration remain the responsibility of the Directors.

We have not made an independent evaluation or appraisal of the assets and liabilities (including without limitation, real property, machinery and equipment) of First REIT or the SHLC Acquisition and we have not been furnished with any such evaluation or appraisal except for the relevant valuation reports by the Independent Valuers. We are not experts in the evaluation or appraisal of assets and liabilities or the determination of the market value of the SHLC property and have relied solely on the Independent Valuers in this respect.

In formulating our opinion and recommendation, we have held discussions with the Directors and management of the Manager and have examined publicly available information and we have relied to a considerable extent on the information set out in the Circular, other public information collated by us and the information, representations, opinions, facts and statements provided to us, whether written or verbal, by the Manager and its other professional advisers. We have relied upon the assurance of the Directors and the management of the Manager that all statements of fact, opinion and intention made by the Directors and the management of the Manager in the Circular have been reasonably made after due and careful enquiry. We have not independently verified such information but have made such reasonable enquiries and exercised our judgement as we deemed appropriate on such information and have no reason to doubt the accuracy or reliability of the information used for the purposes of our evaluation. Accordingly we cannot and do not expressly and impliedly represent or warrant, and do not accept any responsibility for the accuracy, or completeness or adequacy of such information or the manner in which it has been classified or presented or the basis of any valuation which may have been included in the Circular or announced by First Reit. The information which we relied on were based upon market, economic, industry, monetary and other conditions prevailing as at the Latest Practicable Date and may change significantly over a relatively short period of time. Accordingly, we do not express an opinion herein as to the prices at which the Units of First REIT may trade upon completion of the Transactions.

In rendering our services, we have not taken into consideration the specific investment objectives, financial situation, tax position, tax status, risk profiles or particular needs and constraints or circumstances of any individual Unitholder. As each Unitholder would have different investment objectives and profiles, any individual Unitholder who may require specific advice in the context of his specific investment objectives or portfolio should consult his stockbroker, bank manager, solicitor, accountant, tax adviser or other professional adviser immediately.

The Manager has been separately advised by its own advisers in the preparation of the Circular (other than this Letter). We have had no role or involvement and have not provided any advice, financial or otherwise, whatsoever in the preparation, review and verification of the Circular (other than this Letter). Accordingly, we take no responsibility for and express no views, expressed or implied, on the contents of the Circular (other than this Letter).

Our recommendation in respect of the IPT Transactions and the Whitewash Resolution, as set out in sections 4.5 and 9.4 of the Circular, should be considered in the context of the entirety of this Letter and the Circular. Where information in this Letter has been extracted from the Circular, Independent Unitholders are urged to read the corresponding sections in the Circular carefully.

3. INFORMATION ON THE SHLC ACQUSITION

3.1 The SHLC Property

Detailed descriptions of the SHLC Property are set out in Appendix A of the Circular. We recommend that the Independent Directors advise Independent Unitholders to read Appendix A of the Circular very carefully.

3.2 Details of the SHLC Acquisition

Details of the SHLC Acquisition and the conditions precedent for the completion of the sale and purchase of SHLC are set out in sections 3.2 to 3.6 and sections 3.8 to 3.11 of the Circular. We recommend that the Independent Directors advise Independent Unitholders to read these sections of the Circular very carefully.

3.3 Cost of the SHLC Acquisition

The SHLC Acquisition Cost is currently estimated to be approximately S$35.9 million, comprising:

(i) the SHLC Purchase Consideration of S$35.0 million;

(ii) the SHLC Acquisition Fee of approximately S$350,000 payable to the Manager pursuant to Clause 14.2.1 of the Trust Deed which shall be payable in the form of the SHLC Acquisition Fee Units; and

(iii) the estimated professional and other fees and expenses of approximately S$550,000 incurred by First REIT in connection with the SHLC Acquisition.

3.4 Method of Financing

The Manager intends to fund the SHLC Acquisition Cost in cash from the net proceeds of the Rights Issue.

4. THE MASTER LEASES

As part of the MRCCC Acquisition and SHLC Acquisition, PC and GPS have entered into the MRCCC Master Lease Agreement and the SHLC Master Lease Agreement with Lippo respectively, whereby both the MRCCC and the SHLC will be leased to Lippo for an initial period of 15 years commencing upon the completion of the respective acquisitions.

The principal terms of the MRCCC Master Lease Agreement and the SHLC Master Lease Agreement are set out respectively in sections 2.7 and 3.7 of the Circular. We recommend that the Independent Directors advise Independent Unitholders to read these sections in the Circular very carefully.

As both the MRCCC Master Lease and the SHLC Master Lease (collectively, the "**Master Leases**") are structured as part of the MRCCC Acquisition and the SHLC Acquisition respectively, we wish to highlight to the Independent Directors that **by approving the MRCCC Acquisition and the SHLC Acquisition, Independent Unitholders would also be deemed to have approved the MRCCC Master Lease and the SHLC Master Lease**.

5. THE RIGHTS ISSUE

5.1 Overview of the Rights Issue

The Manager is proposing the Rights Issue on a basis of five (5) Rights Units for every four (4) Existing Units held as at the Rights Issue Books Closure Date to raise gross proceeds of approximately S$172.8 million comprising an offer of 345,664,382 Rights Units to be made on a fully underwritten and renounceable basis to Eligible Unitholders.

The Rights Issue is conditional upon, *inter alia*, the following:

(i) approval of the Unitholders at the Extraordinary General Meeting (which is subject to and conditional upon the passing of Resolution 1 (the MRCCC Acquisition), Resolution 2 (the SHLC Acquisition) and Resolution 4 (the Whitewash Resolution)); and

(ii) lodgement of the Offer Information Statement with the MAS.

5.2 Use of Proceeds

The Manager expects to raise gross proceeds of approximately S$172.8 million and net proceeds of approximately S$168.0 million under the Rights Issue.

The Manager intends to utilise the net proceeds of approximately S$168.0 million from the Rights Issue to part finance the MRCCC Acquisition Cost and fully finance the SHLC Acquisition Cost.

5.3 Underwriting of the Rights Issue and Commitment of Lippo

Underwriting of the Rights Issue

The Rights Issue is fully underwritten by the Joint Lead Managers and Underwriters on the terms and subject to the conditions of the Underwriting Agreement.

Commitment of Lippo

To demonstrate its support for First REIT and the Rights Issue, Lippo, which owns an aggregate indirect interest in 60,131,506 Units (comprising approximately 21.74% of the total number of Units in issue) as at the Latest Practicable Date), has:

(i) provided the Irrevocable Undertaking, pursuant to which Lippo will procure that the Subscribing Subsidiaries subscribe for the Proportionate Rights Units, subject to the passing of the Whitewash Resolution; and

(ii) entered into the Commitment Agreement with the Joint Lead Managers and Underwriters, pursuant to which Lippo agrees, either directly or indirectly through one or more of the Subscribing Subsidiaries, to subscribe for the Commitment Rights Units, subject to the passing of the Whitewash Resolution.

Under the terms of the Irrevocable Undertaking and the Commitment Agreement, the Lippo Entities may subscribe for up to 210,414,382 Rights Units being approximately 61.0% of the total number of Rights Units.

Pursuant to the Commitment Agreement, the Joint Lead Managers and Underwriters agree to pay to Lippo from the Underwriting Commission:

(a) a fee of 1.50% of the Issue Price multiplied by the number of Proportionate Rights Units of 75,164,382 Units, representing approximately 21.74% of the Rights Units (which is equivalent to approximately S$0.56 million); and

(b) a fee of 1.50% of the Issue Price multiplied by the number of Commitment Rights Units of approximately 135,250,000 Units, representing 39.13% of the Rights Units (which is equivalent to approximately S$1.01 million),

together with any goods and services tax payable thereon (the "**Sub-Underwriting Fee**").

6. THE WHITEWASH RESOLUTION

In order for the Rights Issue to proceed on an underwritten basis, the Manager is seeking approval from Independent Unitholders for a waiver of their rights to receive a Mandatory Offer from Lippo and parties acting in concert with it for all the remaining issued Units not owned or controlled by Lippo and parties acting in concert with it, in the event that the Lippo Entities incur a mandatory bid obligation pursuant to Rule 14 of the Code as a result of:

(i) the receipt by the Manager in its own capacity of the MRCCC Acquisition Fee Units; and/or

(ii) the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units; and/or

(iii) the Lippo Entities taking up the Proportionate Rights Units allotted and issued to them pursuant to the Irrevocable Undertaking; and/or

(iv) the Lippo Entities subscribing for the Commitment Rights Units pursuant to the Commitment Agreement; and/or

(v) the Lippo Entities acquiring Rights Units through, if applicable:

  (a) applying for the Lippo Excess Rights Units pursuant to the Lippo Excess Application; and/or

  (b) acquiring any Lippo Nil-Paid Rights Units under the Rights Issue.

The Lippo Entities may end up acquiring additional Units which exceeds the threshold pursuant to Rule 14.1(a) of the Code. Rule 14.1(a) of the Code states that Lippo and parties acting in concert with it would be required to make a Mandatory Offer if the Lippo Entities acquire additional Units which increases their aggregate unitholding in First REIT to 30.0% or more.

Unless waived by the SIC, pursuant to Rule 14.1(a) of the Code, Lippo and parties acting in concert with it would then be required to make a Mandatory Offer.

The SIC has, on 4 November 2010, granted this waiver subject to, *inter alia*, Resolution 4 (the Whitewash Resolution) being approved by Independent Unitholders at an Extraordinary General Meeting.

Further details concerning the Whitewash Resolution can be obtained throughout the Circular, in particular within section 9. We recommend that the Independent Directors advise Independent Unitholders to read this section of the Circular carefully.

Independent Unitholders should note that by voting for the Whitewash Resolution,

- **Independent Unitholders are waiving their rights to receive a Mandatory Offer from Lippo and parties acting in concert with it at the highest price paid or agreed to be paid by Lippo and parties acting in concert with it for Units in the six months preceding the acceptance by the Lippo Entities of all of their provisional allotments under the Rights Issue and (i) the subscription for the Commitment Rights Units pursuant to the Commitment Agreement, (ii) application by the Lippo Entities of the Lippo Excess Rights Units pursuant to the Rights Issue and/or (iii) acquisition of Lippo Nil-Paid Rights Units pursuant to the Rights Issue and the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units and/or the MRCCC Acquisition Fee Units; and**

- **Independent Unitholders could also be forgoing the opportunity to receive a general offer from another person who may be discouraged from making a general offer in view of the potential dilutive effect resulting from the acceptance by the Lippo Entities of all of their provisional allotments and (i) the subscription for the Commitment Rights Units pursuant to the Commitment Agreement (ii) application by the Lippo Entities of the Lippo Excess Rights Units pursuant to the Rights Issue and/or acquisition of Lippo Nil-Paid Rights Units pursuant to the Rights Issue and (iii) the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units and/or the MRCCC Acquisition Fee Units.**

7. EVALUATION OF THE IPT TRANSACTIONS AND WHITEWASH RESOLUTION

Please refer to our Summary of Supporting Analysis for the results of our evaluation of the IPT Transactions and Whitewash Resolution.

8. SUMMARY OF ANALYSIS

In arriving at our recommendation in respect of the IPT Transactions and the Whitewash Resolution, we have taken into account the views and representations by the Directors and management of the Manager and the factors set out in our Summary of Supporting Analysis as attached. The key considerations are summarised below. Independent Unitholders should be advised to read the following in conjunction with, and in the context of, the full text of this Letter (including the Summary of Supporting Analysis) and the Circular. We have taken into account the following:

The SHLC Acquisition

(a) we note that the purchase consideration is 12.50% and 15.25% below the appraised values as determined by W&R and Damianus, respectively or at a discount of 13.80% to the average of the two independent valuations of SHLC by the Independent Valuers;

(b) the rationale for the SHLC Acquisition, taken in the entire context of the Transactions, appears to be based on sound commercial grounds;

(c) the positive outlook of the healthcare service industry in Indonesia as noted in the report entitled "Indonesia Healthcare Market Review Report" by Frost & Sullivan;

(d) the net effect of the Transactions is yield accretive to Unitholders as pro forma distribution yield will increase from 8.02% to 8.83%;

(e) the projected distribution yield after the Transactions is higher than the distribution yield without the Transactions for Projection Year 2011; and

(f) the pro forma distribution yield of First REIT of 8.83% is within the range of distribution yields of other REITs listed on SGX-ST and is also above the average of the range. In addition, we also note that the pro forma distribution yield of First REIT is higher than the distribution yield of Parkway Life REIT, being the closest comparable to First REIT in terms of property segment.

The Master Leases

(a) the Manager's rationale for the Master Leases;

(b) the base property yield (calculated based on the base rent divided by the purchase price) of 10.9% for the MRCCC Master Lease and the base property yield of 10.8% for the SHLC Master Lease are within the range of the base property yields of between 7.8% and 15.5% of the Existing Portfolio, and lower than the base property yields of between 12.4% and 15.5% of the Indonesian properties in the Existing Portfolio. However, we note that the Indonesian properties in the Existing Portfolio were leased to Lippo (as opposed to an independent party) and the base property yields then would have taken into account the then prevailing economic and market conditions in Indonesia. In addition, we also note that the market yields (calculated based on the aggregate of base rent and variable rent divided by appraised value as at 31 December 2009) of these Indonesian properties have since come down as their appraised values had significantly increased. In this respect, the base property yields of 10.9% for the MRCCC Master Lease and the base property yield of 10.8% for the SHLC Master Lease are within the range of the market yields of the Indonesian properties in the Existing Portfolio of 8.6% and 11.2%;

(c) the adjustments to the base rent and variable rent component under the terms of the Master Leases will provide potential further upside to the total rent and property yield and will also allow First REIT to benefit from the growth of the Indonesian healthcare industry;

(d) the adjustment features in the Master Leases are substantially the same (save for the different fixed exchange rate used for the conversion of the variable rent payable) as the master lease agreement for the Indonesian properties in the Existing Portfolio. Lippo, which is the lessee for the Master Leases is also the master lessee for the Indonesian properties in the Existing Portfolio;

(e) even though the Properties are located in Indonesia, the rental income to be received from Lippo will be denominated in Singapore Dollars under the Master Leases. This will eliminate any foreign currency exchange risk that First REIT may face from its rental income;

(f) the improvement in the pro forma distribution yield of First REIT from 8.02% to 8.83% with the inclusion of the Master Leases;

(g) the return on base rent (base rent / cost of investment) of 10.9% for the Master Leases is higher than the return on base rent of the master leases of Parkwaylife REIT (3.9%) and the Singapore properties of First REIT (7.8%);

(h) the adjustment features (such as adjustments to the base rent and the computation of the variable rent) of the Master Leases are substantially the same as those for the Indonesian properties in the Existing Portfolio; and

(i) First REIT will be able to benefit from the Lessees' property management and operating expertise and the use of the established "Siloam" brand name for hospitals.

Whitewash Resolution

(a) the rationale for the Rights Issue and Whitewash Resolution as set out in sections 6.5 and 9.3 of the Circular and in the Summary of Supporting Analysis entitled "Rationale in relation to the Rights Issue and Whitewash Resolution";

(b) the Issue Price represents a discount to the VWAP per Unit over the 1, 3, 6 and 12 month periods prior to the Latest Practicable Date and a discount of 47.59% to the VWAP per Unit on the Latest Practicable Date;

(c) the Issue Price represents a discount of approximately 47.37% to the last traded price of S$0.95 as at the Latest Practicable Date, is within the range of corresponding discounts of between 10.00% and 94.74% for the Rights Companies and greater than the mean discount of 42.00% (Please refer to the Summary of Supporting Analysis entitled "Precedent Rights Issue Exercises Analysis" of this Letter for further details relating to the Rights Companies);

(d) the Issue Price represents a discount of approximately 28.57% to the TERP of S$0.70, is within the range of corresponding discounts of between 8.47% and 92.31% for the Rights Companies;

(e) the pro forma financial effects of the Transactions (including the Rights Issue);

(f) the Rights Issue is offered to Entitled Unitholders who get the "right of first refusal" (for their provisional allotments of the Rights Units). The Entitled Unitholders also have the option of applying for Excess Rights Units in priority over that of the Substantial Unitholders and Directors;

(g) the Rights Issue is being offered on a renounceable basis; and

(h) the Sub-Underwriting Fee is in line with the sub-underwriting fees payable to major shareholders or major unitholders in recent rights issue transactions.

However, we also noted that by voting for the Whitewash Resolution:

(a) Independent Unitholders are waiving their rights to receive a Mandatory Offer from Lippo and parties acting in concert with it at the highest price paid or agreed to be paid by Lippo and parties acting in concert with it for Units in the six months preceding the acceptance by the Lippo Entities of all of their provisional allotments under the Rights Issue and (i) the subscription for the Commitment Rights Units pursuant to the Commitment Agreement, (ii) application by the Lippo Entities of the Lippo Excess Rights Units and/or acquisition of Lippo Nil-Paid Rights Units pursuant to the Rights Issue and (iii) the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units and/or MRCCC Acquisition Fee Units;

(b) Independent Unitholders could also be forgoing the opportunity to receive a general offer from another person who may be discouraged from making a general offer in view of the potential dilutive effect resulting from the acceptance by the Lippo Entities of all of their provisional allotments and (i) the subscription for the Commitment Rights Units pursuant to the Commitment Agreement (ii) application by the Lippo Entities of the Lippo Excess Rights Units and/or acquisition of Lippo Nil-Paid Rights Units pursuant to the Rights Issue and (iii) the receipt by the Manager in its own capacity of the SHLC Acquisition Fee Units and/or MRCCC Acquisition Fee Units; and

(c) the Rights Issue is conditional upon the Independent Unitholders voting in favour of Whitewash Resolution and the Transactions. Accordingly, in the event that the Whitewash Resolution is not approved by the Independent Unitholders, the Transactions (which include the Rights Issue) will not take place.

9. RECOMMENDATION AND CONCLUSION

Having carefully considered the information available to us, and based upon the monetary, industry, market, economic and other relevant conditions subsisting on the Latest Practicable Date and based on the factors set out in section 8 above, and subject to the qualifications and assumptions made herein (including the Summary of Supporting Analysis), we are of the view that (i) the IPT Transactions are based on normal commercial terms and are not prejudicial to the interests of First REIT and its Independent Unitholders; and (ii) the Whitewash Resolution, taken in the context of the Rights Issue, is not prejudicial to the interest of the Independent Unitholders. Accordingly, we are of the view that the Independent Directors should recommend that Independent Unitholders vote in favour of the IPT Transactions and the Whitewash Resolution to be proposed at the EGM.

In performing our evaluation and arriving at these conclusions, we wish to emphasise that the opinion set forth herein is based solely on publicly available information and information provided by the Directors and the management of the Manager and therefore does not reflect any projections or future financial performance of First REIT after the completion of the IPT Transactions and the Rights Issue and is based on the economic and market conditions prevailing as of the date of this Letter. Our advice is strictly confined to our views on the IPT Transactions and the Whitewash Resolution when taken in the context of the Rights Issue.

This Letter (for inclusion in the Circular) is addressed to the Independent Directors and the Trustee for their benefit, in connection with and for the purpose of their consideration of the IPT Transactions and the Whitewash Resolution. The recommendation made by the Independent Directors to the Independent Unitholders in relation to the IPT Transactions and the Whitewash Resolution remains the responsibility of the Independent Directors.

This Letter is governed by, and construed in accordance with, the laws of Singapore, and is strictly limited to the matters stated herein and does not imply by implication to any other matter.

Yours faithfully
For and on behalf of
STIRLING COLEMAN CAPITAL LIMITED

ANG KAY TIONG CHIEF EXECUTIVE OFFICER	LUCY LIM EXECUTIVE DIRECTOR

FIRST REAL ESTATE INVESTMENT TRUST

(Constituted in the Republic of Singapore
pursuant to a trust deed dated 19 October 2006 (as amended))

MANAGED BY

BOWSPRIT CAPITAL CORPORATION LIMITED

SUMMARY OF SUPPORTING ANALYSIS

10 November 2010

STIRLING COLEMAN

(Incorporated in the Republic of Singapore)
(Company Registration Number: 200105040N)
www.stirlingcoleman.com

Independent Financial Adviser in respect of the proposed SHLC Acquisition, the Master Leases and the proposed Whitewash Resolution

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In arriving at our opinion, as to whether (i) the IPT Transactions are on normal commercial terms and are prejudicial to the interests of First REIT and its Independent Unitholders; and (ii) the Whitewash Resolution is prejudicial to the interest of Independent Unitholders, we have performed, among other things, the following analysis:

The SHLC Acquisition

- Rationale for the SHLC Acquisition to assess whether the SHLC Acquisition is prejudicial to the interests of First REIT and its Independent Unitholders;
- Financial assessment of the SHLC Acquisition to evaluate the reasonableness of the SHLC Purchase Consideration; and
- Analysis of the pro forma distribution yield of First REIT as compared to other REITs listed on the SGX-ST.

The Master Leases

- Rationale for the Master Leases to assess whether the objective of the Master Leases is prejudicial to interests of First REIT and its Independent Unitholders;
- Analysis of the impact of the Master Leases on property yields and distribution yields; and
- Analysis of the key terms of the Master Leases as compared to other master lease agreements of properties used for healthcare and/or healthcare-related purposes owned by SGX-ST listed REITs.

The Whitewash Resolution

- Rationale in relation to the Rights Issue and Whitewash Resolution to assess whether the Whitewash Resolution is prejudicial to the interest of Independent Unitholders;
- Analysis of the Issue Price to assess whether the issue price of S$0.50 per Unit is prejudicial to the interest of Independent Unitholders;
- Precedent Rights Issue Exercises Analysis to assess the Issue Price as compared to the issue price of rights issue by companies listed on the SGX-ST;
- Dilution Impact Analysis to assess the potential maximum dilution impact to the Independent Unitholders arising from the Rights Issue; and
- Analysis of fee payable to Lippo in relation to the Sub-Underwriting Agreements to assess whether the fee payable is prejudicial to First REIT and Independent Unitholders.

The Manager's rationale for the Transactions is set out in section 6 of the Circular. We reproduce below extracts relevant to the SHLC Acquisition:

"Opportunity to purchase attractive and high quality properties at prices below valuation

The proceeds raised from the Rights Issue will be used to part finance the Acquisitions, which represent an opportunity for First REIT to acquire attractive and high quality hospitals of international standards at prices below the independent valuations of the Properties. MRCCC will be acquired at a discount of 19.7% to the average of the independent valuations by *W&R and Rengganis and SHLC will be acquired at a discount of 13.8% to the average of the independent valuations by Damianus and W&R.*

Unique opportunity to acquire two quality hospitals in Jakarta, Indonesia

The Manager is of the view that this is a unique opportunity to acquire quality hospitals in prime locations in Indonesia. MRCCC, Indonesia's first international standard private comprehensive cancer treatment centre, is well-positioned for the upper-income segment of the hospitality market. SHLC, is also well positioned for the growing residential and industrial areas of East Jakarta.

Increased absolute size of First REIT's asset base which may raise profile of First REIT among global investors and increased portfolio size enhances First REIT's competitive positioning and ability to pursue future acquisitions

First REIT's asset size will grow from S$346.1 million (as at 30 September 2010) to S$603.4 million after the completion of the Acquisitions. The value of First REIT's Deposited Property is expected to increase by 71.3% from S$359.3 million as at 30 September 2010 to S$615.6 million after the completion of the Acquisitions and there will also be a 58.7% increase in the total gross floor area to 132,696.2 sqm after the completion of the Acquisitions from 83,638.2 sqm before the Acquisitions. The total number of hospital beds for the Indonesian properties will increase by 43.8% from 537 to 772.

The larger asset base is expected to enhance First REIT's overall capital management flexibility, which will, among others, facilitate future acquisitions by First REIT.

The MRCCC Acquisition and the SHLC Acquisition are expected to benefit Unitholders by improving diversification of Gross Rental Income due to an increased number of properties. With an enlarged asset base, the operator of MRCCC and SHLC will also enjoy greater operating synergies in the long term which would indirectly benefit First REIT through higher variable rent and potential capital appreciation.

Yield accretive acquisition with expected increase in distribution yield to Unitholders for Projection Year 2011

*The Manager expects that the Acquisitions will improve the distribution yield to Unitholders due to the yield accretive nature of the Acquisitions. To illustrate the yield accretive nature of the Acquisitions which is part financed from a combination of debt financing and proceeds from the Rights Issue, the tables below show First REIT's forecast annualized distribution per Unit ("**DPU**") for the Projection Year 2011 in relation to the Enlarged Portfolio based on an Issue Price of S$0.50 per Rights Unit.*

*The following table has been prepared based on the assumptions set out above and have been examined by the Independent Reporting Accountants, being RSM Chio Lim LLP (the "**Independent Reporting Accountants**"), and should be read together with the assumptions set out in paragraph 8 below and the report set out in **Appendix E**, "Independent Reporting Accountants' Report on the Profit Forecast and Profit Projection".*

Projection Year 2011

	Projection Year 2011	
	Existing Portfolio	***Enlarged Portfolio***
	Before the Transactions	***After the Transactions***(1)
DPU (cents)	*8.14*	*6.40*
Distribution Yield (%)	*8.57*(2)	*9.14*(3)
Aggregate Leverage(4) *(%)*	*18.60*	*17.25*

Notes:

(1) Assuming that the Transactions are completed on 1 January 2011

(2) Distribution yield for before the Transactions issue is calculated based on the Closing Price.

(3) Distribution yield after the Transactions is based on the TERP of S$0.70 per Unit.

(4) "Aggregate Leverage" refers to the ratio of the value of total borrowings and deferred payments (if any) to the value of the Deposited Property.

Upon completion of the Transactions, First REIT's Aggregate Leverage will be lowered from 18.60% to 17.25% for the Projection Year 2011. Accordingly, First REIT's statement of financial position will be strengthened, leaving sufficient capability for debt financing should the need for such financing arises in the future.

The Acquisitions would enable First REIT to grow through the acquisition of a portfolio of hospitals which enhances the diversification of First REIT's portfolio across locations and medical specialisations

The Properties are located in Indonesia in which First REIT already operates and are an extension of First REIT's Existing Portfolio.

MRCCC will be the first private cancer centre and treatment facilities with comprehensive state-of-the-art equipments and the latest generation of smart IT-systems in Indonesia while SHLC is providing a broad range of quality general and specialist services, including Accident and Emergency services with Centres of Excellence in Urology, Internal Medicine and Trauma.

Additionally, MRCCC which is located in the central business district, South Jakarta is highly accessible via public and private transportation and is surrounded by major 5-star international hotels, allowing the hospital to cater to both local and international cancer patients while SHLC which is located in east Jakarta caters to the growing residential and industrial area in East Jakarta. The above qualities of MRCCC and SHLC are expected to enhance the diversification of First REIT's portfolio across locations and medical specialisations.

Increase in attractiveness of the Enlarged Portfolio given the reduction in the weighted average age of the properties in the Enlarged Portfolio after the completion of the Acquisitions

The Enlarged Portfolio will be attractive given, MRCCC, which will begin operations in December 2010, is expected to be Indonesia's first international standard private comprehensive cancer treatment centre. It will be a 29 storey, 160-bed hospital with two basement levels, situated near Plaza Semanggi, the Aryaduta Suites Hotel Semanggi and other international five-star hotels in the central business district, South Jakarta.

Additionally, SHLC, which began operations in 2002 is a six-storey hospital (with a basement and a covered roof space) which will accommodate 75 beds by the end of 2010. It is situated in the growing residential and industrial areas of East Jakarta and is committed to provide a broad range of quality general and specialist services, including Accident and Emergency services with Centres of Excellence in

Urology, Internal Medicine and Trauma. As at 30 September 2010, the weighted average age of properties of the Enlarged Portfolio will decrease from 18.0 years to 12.1 years (or about 32.8%) from that of the Existing Portfolio."

The rationale for the SHLC Acquisition, taken in the entire context of the Transactions, appears to be based on sound commercial grounds.

In evaluating the reasonableness of the SHLC Purchase Consideration, we have considered the following factors which have a bearing on our assessment:

Basis for arriving at the purchase consideration of the SHLC Acquisition

Pursuant to the Sale and Purchase Agreements, the SHLC Purchase Consideration is approximately S$35.0 million.

Cost of the Acquisitions

We note that the SHLC Purchase Consideration was arrived at on a willing-buyer willing-seller basis after taking into account the two independent valuations of SHLC by Damianus which was commissioned by the Manager and by W&R which was commissioned by the Trustee. The valuations were derived by Damianus and W&R using the Income Method of valuation utilising discounted cash flow analysis as the subject property will be under a master lease agreement with the hospital operator as the master tenant. This method considers the subject property as an income producing property.

Valuation of SHLC by the Independent Valuers

Two independent property valuers were appointed for the purpose of determining the market value of SHLC as at 6 September 2010. W&R was appointed by the Trustee and Damianus was appointed by the Manager to value SHLC.

Summarised versions of the valuation reports (the "**Valuation Reports**") are contained in Appendices B of the Circular, with the determined market values as at 6 September 2010 as set out below:

Valuation of the Properties by the Independent Valuers

Valuation of SHLC by the Independent Valuers	
	(S$ million)
W&R	40.0
Damianus	41.3

Our observations in relation to the Valuation Reports are as follows:

- The Valuation Report prepared by W&R has adopted the basis of market value in accordance with the Indonesian Valuation Standards (Standar Penilaian Indonesia / SPI) 2007 and the International Valuation Standards (IVS) 2007.

  The Valuation Report prepared by Damianus has adopted the basis of market value in accordance with the Indonesian Valuation Standards (Standar Penilaian Indonesia / SPI) 2007 and 2002.

- The Valuation Reports assess the 'market value' of SHLC as at 6 September 2010, which is close to the dates for the SHLC Sale and Purchase Agreement. The market value is the estimated amount for which an asset should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion.

- The income method utilising discounted cash flow (DCF) analysis was used for the purposes of completing the Valuation Reports.

  According to the W&R and Damianus, DCF analysis was used considering that SHLC is an income producing property. The valuation had taken into account the terms of the SHLC Master Lease and was conducted having regard to the prevailing market conditions as at 6 September 2010, especially those pertaining to the healthcare services industry in the locality of SHLC.

- The appraised value of SHLC as at 6 September 2010 was between S$40.0 million and S$41.3 million. The agreed purchase consideration is S$35.0 million. We note that the purchase consideration is 12.50% and 15.25% below the appraised values as determined by W&R and Damianus, respectively or at a discount of 13.80% to the average of the two independent valuations of SHLC by the Independent Valuers.

In addition to the Valuation Reports reviewed, we were provided with a copy of the report entitled "Indonesia Healthcare Market Review Report" by Frost & Sullivan, in relation to which we note the following:

- Indonesia has a steady GDP CAGR of 6% and it is one of the fastest growing economies with an emerging middle class. Jakarta has the highest concentration of the country's middle class, up to 75%.

- Majority of the healthcare services in Indonesia are concentrated in urban areas, especially around major cities, with Jakarta having the highest concentration of healthcare infrastructure.

- The total expenditure on healthcare in Indonesia is one of the lowest in the region and is reflected by the chronic shortage of healthcare resources and work force across the entire country. The emerging demand coupled with insufficient healthcare services provision annually forces as much as 400,000 Indonesians seeking medical help abroad each year.

- The key demand drivers for the Indonesia healthcare services include (i) population growth and ageing population, (ii) emergence of lifestyle diseases and higher prevalence of chronic diseases and cancer and (iii) the growing middle-class which will increase demand for better quality healthcare services.

- Oncology services in Indonesia are provided by 5 centers in Jakarta and 22 nationwide. With cancer being the 6th largest mortality cause, the underserved population either seeks help from traditional healers or, those more affluent, in the neighboring countries.

Further information regarding the Valuation Reports and the "Indonesia Healthcare Market Review Report" can be obtained throughout the Circular, in particular within Appendices B and C of the Circular. We recommend that the Independent Directors advise Independent Unitholders to read these sections of the Circular carefully.

We advise that you highlight the following factors to the Independent Unitholders, which should be considered, together with the other comments and issues raised in this Letter and the contents of the Circular.

Financial Effects of the Transactions

The pro-forma financial effects of the Transactions are set out in sections 7.1, 7.2 and 7.3 of the Circular, and are reproduced below for convenience. We note that assumptions were made for the purposes of analysing the pro-forma financial effects. We recommend that the Independent Directors advise Independent Unitholders to read these carefully, as well as take them into consideration when considering the financial effects.

Financial Year Ended 31 December 2009

Pro Forma DPU and distribution yield

The pro forma financial effects of the Acquisitions on the DPU and distribution yield for FY2009, as if First REIT had purchased the Properties and completed the Rights Issue on 1 January 2009, and held and operated the Properties through to 31 December 2009, are as follows:

	Before the Transactions[1]	After the Transactions
Distributable income (S$'000)	20,964	38,542
Units in issue and to be issued ('000)	275,474	624,104
DPU (cents)	7.62	6.18
Distribution yield (%)	8.02[2]	8.83[3]

Notes:

(1) Based on the FY2009 Audited Consolidated Financial Statements.

(2) Based on the actual DPU divided by the Closing Price.

(3) Based on the adjusted DPU divided by the TERP of S$0.70 per Unit.

Based on the figures above, we note that the distribution yield will increase from 8.02% to 8.83%.

Pro forma NAV per Unit

The pro forma financial effects of the Acquisitions on the NAV per Unit as at 31 December 2009, as if First REIT had purchased the Properties and completed the Rights Issue on 31 December 2009 are as follows:

	Before the Transactions[1]	After the Transactions
NAV (S$'000)	271,027	474,200
Units in issue and to be issued ('000)	275,474	624,104
NAV per Unit (S$)	0.98	0.76

Note:

(1) Based on the FY2009 Audited Consolidated Financial Statements.

Based on the figures above, we note that the pro forma NAV per Unit will decrease from S$0.98 to S$0.76. We note that the abovementioned fall is largely due to the Rights Units being offered at a discount to the existing NAV per unit of First REIT as well as the increase in the number of Units pursuant to the Rights Issue.

Pro forma capitalisation

The following table sets forth the pro forma capitalisation of First REIT as at 31 December 2009, as if First REIT had purchased the Properties and completed the Rights Issue on 31 December 2009.

	As at 31 December 2009	
	Actual	**As Adjusted for the Transactions**
	(S$ '000)	(S$ '000)
Short-term debt:		
Unsecured	–	–
Secured	–	–
Total short-term debt	–	–
Long-term debt:		
Unsecured	–	–
Secured	52,301	91,723
Total long-term debt	52,301	91,723
Total debt	52,301	91,723
Unitholders funds	271,027	474,200
Total Capitalisation	**323,328**	**565,923**

Based on the figures above, we note that the total capitalisation will increase from S$323.33 million to S$565.92 million.

Nine Months Ended 30 September 2010

Pro Forma DPU and distribution yield

The pro forma financial effects of the Acquisitions on the DPU and distribution yield for FY2009, as if First REIT had purchased the Properties and completed the Rights Issue on 1 January 2010, and held and operated the Properties through to 30 September 2010, are as follows:

	Before the Transactions (1)	**After the Transactions**
Distributable amount (S$'000)	15,900	29,579
Units in issue and to be issued ('000)	276,281	624,911
DPU (cents)	5.76	4.73
Distribution yield (%)	6.06(2)	6.76(3)

Notes:

(1) Based on the 9M2010 Unaudited Financial Statements.

(2) Based on the actual DPU divided by the Closing Price of S$0.95 per Unit as at the Latest Practicable Date.

(3) Based on the adjusted DPU divided by the TERP of S$0.70 per Unit.

Based on the figures above, we note that the distribution yield will increase from 6.06% to 6.76%.

Pro forma NAV per Unit

The pro forma financial effects of the Acquisitions on the NAV per Unit as at 30 September 2010, as if First REIT had purchased the Properties and completed the Rights Issue on 30 September 2010, are as follows:

	Before the Transactions [1]	After the Transactions
NAV (S$ '000)	270,122	473,295
Units in issue and to be issued ('000)	276,281	624,911
NAV per Unit (S$)	0.98	0.76

Note:

(1) Based on the 9M2010 Unaudited Financial Statements.

Based on the figures above, we note that the pro forma NAV per Unit will decrease from S$0.98 to S$0.76. We note that the abovementioned fall is largely due to the Rights Units being offered at a discount to the existing NAV per unit of First REIT as well as the increase in the number of Units pursuant to the Rights Issue.

Pro forma capitalisation

The following table sets forth the pro forma capitalisation of First REIT as at 30 September 2010, as if First REIT had purchased the Properties and completed the Rights Issue on 30 September 2010.

	As at 30 September 2010	
	Actual	As Adjusted for the Transactions
	(S$ '000)	(S$ '000)
Short-term debt:		
Unsecured	–	–
Secured	–	–
Total short-term debt	–	–
Long-term debt:		
Unsecured	–	–
Secured	56,847	96,269
Total long-term debt	56,847	96,269
Total debt	56,847	96,269
Unitholders funds	270,122	473,295
Total Capitalisation	**326,969**	**569,564**

Based on the figures above, we note that the total capitalisation will increase from S$326.97 million to S$569.56 million.

Analysis of the Pro Forma Distribution Yield of First REIT

We have extracted the distribution yield (on a trailing 12-month basis) of other REITs listed on the SGX-ST ("Singapore REITs") in order to compare the distribution yields offered by the Singapore REITs with the pro forma distribution yield of First REIT.

The information in the table presented below is for illustration purposes only. While we have made our comparisons against the Singapore REITs as shown in the table below, we recognised that the properties of the Singapore REITs may differ significantly from the properties owned by First REIT in terms of property segments, building size and design, building age, location, accessibility, tenant composition, market risks, future prospects, operating history and other relevant criteria. There is no REIT which may be considered identical to First REIT in terms of the aforesaid factors.

Accordingly, the Independent Directors should note that any comparison made with respect to the Singapore REITs serves as an illustrative guide only.

Comparable REIT Yield			
Name	**Yield**	**Trailing 12 months Distribution Per Unit (S$ cents)**	**Closing Price as at the Latest Practicable Date (S$)**
AIMS AMP Capital Industrial REIT	8.13%	1.83	0.225
Ascendas India Trust	6.93%	7.00	1.01
Ascendas Real Estate Investment Trust	6.09%	12.67	2.08
Ascott Residence Trust	5.80%	7.25	1.25
Cambridge Industrial Trust	9.32%	5.08	0.545
CapitaCommericial Trust	5.25%	7.77	1.48
Capitamall Trust	4.66%	9.28	1.99
CapitaRetail China Trust	6.46%	8.33	1.29
CDL Hospitality Trusts	4.57%	10.01	2.19
Fortune Real Estate Inv Trust	7.05%	4.76	0.675
Frasers Centrepoint Trust	5.54%	8.20	1.48
Frasers Commercial Trust	6.79%	1.12	0.165
K-REIT Asia	4.42%	6.10	1.38
Lippo-Mapletree Indonesia Retail Trust	8.32%	4.49	0.54
Mapletree Logistics Trust	6.72%	6.08	0.905
Parkway Life REIT	4.83%	8.16	1.69
Starhill Global REIT	6.23%	3.83	0.615
Suntec Real Estate Inv Trust	6.77%	10.43	1.54
High	**9.32%**		
Low	**4.42%**		
Simple Average	**6.33%**		
First REIT(1)	**8.83%**		

Source: Bloomberg

Note:

(1) Based on the pro forma distribution yield.

From the table above, we noted the following:

(a) The distribution yields of the Singapore REITs range between 4.42% and 9.32%;

(b) The pro forma distribution yield of First REIT of 8.83% is within the above range and is also above the average of the range. In addition, we also note that the pro forma distribution yield of First REIT is higher than the distribution yield of Parkway Life REIT, being the closest comparable to First REIT in terms of property segment.

Based on the above and having regard to the SHLC Acquisition being contingent upon, amongst other things, the MRCCC Acquisition, the SHLC Purchase Consideration does not appear to be unreasonable or prejudicial to the interests of First REIT and its Independent Unitholders.

The Manager's rationale for the Transactions is set out in section 6 of the Circular. We reproduce below extracts relevant to the Master Leases:

"Increased income stability of First REIT through the MRCCC Master Lease Agreement and the SHLC Master Lease Agreement and increase in First REIT's weighted average lease to expiry

The MRCCC Master Lease and the SHLC Master Lease will be beneficial to First REIT as the Properties are expected to provide stability in First REIT's Gross Rental Income over the next 15 to 30 years. The step-up feature of the base and variable rental components under the MRCCC Master Lease Agreement and the SHLC Master Lease Agreement would also provide locked-in organic growth in First REIT's cash flow. To ensure stability in First REIT's Gross Rental Income from the Properties, security deposits equivalent to 6 months of (i) MRCCC's annual rental payable (amounting to S$9,317,500) and (ii) SHLC's annual rental payable (amounting to S$1,884,000) will be made to First REIT in the form of bankers' guarantee. Such security deposit amounts will be adjusted at relevant rent review dates.

The Acquisitions are also in line with the Manager's acquisition growth strategy of pursuing opportunities for asset acquisitions that will provide stable cash flows and returns relative to First REIT's cost of capital and opportunities for future income and capital growth.

Currently, the master leases of the properties in the Existing Portfolio are between 10 to 15 years. With the Acquisitions, First REIT will benefit from the increase in the Enlarged Portfolio's weighted average lease to expiry based on secured Gross Rental Income with MRCCC being the main contributor to the total Gross Rental Income under the MRCCC Master Lease Agreement. The weighted average lease to expiry of the Enlarged Portfolio will increase to approximately 12.4 years after the completion of the Acquisitions from approximately 10.6 years from that of the Existing Portfolio as at 30 September 2010."

The base property yield[1] of the MRCCC Master Lease is 10.9% based on the Purchase Consideration and the annual base rent of S$18.635 million guaranteed under the MRCCC Master Lease Agreement. Similarly, the base property yield of SHLC is 10.8%, based on the Purchase Consideration and annual base rent of S$3.768 million guaranteed under the SHLC Master Lease Agreement.

The estimated base property yields of MRCCC and SHLC of 10.9% and 10.8% respectively are within the range of the base property yields of between 7.8% and 15.5% of the Existing Portfolio of First REIT computed on a similar basis and lower than the base property yields of between 12.4% and 15.5% of the Indonesian properties in the Existing Portfolio. However, we note that the Indonesian properties in the Existing Portfolio were leased to Lippo (as opposed to an independent party) and the base property yields then would have taken into account the then prevailing economic and market conditions in Indonesia. In addition, we also note that the market yields (calculated based on the aggregate of base rent and variable rent divided by appraised value as at 31 December 2009) of these Indonesian properties have since come down as their appraised values had significantly increased. In this respect, the base property yields of 10.9% for the MRCCC Master Lease and the base property yield of 10.8% for the SHLC Master Lease are within the range of the market yields of the Indonesian properties in the Existing Portfolio of 8.6% and 11.2%.

Further, the adjustment features in the Master Leases such as the adjustments to the base rent and the variable rent component can provide potential further upside to the total rent and in turn increase the property yields of the Master Leases.

We note that the abovementioned adjustment features in the Master Leases are substantially the same (save for the different fixed exchange rate used for the conversion of the variable rent payable) as the master lease agreement for the Indonesian properties in the Existing Portfolio. Lippo, which is the lessee for the Master Leases is also the master lessee for the Indonesian properties in the Existing Portfolio.

Further, we note that even though the Properties are located in Indonesia, the rental income to be received from Lippo will be denominated in Singapore Dollars under the Master Leases. This will eliminate any foreign currency exchange risk that First REIT may face from its rental income.

The Master Leases are for a period of 15 years with an option to renew for a further 15 years (on terms as may be agreed between the parties) and will provide strong underpinning to property yields and stability in rental income for First REIT for the next 15 to 30 years. Currently, the years to lease expiry of the properties in the Existing Portfolio are between 10 to 15 years. With the Master Leases in place, First REIT will benefit from the increase in its weighted average years to lease expiry for its Enlarged Portfolio.

Further, based on the pro forma figures set out in section 7 of the Circular, with the inclusion of the Master Leases, the distribution yield is expected to increase from 8.02% to 8.83%.

[1] Base property yield is calculated based on the base rent divided by the purchase price.

We note that while there are many precedents for such master lease agreements of properties owned by SGX-ST listed REITs (for example, Ascendas REIT, CapitaCommercial Trust, CDL Hospitality Trust, Frasers Commercial Trust), they are mostly in other property segment, such as the commercial and retail property segments. As such, most of these master lease agreements have their own unique features (such as rent-free period, fixed rent adjustments, performance-based variable rents, etc), which makes it difficult for comparisons to be made to them.

For our purpose, we made a comparison of the principal terms of the Master Leases to the master lease agreements for properties used for healthcare and/or healthcare-related purposes, set out in the table below:

Companies / REIT	Return on base rent(1)	Annual adjustment to base rent	Variable rent
Parkway Life REIT	3.9%	None	Equivalent to 3.8% of the adjusted hospital revenue(3) of the preceding financial year Provided that total rent payable (base + variable) shall not be lower than: Total rent for preceding year x (1 + (CPI + 1%)), where if CPI is negative, it is deemed to be zero.
Singapore properties in the Existing Portfolio that are leased to third parties	7.8%	Base rent x (2 x CPI(2) % increase) Subject to floor of 0% and cap of 2%.	None
Master Leases	10.9%	Base rent x (2 x CPI % increase) Subject to floor of 0% and cap of 2%.	Payable from the second year of lease based on fixed exchange rate of S$1 = Rp. 6,600 Based on the percentage growth in gross revenue in the preceding financial year compared to the year before ("GRG%"). a) If 5% < GRG% < 15%, Equivalent to 0.75% of GR b) If 15% < GRG% < 30%, Equivalent to 1.25% of GR c) If 30% < GRG%, Equivalent to 2.0% of GR

Source: Extracted from the prospectus or latest available annual report of the relevant REITs

Notes:

(1) Return on base rent = base rent / cost of investment.

(2) CPI refers to the consumer price index of Singapore for the preceding calendar year.

(3) Refers to invoice value of revenue relating to inpatient revenue, outpatient revenue, rental and licence fees, carpark revenue, retail pharmacy revenue and food and beverage revenue, excluding all other revenue and revenue collected on behalf of physicians or providers of ancillary services, service, cess and GST charges.

Comparison of the key terms of the Master Leases

In our comparison of the key terms of the Master Leases, we note the following:

- the return on base rent of 10.9% for the Master Leases compares favorably to the return on base rent of 3.9% for the master leases of Parkway Life REIT and 7.8% for the Singapore properties of First REIT;

- for the master lease agreements of Parkway Life REIT, there is no annual adjustment feature for the base rent. The Singapore properties of the Existing Portfolio and the Master Leases both provide for potential upward adjustment to the base rent, based on two times the increase in the consumer price index of Singapore for the preceding calendar year, subject to a floor of 0% and cap of 2.0%;

- the variable rent for the Master Leases is up to 2.0% of the audited gross revenue of the hospital (depending on the year-on-year growth of the gross revenue), while the variable rent for the master leases of Parkway Life REIT is fixed at 3.8% of the adjusted hospital revenue. The Singapore properties in the Existing Portfolio do not have any variable rent component; and

- as MRCCC will only commence operation in December 2010, the variable rent for the second year of the MRCCC Master Lease will be based on 2.0% of the audited gross revenue of the hospital in the preceding financial year.

We advise that you highlight the following factor to the Independent Unitholders, which should be considered, together with the other comments and issues raised in this Letter and the contents of the Circular.

Benefits from the Lippo's property management and operating expertise and the use of the established "Siloam" brand name for hospitals

Both the MRCCC Lessee and the SHLC Lessee are part of the Lippo group of companies. Lippo is an internationally recognised corporation and is one of the largest broad-based property companies in Indonesia listed on both the Jakarta Stock Exchange and the Surabaya Stock Exchange. Lippo has a large property portfolio comprising townships and residential developments, commercial and retail development properties, healthcare, infrastructure and hospitality properties with a recognised track record in the planning and development of large property, infrastructure and township projects as well as ongoing maintenance, upkeep and renovation of properties.

Lippo ventured into the healthcare business in 1995 when it established and developed Siloam Hospitals Lippo Karawaci. Since then, it had developed and acquired several hospitals, such as Siloam Hospitals Lippo Cikarang, Siloam Hospitals Surabaya, Siloam Hospitals West Jakarta under it "Siloam" brand of hospitals and built up its expertise in managing healthcare businesses including the Indonesian properties of the Existing Portfolio.

Upon entering into the Master Leases, both the MRCCC and the SLHC will be able to benefit from Lippo's expertise in property management and operating expertise as well as being managed under the "Siloam" brand, which is an established brand name for hospitals in Indonesia.

The Manager's rationale for the Transactions is set out in section 6 of the Circular. We reproduce below extracts relevant to the Rights Issue:

"Increased market capitalisation and potential increased liquidity through the Rights Issue

To part finance the Acquisitions, up to 345,664,382 Rights Units will be issued. The Rights Units will constitute 125.0% of the Units in issue as at the Latest Practicable Date. The issue of the Rights Units is expected to increase the market capitalisation of First REIT and will increase the number of Units in issue. This may therefore facilitate improvement in the trading liquidity of Units on the SGX-ST.

With the increased market capitalisation and liquidity of First REIT, the Manager believes that First REIT's competitive positioning with respect to its acquisition growth strategy will be enhanced and that the profile of First REIT among investors will be raised."

We reproduce below extracts relevant to the Whitewash Resolution:

"Rationale to subscribe for the Proportionate Rights Units and the Commitment Rights Units

Given the recent months of market uncertainty and volatility and the resulting challenging market conditions, the Joint Lead Managers and Underwriters have confirmed that they will only underwrite the Rights Issue if Lippo enters into the Commitment Agreement. By committing to this arrangement, Lippo is demonstrating its support for First REIT and facilitating the underwriting of the Rights Issue by the Joint Lead Managers and Underwriters, thereby enhancing the chances of a successful Rights Issue.

Rationale to allow Lippo to apply for Lippo Excess Rights Units and/or acquire the Lippo Nil-Paid Rights Units

The Manager is of the view that the Lippo Entities should not be treated differently from any other Unitholder and should be given the opportunity to apply for Excess Rights Units. In addition, any Lippo Excess Application, to be made by Lippo at its discretion, will further demonstrate Lippo's support for and confidence in the Rights Issue and its long-term commitment to First REIT and will enhancing the chances of a successful Rights Issue. In the allotment of Excess Rights Units, preference will be given to the rounding of odd lots (if any), followed by allotment to the Unitholders who are neither Substantial Unitholders nor Directors. Lippo, the Subscribing Subsidiaries, other Substantial Unitholders and Directors will rank last in priority.

The Manager is also of the view that the Lippo Entities should not be treated differently from any other Unitholder and should be given the opportunity to acquire Lippo Nil-Paid Rights Units and that allowing the Lippo Entities to acquire Lippo Nil-Paid Rights Units in the open market or otherwise by way of private arrangement would enhance liquidity in relation to the Lippo Nil-Paid Rights Units. The liquidity of the market in the Lippo Nil-Paid Rights Units is important because any illiquidity will impact upon the ability of a Unitholder who wishes to realise part or all of its Nil-Paid Rights Units to do so without losing value."

The Issue Price of S$0.50 per Rights Unit is set out in greater detail in section 5 of the Circular.

The Issue Price represents a discount of approximately 47.37% to the Closing Price and a discount of approximately 28.57% to the TERP per Unit.

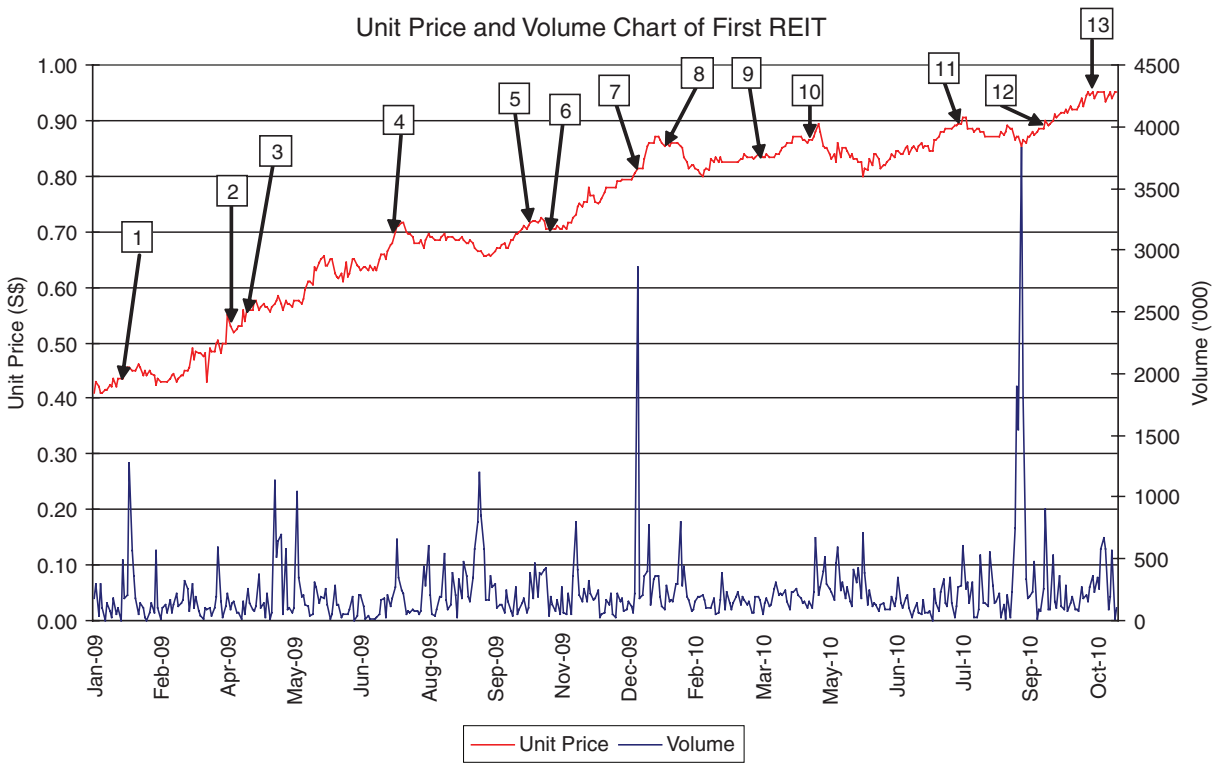
In assessing the Issue Price from a financial viewpoint, we have taken into consideration the following salient factors which we consider as having a significant bearing on our assessment:

Price Performance of the Units

In evaluating the Issue Price of S$0.50 per Rights Unit from a financial viewpoint, on the premise that the market may be considered to provide an efficient mechanism by which such price expectations may be expressed, we have considered whether current and historical unit prices of First REIT are reasonable indicators for assessing the financial value of the units at a given point in time. Under ordinary circumstances, the market valuation of units traded on a recognised stock exchange may be affected by, *inter alia*, its relative liquidity, the size of its free float, the extent of research coverage and investor interest it attracts, and the general market sentiment at a given point in time. Therefore, this analysis serves as an illustrative guide only.

The following chart shows the price performance of the Units for the period beginning 1 January 2009 to the Latest Practicable Date:

Chart: Price and Volume



Source: Bloomberg

Since 1 January 2009, First REIT has made the following announcements:

Legend No.	Date	Description
1	22 Jan 2009	Release of financial results for the year ended 31 Dec 2008
2	6 Apr 2009	First REIT secures a three year S$70m multi-currency transferable loan facility
3	23 Apr 2009	Release of financial results for 1Q2009 ended 31 Mar 2009
4	23 Jul 2009	Release of financial results for 2Q2009 ended 30 Jun 2009
5	22 Oct 2009	Release of financial results for 3Q2009 ended 30 Sep 2009
6	2 Nov 2009	Collaboration agreement in relation to enhancement of Adam Road Hospital
7	28 Dec 2009	Completion of annual valuations for 2009
8	22 Jan 2010	Release of financial results for the year ended 31 Dec 2009
9	24 Mar 2010	Announcement of expansion of manager's investment policy in First REIT
10	23 Apr 2010	Release of financial results for 1Q2010 ended 31 Mar 2010
11	26 Jul 2010	Release of financial results for 2Q2009 ended 30 Jun 2010
12	20 Sep 2010	Announcement of property acquisition - 2 healthcare properties in Indonesia
13	22 Oct 2010	Release of financial results for 3Q2010 ended 30 Sep 2010

Source: company announcements of First REIT on the SGX-ST website

We set out below a table which shows the volume weighted average price (**"VWAP"**) of the Units and the discount of the Issue Price over the VWAP of the Units for one month, three months, six months, nine months and twelve months respectively preceding the Latest Practicable Date.

VWAP Analysis				
Reference period	**Highest price (S$)**	**Lowest price (S$)**	**VWAP (S$)**	**Discount of Rights Issue Price over VWAP**
Periods prior to the Latest Practicable Date				
One year prior	0.970	0.700	0.852	41.31%
6 month prior	0.970	0.800	0.875	42.86%
3 month prior	0.970	0.850	0.888	43.69%
1 month prior	0.970	0.915	0.942	46.92%
One market day prior	0.950	0.945	0.949	47.31%
Latest Practicable Date	**0.955**	**0.950**	**0.954**	**47.59%**

Source: Bloomberg

As shown in the table above, the Issue Price represents a discount to the VWAP per Unit over the 1, 3, 6 and 12 month periods prior to the Latest Practicable Date and a discount of 47.59% to the VWAP per Unit on the Latest Practicable Date.

Rights Issue Transactions

In reviewing the reasonableness of the premium over / discount to market prices of the Units as implied by the Issue Price, we have reviewed and selected completed precedent rights issues announced by companies listed on the SGX-ST during the 12-month period prior to the Latest Practicable Date ("Rights Companies") to give an indication of current market expectations of the prices of the rights shares as a premium over/discount to the market prices of the shares of the Rights Companies immediately before the announcement of their rights issues, and to their respective theoretical ex-rights price (**"TERP"**).

Precedent Rights Issue Transactions					
Company Name	**Date of announcement**	**Terms of rights issue**	**Rights issue price (S$)**	**Discount of rights issue price to LTP[1]**	**Discount of rights issue price to TERP[2]**
Ezra Holdings Limited	31 Aug 2010	1 for 5	1.18	33.33%	29.41%
Sinotel Technologies Ltd.	30 Aug 2010	1 for 4	0.28	23.29%	19.54%
AIMS AMP Cap Industrial REIT	23 Aug 2010	7 for 20	0.155	29.55%	23.70%
Federal Int (2000) Ltd	14 Aug 2010	7 for 10	0.08	51.52%	38.46%
Sinwa Limited	11 Aug 2010	1 for 2	0.138	54.00%	43.90%
CPH Ltd	2 Aug 2010	3 for 2	0.01	50.00%	28.57%
China Healthcare Limited	29 Jul 2010	1 for 4	0.125	16.67%	13.79%
Top Global Limited	25 Jun 2010	3 for 1	0.01	71.43%	38.46%
Spice i2i Limited	15 Jun 2010	1 for 1	0.10	51.22%	34.43%
New Toyo International Holdings Ltd	8 Jun 2010	3 for 5	0.12	48.94%	37.46%
China Paper Holdings Limited	2 June 2010	3 for 5	0.12	25.00%	17.24%
PT Berlian Laju Tanker Tbk	26 May 2010	1 for 1	0.034	51.43%	34.62%
PSL Holdings Ltd	21 May 2010	1 for 2	0.02	94.74%	92.31%
Superior Multi-Packaging Ltd	19 May 2010	1 for 1	0.055	56.00%	38.89%
Hotel Royal Ltd	12 May 2010	2 for 5	1.50	49.15%	40.85%
Swing Media Technology Group Ltd	31 Mar 2010	1 for 2	0.045	25.00%	18.18%
Lafe Corporation Ltd	30 Mar 2010	1 for 6	0.06	20.00%	17.65%
Eastgate Technology Ltd	30 Mar 2010	1 for 1	0.002	60.00%	42.86%
Ultro Technologies Ltd	10 Mar 2010	1 for 2	0.025	54.55%	44.44%
The Style Merchants Limited	2 Mar 2010	3 for 1	0.015	81.25%	52.00%
Anwell Technologies Ltd	26 Feb 2010	1 for 5	0.36	37.93%	33.74%
UPP Holdings Limited	6 Jan 2010	1 for 1	0.10	20.00%	11.11%
M Development Ltd	6 Jan 2010	1 for 5	0.045	10.00%	8.47%
Samko Timber Ltd	11 Dec 2009	1 for 2	0.065	27.78%	22.83%
Juken Technology Ltd	21 Dec 2009	6 for 10	0.04	33.33%	23.81%
Popular Holdings Ltd	11 Dec 2009	3 for 10	0.13	27.78%	22.83%
VGO Corp. Ltd	2 Dec 2009	1 for 5	0.03	14.29%	12.20%

Precedent Rights Issue Transactions					
Company Name	**Date of announcement**	**Terms of rights issue**	**Rights issue price (S$)**	**Discount of rights issue price to LTP(1)**	**Discount of rights issue price to TERP(2)**
ASJ Holdings Ltd	24 Nov 2009	1 for 4	0.04	57.89%	52.38%
Min				**10.00%**	**8.47%**
Mean				**42.00%**	**31.93%**
Median				**43.44%**	**31.58%**
Max				**94.74%**	**92.31%**
First REIT(3)	**4 Nov 2010**	**5 for 4**	**0.50**	**47.37%**	**28.57%**

Source: Rights issue announcements of companies on SGX-ST website

Notes:

(1) Last traded price prior to the announcement date of the rights issue price.

(2) TERP (Theorectical Ex-Rights Price) = (Market capitalisation prior to the announcement date of the rights issue price + gross proceeds from the rights issue)/total shares/units outstanding after the rights issue.

(3) Based on the Latest Practicable Date.

The Independent Directors should note that certain circumstances and terms relating to the rights issue of the Rights Companies are unique and might not be identical to the Rights Issue, and are largely dependent on the market sentiments prevailing at the time of such rights issues.

The above table captures only the premium over/discount to the rights share price vis-à-vis the market price in determining an appropriate premium/discount by companies for the rights shares to induce and attract its shareholders to subscribe for their rights issues. Moreover, as First REIT may not be directly comparable to these companies in terms of size, market capitalisation, business activities, cash flow requirement, track record and prospects, the above comparison merely serves as a general guide. We also wish to highlight that only the issue price of the rights shares has been considered in the above table and no consideration is taken into account for other convertible securities (such as free warrants) or debt securities, if any, attached to the rights issues for the said Rights Companies.

In assessing the Issue Price in relation to the pricing of rights shares pursuant to rights issues by the Rights Companies, we have considered the following findings:-

(i) the Issue Price represents a discount of approximately 47.37% to the last traded price of S$0.95 as at the Latest Practicable Date, is within the range of corresponding discounts of 10.00% and 94.74% for the Rights Companies and greater than the mean discount of 42.00%; and

(ii) the Issue Price represents a discount of approximately 28.57% to the TERP of S$0.70, is within the range of corresponding discounts of 8.47% to 92.31% for the Rights Companies.

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As at the Latest Practicable Date, Lippo, through (i) its indirect wholly-owned subsidiary, Bridgewater International Ltd and (ii) the Manager, holds an aggregate indirect interest in 60,131,506 Units (comprising approximately 21.74% of the total number of Units in issue) as at the Latest Practicable Date), with Bridgewater International Ltd having a direct interest in 55,000,000 Units and the Manager having a direct interest in 5,131,506 Units.

We have analysed the following three scenarios for the purposes of assessing the potential dilutive impact of the Rights Issue:

- If all Unitholders (including the Lippo Entities) accept their Rights Entitlements in full, and the Manager receives (in its own capacity) the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units, the unitholdings of the Lippo Entities after the completion of the Rights Issue and upon the acceptance of all of their provisional allotments under the Rights Issue will be approximately 22.1% of the enlarged unitholdings after the Rights Issue and the issue of the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units ("**Whitewash Scenario 1**"). There will be no dilution in the collective unitholdings of the Independent Unitholders in Whitewash Scenario 1.

- In the scenario where the Lippo Entities subscribe for not only their Proportionate Rights Units but also subscribe for all the Commitment Rights Units pursuant to the Commitment Agreement and the Manager receives (in its own capacity) the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units, (being an aggregate of 273,481,603 Units) and assuming that the Lippo Entities do not apply for any Excess Rights Units and/or acquire any Lippo Nil-Paid Rights Units under the Rights Issue, the aggregated unitholding of the Lippo Entities immediately after the completion of the Rights Issue and upon the subscription for all of the Rights Units will be approximately 43.75% of the enlarged unitholdings after the Rights Issue and the issue of the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units ("**Whitewash Scenario 2**"). Accordingly, the collective unitholdings of the Independent Unitholders will be diluted in Whitewash Scenario 2.

- The maximum possible increase in the unitholdings of the Lippo Entities would occur in the scenario where (i) none of the other Unitholders subscribe for their Rights Entitlements, (ii) the Manager receives (in its own capacity) the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units, (iii) the Lippo Entities subscribe for all the Proportionate Rights Units pursuant to the Irrevocable Undertaking, (iv) the Lippo Entities subscribe for all of the Commitment Rights Units pursuant to the Commitment Agreement and (v) apply for and receive such maximum number of Excess Rights Units and/or acquire any Lippo Nil-Paid Rights Units under the Rights Issue, without breaching the "public" float requirement set out in Rule 723 of the Listing Manual (i.e. such that 100.0% of the Rights Units are taken up by the Lippo Entities), being an aggregate of 408,731,603 Rights Units, the aggregated unitholding of the Lippo Entities immediately after the completion of the Rights Issue will be 65.38% of the enlarged unitholdings after the Rights Issue and the issue of the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units ("**Whitewash Scenario 3**"). Accordingly, the collective unitholdings of the Independent Unitholders will be diluted in Whitewash Scenario 3.

The following table sets out the respective unitholdings of the Lippo Entities in the scenarios outlined above, based on the Rights Ratio for the Rights Issue.

	Before the Rights Issue	Immediately after the Rights Issue and issuance of the MRCCC Acquisition Fee Units and the SHLC Acquisition Fee Units		
		Whitewash Scenario 1	Whitewash Scenario 2	Whitewash Scenario 3
Issued Units	276,531,506	625,131,603	625,131,603	625,131,603
Number of Units held by the Lippo Entities	60,131,506	138,231,603	273,481,603	408,731,603
Number of Units held by Unitholders, other than the Lippo Entities	216,400,000	486,900,000	351,650,000	216,400,000
% of issued Units held by the Lippo Entities	21.74	22.11	43.75	65.38
% of Issued Units held by Unitholders, other than the Lippo Entities	78.26	77.89	56.25	34.62

The Independent Directors should note that in the event that the Whitewash Resolution is passed by a majority of the Independent Unitholders, the Lippo Entities may increase their unitholdings in First REIT in accordance with the table shown.

It is possible that the Lippo Entities may hold 50% or more of the unitholdings in First REIT after the completion of the Rights Issue. In such an event, the Lippo Entities will be in a position to exercise statutory control of First REIT. This means that the Lippo Entities will be in a position to pass ordinary resolutions on all matters in which the Lippo Entities do not have an interest in and which are tabled to Unitholders at its general meetings. As a consequence, First REIT may be a relatively less favourable target for third party offers, assuming that it is the intention of the offerors to acquire a significant interest or control in First REIT, should the Lippo Entities intend to retain majority control of First REIT.

Fee payable to Lippo in relation to the Commitment Agreement

Pursuant to the Commitment Agreement, the Joint Lead Managers and Underwriters agree to pay Lippo from the Underwriting Commission:

(i) a fee of 1.50% of the Issue Price multiplied by the number of Proportionate Rights Units of 75,164,382 Units, representing approximately 21.74% of the Rights Units (which is equivalent to approximately S$0.56 million); and

(ii) a fee of 1.50% of the Issue Price multiplied by the number of Commitment Rights Units of approximately 135,250,000 Units, representing 39.13% of the Rights Units (which is equivalent to approximately S$1.01 million),

together with any goods and services tax payable thereon (the "**Sub-Underwriting Fee**").

The Sub-Underwriting Fee payable to Lippo will be paid by the Joint Lead Managers and Underwriters from the Underwriting Commission and the percentage level of the commission payable by the Joint Lead Managers and Underwriters to Lippo pursuant to the Commitment Agreement will not be more than the percentage level of the commission which the Joint Lead Managers and Underwriters receive pursuant to the Underwriting Agreement.

In determining whether the Sub-Underwriting Fee is fair and not prejudicial to First REIT, we have considered similar sub-underwriting fees payable in recent rights issue transactions conducted by companies listed on the SGX-ST (the "**Comparable Rights Issue Transactions**"). Specifically, we have looked at sub-underwriting fees payable to major shareholders or major unitholders who have provided similar commitments to those assumed by Lippo.

It should be noted, however, that the Comparable Rights Issue Transactions may not be truly comparable to the Rights Issue in terms of the size and terms and conditions of the rights issue transaction. Furthermore, the companies represented in the Comparable Rights Issue Transactions may vary from the Rights Issue in terms of the company's composition of business activities, scale of operations, risk profile, geographical spread of activities, financial condition, track record, future prospects and other relevant criteria. Accordingly, any comparison made with respect to the Comparable Rights Issue Transactions merely serves as an illustrative guide.

Comparables: Arrangement of sub-underwriting fees payable

		Sub-underwriting fees	
Date	**Company**	**Pro rata units**	**Commitment rights units**
23 Aug 2010	AIMS AMP Capital Industrial REIT	2.00%	1.25%(1)
6 Nov 2009	AIMS AMP Capital Industrial REIT	2.00%	2.00%(2)
10 Sep 2009	Indiabulls Properties Investment Trust	1.75%	2.25%(3)
24 Aug 2009	Fortune REIT	1.75%	2.25%(4)
14 Aug 2009	Cityspring Infrastructure Trust	1.75%	2.25%(5)
30 Jun 2009	Fraser Commercial Trust	n.a.(6)	2.25%(7)
22 Jun 2009	Starhill Global REIT	1.75%	2.25%(8)
29 May 2009	CapitaCommercial Trust	1.75%	n.a.(6)
06 Mar 2009	CapitaMall Trust	1.75%	2.25%(9)

Source: Rights issue announcements of companies on SGX-ST website.

Notes:

(1) Commitment rights units defined as 100.0% of the total number of rights units less the number of the sub-underwriting unitholders' proportionate rights units.

(2) Commitment rights units defined as 20.7% of the total number of rights units less the number of the sponsor's proportionate rights units.

(3) Commitment rights units defined as 90.0% of the total number of rights units less the number of controlling unitholder's proportionate rights units.

(4) Commitment rights units defined as 43.2% of the total number of rights units less the number of sponsor *pro rata* units.

(5) Commitment rights units defined as 32.01% of the total number of rights units less the number of sponsor *pro rata* units.

(6) Denotes not applicable.

(7) Commitment rights units defined as 32.7% of the total number of rights units less the number of sponsor proportionate rights units.

(8) Commitment rights units defined as 75.0% of the total number of rights units less the number of sponsor proportionate rights units.

(9) Commitment rights units defined as 60.0% of the total number of rights units less the number of sponsor proportionate rights units.

From the table above, we note that the Sub-Underwriting Fee is in line with the sub-underwriting fees payable to major shareholders or major unitholders in recent rights issue transactions.

In addition to the above, we also note that the Directors are of the view that:

(a) the Joint Lead Managers and Underwriters have indicated that they will only underwrite the Rights Issue if Lippo enters into the Commitment Agreement and provides the Irrevocable Undertaking and that the entry into of the Commitment Agreement and the provision of the Irrevocable Undertaking will facilitate the underwriting of the Rights Issue by the Joint Lead Managers and Underwriters, thereby enhancing the chances of a successful Rights Issue; and

(b) as Lippo is making an upfront commitment, it will be assuming market risks for the entire Rights Issue period and forgoing its ability to trade its Rights Entitlements.

We are of the view that the Sub-Underwriting Fee payable to Lippo is not unreasonable and hence not prejudicial to First REIT and to other Unitholders. Our comments in this regard relate specifically to the quantum of the Sub-Underwriting Fee payable, as disclosed in the Circular.

We advise that you highlight the following factors to the Independent Unitholders, which should be considered, together with the other comments and issues raised in this Letter and the contents of the Circular.

The financial effects of the Rights Issue

The financial effects of the Transactions (which include the Rights Issue) are set out in section 7 of the Circular and are reproduced with applicable commentary as set out in the Summary of Supporting Analysis entitled "Other Considerations relating to the SHLC Acquisition" of this Letter.

Rights Units offered on a pro rata basis

The Rights Issue is offered on a *pro rata* basis to all Eligible Unitholders who will be entitled to subscribe to their provisional allotments under the Rights Issue based on their unitholdings as at the Rights Issue Books Closure Date. In addition, Eligible Unitholders are eligible to apply for Excess Rights Units in excess of their Rights Entitlements under the Rights Issue except preference will be given to the rounding of odd lots, followed by allotment to the Unitholders who are neither Substantial Unitholders nor Directors. Lippo, the Subscribing Subsidiaries, other Substantial Unitholders and Directors will rank last in priority. Accordingly, we note that the Independent Unitholders will not be disadvantaged by the Rights Issue or the process involved in the allotment of Excess Rights Units.

Offering of the Rights Issue on a renounceable basis

Eligible Unitholders will be at liberty to accept in part or in full, decline or otherwise renounce or trade (during the "nil-paid" rights trading period prescribed by the SGX-ST) their Rights Entitlements and are eligible to apply for Excess Rights Units in excess of their Rights Entitlements. Accordingly, we note that the Independent Unitholders will not be disadvantaged by the Rights Issue.

INDEPENDENT REPORTING ACCOUNTANTS' REPORT ON THE PROFIT FORECAST AND PROFIT PROJECTION

10 November 2010

The Board of Directors
Bowsprit Capital Corporation Limited
(In its capacity as manager of First REIT)
1 Phillip Street #15-00
Singapore 048692

HSBC Institutional Trust Services (Singapore) Limited
(In its capacity as Trustee of First REIT)
21 Collyer Quay, #14-01 HSBC Building
Singapore 049320

Dear Sirs

LETTER FROM THE INDEPENDENT REPORTING ACCOUNTANTS ON THE PROFIT FORECAST FOR THE FINANCIAL YEAR ENDING 31 DECEMBER 2010 AND THE PROFIT PROJECTION FOR THE FINANCIAL YEAR ENDING 31 DECEMBER 2011

For purposes of this letter, capitalised terms not otherwise defined shall have the meaning given to them in the circular dated 10 November 2010 to unitholders of First REIT

This letter has been prepared for inclusion in the Circular to Unitholders (the "Circular") issued in connection with the MRCCC Acquisition and the SHLC Acquisition (collectively, the "Acquisitions") and issuing certain Rights Units referred to in this Circular as the "Transactions".

We have examined the Profit Forecast of First REIT for the financial year ending 31 December 2010 and the Profit Projection for the financial year ending 31 December 2011 as set out on pages 49 to 53 of the Circular in accordance with Singapore Standards on Assurance Engagements applicable to the examination of prospective financial information.

The directors of Bowsprit Capital Corporation Limited (the "Directors") are responsible for the preparation and presentation of the Forecast and Projected Statements of Total Return for the financial year ending 31 December 2010 (the "Profit Forecast") and the financial year ending 31 December 2011 (the "Profit Projection") in each case with respect to First REIT as set out on pages 51 to 52 of the Circular, including their assumptions as set out on pages 49 to 51 of the Circular.

Profit Forecast

Based on our examination of the evidence supporting the assumptions, nothing has come to our attention which causes us to believe that these assumptions do not provide a reasonable basis for the Profit Forecast. Further, in our opinion the Profit Forecast, so far as the accounting policies and calculations are concerned, is properly prepared on the basis of the assumptions, is consistent with the accounting policies adopted by First REIT for its FY2009 Audited Consolidated Financial Statements, and is presented in accordance with the Singapore Financial Reporting Standards ("SFRS") (but not all the disclosures required by SFRS are made for the purpose of this letter) as issued by the Singapore Accounting Standards Council, and Statement of Recommended Accounting Practice 7 "Reporting Framework for Unit Trusts" issued by the Institute of Certified Public Accountants of Singapore which is the financial reporting framework adopted by First REIT in the preparation of its financial statements.

Profit Projection

The Profit Projection has been prepared to show a possible outcome based on the stated assumptions. As First REIT is entering into the agreements for the MRCCC Acquisition and the SHLC Acquisition (without any history of activities and because the length of the period covered by the Profit Projection extends beyond the period covered by the Profit Forecast), the assumptions used in the Profit Projection (which include hypothetical assumptions about future events and management's actions that are not necessarily expected to occur) are more subjective than would be appropriate for a profit forecast. The Profit Projection does not therefore constitute a profit forecast.

Based on our examination of the evidence supporting the relevant assumptions, nothing has come to our attention which causes us to believe that these assumptions do not provide a reasonable basis for the Profit Projection. Further, in our opinion the Profit Projection, so far as the accounting policies and calculations are concerned, is properly prepared on the basis of the assumptions, is consistent with the accounting policies set out in First REIT's FY2009 Audited Consolidated Financial Statements, and is presented in accordance with the Singapore Financial Reporting Standards (but not all the required disclosures for the purpose of this letter) as issued by the Singapore Accounting Standards Council, and Statement of Recommended Accounting Practice 7 "Reporting Framework for Unit Trusts" issued by the Institute of Certified Public Accountants of Singapore which is the financial reporting framework adopted by First REIT in the preparation of its financial statements.

Events and circumstances frequently do not occur as expected. Even if the events anticipated under the hypothetical assumptions occur, actual results are still likely to be different from the Profit Forecast and Profit Projection since other anticipated events frequently do not occur as expected and the variation may be material. The actual results may therefore differ materially from that forecast and projected. For the reasons set out above, we do not express any opinion as to the possibility of achievement of the Profit Forecast and Profit Projection.

Yours faithfully

RSM Chio Lim LLP
Public Accountants and
Certified Public Accountants
Singapore

Partner-in-charge: Kaka Singh
A member of the Institute of Certified Public Accountants of Singapore

TAX CONSIDERATIONS

The following summary of certain Singapore income tax considerations to Unitholders in respect of the Acquisitions is based upon tax laws, regulations, rulings and decisions now in effect, all of which are subject to change (possibly with retroactive effect) and announced 2010 Budget measures which are subject to enactment. The summary is not a tax advice and does not purport to be a comprehensive description of all the considerations that may be relevant to Unitholders. Unitholders should consult their own tax advisers on the tax implications that may apply to their own individual circumstances.

Singapore Income Tax

Income derived from the Properties

The rental income and other related income earned from the Properties will be received in Singapore by the relevant Singapore subsidiaries in a combination of some of the following forms:

(i) dividend income;

(ii) interest income; and

(iii) proceeds from repayment of shareholder's loans.

The dividend income received in Singapore by the relevant Singapore subsidiaries in respect of the Properties (the "**Foreign Dividend Income**") will be exempt from tax under Section 13(8) of the Income Tax Act, Chapter 134 of Singapore (the "**Income Tax Act**") provided that each of the relevant Singapore subsidiaries is a tax resident of Singapore and the following conditions are met:

(i) in the year the Foreign Dividend Income is received in Singapore, the headline corporate tax rate of the jurisdiction from which it is received is at least 15.0%;

(ii) the Foreign Dividend Income has been subjected to tax in the jurisdiction from which it is received; and

(iii) the Singapore Comptroller of Income Tax is satisfied that the tax exemption would be beneficial to the relevant Singapore subsidiary.

The relevant Singapore subsidiaries in respect of the Properties will make an application to the Inland Revenue Authority of Singapore to exempt the interest income received in Singapore in respect of the Properties from Singapore income tax under Section 13(12) of the Income Tax Act.

This tax exemption, if granted to the relevant Singapore subsidiaries, will be subject to stipulated conditions and will only apply to interest income received in Singapore on or before 31 March 2015. Unless the tax exemption is subsequently extended by the Singapore Government, any of such interest income received in Singapore after 31 March 2015 may be subject to Singapore income tax at the prevailing corporate rate of tax, currently 17.0%.

Cash that cannot be repatriated by the Indonesian Subsidiaries in the form of dividends may be used by these Indonesian Subsidiaries to repay the principal amount of shareholder's loans. The proceeds from the repayment of shareholder's loans received in Singapore by the relevant Singapore subsidiaries are capital receipts and hence not subject to Singapore income tax.

First REIT will in turn receive dividends, redemption (at cost) of preference shares or repayment of the principal amount of shareholder's loan or a combination of these from the relevant Singapore subsidiaries. Provided these Singapore subsidiaries are residents of Singapore for income tax purposes, the dividends received by First REIT will be one-tier (tax-exempt) dividends and hence exempt from Singapore income tax. The proceeds from redemption (at cost) of preference shares and repayment of shareholder's loan received by First REIT are capital receipts and not subject to Singapore income tax.

Distributions to Unitholders

Distributions made by First REIT out of the income or cashflow generated from the Properties may comprise either or both of the following two components:

(i) tax-exempt income component ("**Tax-Exempt Income Distributions**"); and

(ii) capital component ("**Capital Distributions**").

Tax-Exempt Income Distributions refer to distributions made by First REIT out of its tax-exempt income (which comprises mainly the one-tier (tax-exempt) dividends that it will receive from the relevant Singapore subsidiaries). Such distributions are exempt from Singapore income tax in the hands of Unitholders. No tax will be deducted at source on such distributions.

For this purpose, the amount of Tax-Exempt Income Distributions that First REIT can distribute for a distribution period will be to the extent of the amount of tax-exempt income that it has received and is entitled to receive in that distribution period. Any distribution made for a distribution period out of profits or income which First REIT is entitled to receive as its own tax-exempt income after the end of that distribution period will be treated as a capital distribution and the tax treatment described in the next paragraph on "Capital Distributions" will apply. The amount of such tax-exempt income that is subsequently received may be used to frank tax-exempt income distributions for subsequent distribution periods.

Capital Distributions refer, *inter alia*, to distributions made by First REIT out of proceeds received from the redemption of preference shares or repayment of shareholder's loan, as the case may be. Unitholders will not be subject to Singapore income tax on such distributions. These distributions are treated as returns of capital for Singapore income tax purposes and the amount of Capital Distributions will be applied to reduce the cost of Units held by Unitholders. Accordingly, the reduced cost base will be used for the purpose of calculating the amount of taxable trading gains for those Unitholders who hold Units as trading or business assets and are liable to Singapore income tax on gains arising from the disposal of Units. If the amount of Capital Distributions exceeds the cost or the reduced cost, as the case may be, of Units, the excess will be subject to tax as trading income of such Unitholders.

INDEPENDENT INDONESIAN TAXATION REPORT

pb
Taxand

Jakarta, 24 September 2010

Letter No. THR - 0027

The Board of Directors
Bowsprit Capital Corporation Limited
As Manager (the "Manager") of First Real Estate Investment Trust
1 Phillip Street #15-00
Singapore 048692

HSBC Institutional Trust Services (Singapore) Limited
As Trustee of First Real Estate Investment Trust
21 Collyer Quay
#10-01 HSBC Building
Singapore 049320

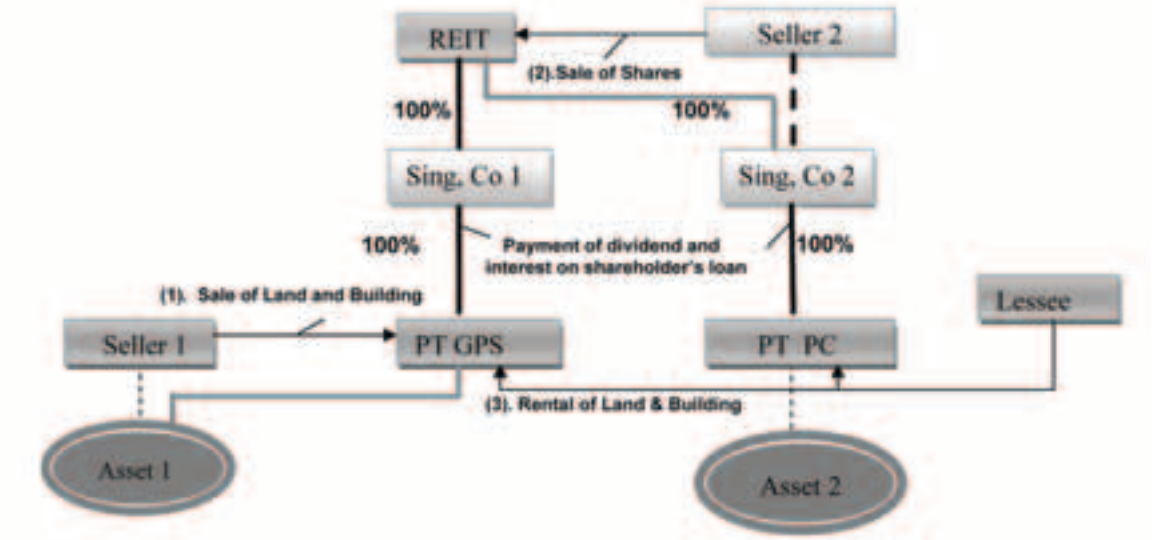
Dear Sirs,

Re: Tax Implications on acquisition of Land& Building and Shares by First REIT

This letter has been prepared for First REIT, a Real Estate Investment Trust, to be included in the submission for Singapore Exchange Securities Trading Limited (the "SGX-ST"). The purpose of this letter is to provide a general overview of the Indonesian tax implications attributable to the transactions by First REIT ("REIT") in Indonesia.

Herewith please find below our tax opinion on the above matter:

Transaction Scheme:



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Notes :

Sing. Co1 : - **Platinum Strategic Investments Pte. Ltd (95% ownership); and**
- **Ultra Investment Pte. Ltd (5% ownership)**

Sing. Co2 : - **Gold Capital Pte. Ltd (95% ownership); and**
- **Higrade Capital P/L (5% ownership)**

Fact :

"(1) & (2)" :
REIT intends to acquire the following
- The land and building of Siloam Hospital Lippo Cikarang ("SHLC") from PT East Jakarta Medika ("PT EJM") through its subsidiary PT Graha Pilar Sejahtera ("PT GPS");
- "Sing Co 2" from Seller 2. Since the land and building of Mochtar Riady Comprehensive Cancer Center ("MRCCC") belong to PT Primalama Cemerlang ("PT PC") which is 100% owned by Sing Co 2. REIT will be the owner of PT PC upon the acquisition of Sing Co 2.

"(3)" : Lessee will lease land and building of SHLC and MRCCC from PT GPS and PT PC, respectively (together will be known as "Lessors")

Discussion:

A. Purchase of Land and Building from PT EJM by PT GPS

- **PT GPS**

Land and Building Acquisition Tax
The purchase of land and building from PT EJM by PT GPS is subject to the land and building acquisition tax at the rate of 5%, whichever is higher between the purchase price or the Sale Value of the Tax Object (NJOP) as determined by the Indonesian Regional Tax Office

Value Added Tax (VAT)
PT GPS will be charged VAT at the rate of ten per cent (10%) on the purchase of land and building by PT EJM. However, the VAT charges by PT EJM will be treated as input VAT, which can be used to offset the output VAT from rental income of PT GPS.

B. Rent of Land and/or Building by Lessee to Lessors

- Lessors

Corporate Income Tax
The rental income (including the service charge, if any) from Lessors is subject to final income tax, as stated in Article 4 paragraph 2 of the Income Tax Law
The imposition of final income tax does not mean that the income from the lease of land and/or building does not need to be reported in the annual income tax return (*SPT PPh*). The income still needs to be reported in the income tax return, but it does not need to be combined with the other income which is not subject to final income tax in the calculation of the taxable income in the relevant tax year

Value Added Tax on the Rent of Land and/or Buildings
Lessors must charge VAT on the rent of land and/or building including service charge (if any) to Lessee at the rate of ten per cent (10%)

- Lessee

Article 4(2) Withholding Income Tax
The payment of rental on land and/or buildings leased by Lessee to Lessors will be subject to a final income tax at the rate of ten (10) per cent on the gross value of the rental of land and/or building, including the service charge (if any)

C. Payment of Dividends from PT GPS and PT PC to Sing,Co1 & Sing,Co 2

- PT GPS and PT PC

Value Added Tax on Payment of Dividend
There will be no VAT on the payment of dividend

Article 26 Withholding Income Tax on Payment of Dividend
The Indonesian tax laws generally require a twenty (20) per cent tax to be withheld on the payment of dividend from an Indonesian taxpayer to an offshore taxpayer. Under the tax treaty between Singapore and Indonesia, the rate of withholding tax is reduced to ten (10) per cent on the payment of dividend

The reduced withholding tax rate of ten (10) per cent set out in the Singapore-Indonesia tax treaty can be used on the payment of dividend by PT GPS and PT PC to Sing. Co1 and Sing. Co2 if Sing. Co1 and Sing. Co2 can fulfill the conditions set out in Article 4 paragraph 2 of Director General of Taxes Regulation No. 52/PJ./2009 dated November 5, 2009 which has been

amended by Director General of Taxes Regulation No 25/PJ/2010 dated April 30 2010 regarding the *Prevention of Tax Treaty Abuse*:

1 The company is established in the tax treaty partner country or has a structure/scheme transaction arrangement which is not solely intended to take advantage of a tax treaty benefit, and
2 Its operation is managed by the management itself who has sufficient authority to do transactions and
3 The company has employees; and
4 The company has activities or active business; and
5 The Indonesia sourced income is subject to tax in the recipient country, and
6 The company does not use more than fifty percent (50%) of its total income to fulfill its obligations to other parties in the form of interest royalty or other types of compensation

and Sing. Co1 and Sing. Co2 must submit the original copy of its Certificate of Domicile (DGT Form 1) to PT GPS and PT PC to demonstrate that it is the beneficial owner of the dividend payment

Indonesian tax laws do not regulate when a dividend should be declared Meanwhile, the time when dividend can be declared and remitted by PT GPS and PT PC to the Sing Co1 and Sing. Co2 should be in accordance to the rules set out in the Indonesian General Accepted Accounting Principle ("GAAP")

There is no need for the PT GPS and PT PC to obtain tax clearance in order to declare or remit dividends

D. **Payment of Shareholders' Loans**

- **PT GPS and PT PC**

The Repayment of Principal from Shareholders' loans
The repayment of principal from the shareholder's loans will not be subject to any form of Indonesian tax

Interest on shareholders' loan
The Indonesian tax rules generally require a twenty (20) per cent tax to be withheld on the payment of interest from an Indonesian taxpayer to an offshore taxpayer. Under the tax treaty between Singapore and Indonesia, the rate of withholding tax is reduced to ten (10) per cent on the payment of interest

The reduced withholding tax rate of ten (10) per cent set out in the Singapore-Indonesia tax treaty can be used on the payment of interest by PT GPS and PT PC to Sing. Co1 and Sing. Co2 if Sing. Co1 and Sing. Co2 can fulfill the conditions set out in Article 4 paragraph 2 of Director General of Taxes Regulation No. 62/PJ./2009 dated November 5, 2009 which has been amended by Director General of Taxes Regulation No. 25/PJ/2010 dated April 30, 2010 regarding the *Prevention of Tax Treaty Abuse*.

1. The company is established in the tax treaty partner country or has a structure/scheme transaction arrangement which is not solely intended to take advantage of a tax treaty benefit; and
2. Its operation is managed by the management itself who has sufficient authority to do transactions, and
3. The company has employees, and
4. The company has activities or active business and
5. The Indonesia sourced income is subject to tax in the recipient country, and
5. The company does not use more than fifty percent (50%) of its total income to fulfil its obligations to other parties in the form of interest, royalty or other types of compensation

and Sing. Co1 and Sing. Co2 must submit the original copy of its Certificate of Domicile (DGT Form 1) to PT GPS and PT PC to demonstrate that it is a beneficial owner of the interest payment.

There is no need for the PT GPS and PT PC to obtain tax clearance in order to remit interest

E. Sale of shares of Sing. Co2 by Seller 2 to REIT

PT PC

In the latest amendment of the Indonesian Income Tax Law, **the sale of shares of conduit company or special purpose company** that is established in the country **which provides tax protection (tax haven country)** that has a special relationship with an entity that is established in Indonesia, can be deemed as the sale of share of an entity that is established in Indonesia which is subject to final tax at the effective rate of five (5) per cent of the selling price. The final income tax on the alienation of shares must be borne by PT PC

Until now, the Indonesian Tax Office has not yet issued the list of countries which are considered as tax haven countries. However, in year 2009, the Indonesian Tax Office has issued a regulation which stipulates the criteria of a tax haven country, which are as follows

a. A country which imposes low tax rates or a country which does not impose income tax; or

b. A country which applies bank confidentiality policy **and** does not perform exchange of information

- A country considered to be imposing low tax rates is a country which imposes tax rates on income below fifty (50) per cent of the corporate income tax rate in Indonesia (for year 2010 below 12.5%)

- A country which applies bank confidentiality policy and does not perform exchange of information is a country or jurisdiction which based on its laws prohibits the supply of customer information including for the purpose of information related to taxation

Sing. Co2 must fulfill the conditions set out in Article 4 paragraph 2 of Director General of Taxes Regulation No. 62/PJ/2009 dated November 5, 2009 which has been amended by Director General of Taxes Regulation No. 25/PJ/2010 dated April 30, 2010 regarding the Prevention of Tax Treaty Abuse then Sing. Co2 will not be categorized as a conduit company or a special purpose company, and there will be no tax implication in Indonesia related to the alienation of shares by Seller2 to REIT

A company is not considered as a special purpose vehicle if it meets the following conditions:

1 The company is established in the tax treaty partner country or has a structure/scheme transaction arrangement which is not solely intended to take advantage of a tax treaty benefit, and
2 Its operation is managed by the management itself who has sufficient authority to do transactions, and
3 The company has employees, and
4 The company has activities or active business; and
5 The Indonesia sourced income is subject to tax in the recipient country; and
6 The company does not use more than fifty percent (50%) of its total income to fulfill its obligations to other parties in the form of interest, royalty or other types of compensation

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Should you have any questions regarding this matter, please do not hesitate to contact us

Sincerely yours

M. Hariansyah
Partner

NOTICE OF EXTRAORDINARY GENERAL MEETING

NOTICE IS HEREBY GIVEN that an EXTRAORDINARY GENERAL MEETING of First Real Estate Investment Trust ("**First REIT**") will be held at 2.00 p.m. on 29 November 2010 at Mandarin Ballroom 2, Level 6, Main Tower, Mandarin Orchard Singapore, 333 Orchard Road, Singapore 238867 for the purpose of considering and, if thought fit, passing, with or without modifications, the following resolutions:

ORDINARY RESOLUTION

1. THE PROPOSED MRCCC ACQUISITION

That subject to and contingent upon the passing of Resolutions 2, 3 and 4:

(i) approval be and is hereby given for the acquisition of Mochtar Riady Comprehensive Cancer Centre ("**MRCCC**") by First REIT through the acquisition of the entire issued share capital of Gold Capital Pte. Ltd. (which, directly and through its wholly-owned subsidiary, Higrade Capital Pte. Ltd., wholly-owns PT Primatama Cemerlang ("**PC**") which in turn holds MRCCC) from Wincatch Limited ("**Wincatch**") at the purchase consideration described in the circular dated 10 November 2010 issued by Bowsprit Capital Corporation Limited (in its capacity as manager of First REIT (the "**Manager**") to holders of units in First REIT ("**Unitholders**" and the circular issued to Unitholders, the "**Circular**")) and on the terms and conditions set out in the sale and purchase agreement dated 8 November 2010 entered into between HSBC Institutional Trust Services (Singapore) Limited (in its capacity as trustee of First REIT) (the "**Trustee**") and Wincatch, and for payment of all fees and expenses relating to the MRCCC Acquisition (as described in the Circular);

(ii) approval be and is hereby given for First REIT to grant (through PC) the MRCCC Master Lease (as defined in the Circular and which constitutes an "interested party transaction" under Chapter 9 of the Listing Manual of Singapore Exchange Securities Trading Limited (the "**SGX-ST**" and the Listing Manual of the SGX-ST, the "**Listing Manual**")) to PT Lippo Karawaci Tbk ("**Lippo**") on the terms and conditions set out in the master lease agreement dated 8 November 2010 entered into between PC and Lippo; and

(iii) the Manager, any director of the Manager and the Trustee be and are hereby severally authorised to complete and do all such acts and things (including executing all such documents as may be required) as the Manager, such director of the Manager or, as the case may be, the Trustee may consider expedient or necessary or in the interests of First REIT to give effect to the MRCCC Acquisition and the MRCCC Master Lease.

ORDINARY RESOLUTION

2. THE PROPOSED SHLC ACQUISITION

That subject to and contingent upon the passing of Resolutions 1, 3 and 4:

(i) approval be and is hereby given for the acquisition of Siloam Hospitals Lippo Cikarang ("**SHLC**") by First REIT through the acquisition of SHLC from PT East Jakarta Medika, which is 90.8% owned by Lippo, at the purchase consideration described in the Circular and on the terms and conditions set out in the sale and purchase agreement dated 8 November 2010 entered into between PT Graha Pilar Sejahtera ("**GPS**"), an indirect wholly-owned subsidiary of First REIT, and Lippo, and for payment of all fees and expenses relating to the SHLC Acquisition (as described in the Circular), such acquisition being an "interested person transaction" (as defined in the Listing Manual) as well as an "interested party transaction" (as defined in Appendix 2 of the Code on Collective Investment Schemes issued by the Monetary Authority of Singapore in relation to real estate investment trusts);

(ii) approval be and is hereby given for First REIT to grant (through GPS) the SHLC Master Lease (as defined in the Circular and which constitutes an Interested Person Transaction under Chapter 9 of the Listing Manual) to Lippo on the terms and conditions set out in the master lease agreement dated 8 November 2010 entered into between GPS and Lippo; and

(iii) the Manager, any director of the Manager and the Trustee be and are hereby severally authorised to complete and do all such acts and things (including executing all such documents as may be required) as the Manager, such director of the Manager or, as the case may be, the Trustee may consider expedient or necessary or in the interests of First REIT to give effect to the SHLC Acquisition and the SHLC Master Lease.

ORDINARY RESOLUTION

3. THE PROPOSED RIGHTS ISSUE

That subject to and contingent upon the passing of Resolutions 1, 2 and 4:

(i) approval be and is hereby given for the issue of new units in First REIT ("**Rights Units**") under the renounceable and underwritten rights issue (the "**Rights Issue**") on a basis of five (5) Rights Units for every four (4) existing units in First REIT ("**Units**", and the basis of the Rights Issue, the "**Rights Ratio**") held as at 5.00 p.m. on 3 December 2010, being the time and date to be determined by the directors of the Manager for the purpose of determining the Unitholders' entitlements under the Rights Issue (the "**Rights Issue Books Closure Date**"), in the manner described in the Circular;

(ii) the Rights Issue shall be carried out on the terms of and subject to the conditions set out below and/or otherwise on such terms and conditions as the Manager deems fit:

(a) that the provisional allotments of the Rights Units under the Rights Issue shall be made on a renounceable and underwritten basis to Unitholders with Units standing to the credit of their securities accounts with The Central Depository (Pte) Limited ("**CDP**") and (I) whose registered addresses with CDP are in Singapore as at the Rights Issue Books Closure Date or who have, at least three Market Days[1] prior to the Rights Issue Books Closure Date, provided CDP with addresses in Singapore for the service of notices and documents or (II) who the Manager in consultation with the Joint Lead Managers and Underwriters (as defined below) considers, in its sole discretion, may be offered Rights Units without breaching applicable securities laws ("**Eligible Unitholders**");

(b) no provisional allotment of Rights Units shall be made in favour of Unitholders other than Eligible Unitholders;

(c) the provisional allotments of Rights Units not taken up or allotted for any reason shall be used to satisfy applications for Excess Rights Units[2] (if any) as the Manager may, in its discretion, deem fit; and

(d) the Rights Issue shall be underwritten by Oversea-Chinese Banking Corporation Limited and Credit Suisse (Singapore) Limited, as the joint lead managers and underwriters for the Rights Issue (the "**Joint Lead Managers and Underwriters**"), on the terms of the underwriting agreement entered into between the Manager and the Joint Lead Managers and Underwriters on 8 November 2010, and

(iii) the Manager and any director of the Manager be and are hereby severally authorised to complete and do all such acts and things (including executing all such documents as may be required) as the Manager or such director of the Manager may consider expedient or necessary or in the interests of First REIT to give effect to the Rights Issue and to allow

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1 "**Market Day**" refers to any day (other than a Saturday, Sunday or gazetted public holiday) on which commercial banks are open for business in Singapore and the SGX-ST is open for trading.

2 "**Excess Rights Units**" means the Rights Units represented by the provisional allotments (A) of (i) Eligible Unitholders who decline, do not accept, and elect not to renounce or sell their Rights Entitlements under the Rights Issue (during the "nil-paid" rights trading period prescribed by the SGX-ST) and/or (ii) Ineligible Unitholders (as defined in the Circular) which have not been sold during the "nil-paid" rights trading period or (B) that have not been validly taken up by the original allottees, renouncees of the provisional allotments or the purchasers of the "nil-paid" rights units.

the Rights Units to participate in any distributions which may accrue for the period from 1 October 2010 to 31 December 2010, notwithstanding that the Rights Units is expected to be issued sometime in December 2010.

ORDINARY RESOLUTION

4. THE PROPOSED WHITEWASH RESOLUTION

That subject to the conditions in the letter from the Securities Industry Council dated 4 November 2010 being fulfilled, Unitholders, other than Lippo, parties acting in concert with it and parties which are not independent of Lippo, hereby (on a poll taken) waive their rights to receive a mandatory offer from Lippo and parties acting in concert with it, which includes:

(i) the subsidiary of Lippo which hold either a direct or indirect interest in Units, being Bridgewater International Ltd;

(ii) Bowsprit Capital Corporation Limited; and

(iii) any one or more subsidiaries of Lippo whether existing or to be incorporated by Lippo,

(collectively the "**Subscribing Subsidiaries**"), for all the remaining issued Units not owned or controlled by Lippo and parties acting in concert with it, in the event that they incur a mandatory bid obligation pursuant to Rule 14 of the Singapore Code on Take-overs and Mergers as a result of:

(a) Lippo and the Subscribing Subsidiaries acquiring Rights Units through:

(i) taking up provisional allotments of Rights Units issued and allotted to them; and/or

(ii) if applicable, through applying for Excess Rights Units (as defined in the Circular); and/or

(iii) if applicable, acquiring "nil-paid" rights entitlements on the open market during the "nil-paid" rights trading period or otherwise by way of private arrangement and subsequently exercising the "nil-paid" rights entitlements to acquire Rights Units; and/or

(b) Lippo and the Subscribing Subsidiaries subscribing for Rights Units pursuant to the commitment agreement dated 8 November 2010 entered into between Lippo and the Joint Lead Managers and Underwriters; and/or

(c) the receipt in Units by Bowsprit Capital Corporation Limited of the acquisition fee in relation to the acquisition of SHLC and/or MRCCC.

BY ORDER OF THE BOARD
Bowsprit Capital Corporation Limited
(as manager of First Real Estate Investment Trust)
Company Registration No. 200607070D

Elizabeth Krishnan
Company Secretary
Singapore
10 November 2010

Notes:

(1) A Unitholder of First REIT entitled to attend and vote at the Extraordinary General Meeting is entitled to appoint not more than two proxies to attend and vote in his stead. A proxy need not be a Unitholder of First REIT.

(2) The instrument appointing a proxy must be deposited at the office of the Unit Registrar at 50 Raffles Place, #32-01 Singapore Land Tower, Singapore 048623 not less than 48 hours before the time appointed for the Extraordinary General Meeting.

FIRST REAL ESTATE INVESTMENT TRUST

(Constituted in the Republic of Singapore
pursuant to a trust deed dated 19 October 2006 (as amended))

IMPORTANT

1. For investors who have used their CPF money to buy units in First REIT, this Circular is forwarded to them at the request of their CPF Approved Nominees and is sent FOR INFORMATION ONLY.
2. This Proxy Form is not valid for use by CPF Investors and shall be ineffective for all intents and purposes if used or is purported to be used by them.
3. **CPF investors who wish to attend the Extraordinary General Meeting as observers have to submit their requests through their respective CPF Approved Nominees so that their CPF Approved Nominees may register with the Unit Registrar.**
4. **PLEASE READ THE NOTES TO THE PROXY FORM.**

PROXY FORM
EXTRAORDINARY GENERAL MEETING

I/We _____
(Name)

of _____
(Address)

being a unitholder/unitholders of First Real Estate Investment Trust ("**First REIT**"), hereby appoint:

Name	Address	NRIC/Passport Number	Proportion of Unitholdings	
			No. of Units	%

and/or (delete as appropriate)

Name	Address	NRIC/Passport Number	Proportion of Unitholdings	
			No. of Units	%

or, both of whom failing, the Chairman of the Extraordinary General Meeting as my/our proxy/proxies to attend and to vote for me/us on my/our behalf and if necessary, to demand a poll, at the Extraordinary General Meeting of First REIT to be held at Mandarin Ballroom 2, Level 6, Main Tower, Mandarin Orchard Singapore, 333 Orchard Road, Singapore 238867 on 29 November 2010 at 2.00 p.m. and any adjournment thereof. I/We direct my/our proxy/proxies to vote for or against the resolutions to be proposed at the Extraordinary General Meeting as indicated hereunder. If no specific direction as to voting is given, the proxy/proxies will vote or abstain from voting at his/their discretion, as he/they will on any other matter arising at the Extraordinary General Meeting.

No.	Resolutions	To be used on a show of hands		To be used in the event of a poll	
		For *	Against *	No. of Votes For **	No. of Votes Against **
	ORDINARY RESOLUTION				
1.	To approve the MRCCC Acquisition (Resolution 1) (Conditional upon Resolutions 2, 3 and 4 being passed)				
2.	To approve the SHLC Acquisition (Resolution 2) (Conditional upon Resolutions 1, 3 and 4 being passed)				
3.	To approve the Rights Issue (Resolution 3) (Conditional upon Resolutions 1, 2 and 4 being passed)				
4.	To approve the Whitewash Resolution (Resolution 4)				

* If you wish to exercise all your votes "For" or "Against", please tick (√) within the box provided.

** If you wish to exercise all your votes "For" or "Against", please tick (√) within the box provided. Alternatively, please indicate the number of votes as appropriate.

Dated this _____ day of _____ 2010

Total number of Units held

_____
Signature(s) of Unitholder(s)/Common Seal

IMPORTANT: PLEASE READ THE NOTES TO PROXY FORM BELOW

Notes to Proxy Form

1. A unitholder of First REIT ("**Unitholder**") entitled to attend and vote at the Extraordinary General Meeting is entitled to appoint one or two proxies to attend and vote in his stead.
2. Where a Unitholder appoints more than one proxy, the appointments shall be invalid unless he specifies the proportion of his holding (expressed as a percentage of the whole) to be represented by each proxy.
3. A proxy need not be a Unitholder.
4. A Unitholder should insert the total number of Units held. If the Unitholder has Units entered against his name in the Depository Register maintained by The Central Depository (Pte) Limited ("**CDP**"), he should insert that number of Units. If the Unitholder has Units registered in his name in the Register of Unitholders of First REIT, he should insert that number of Units. If the Unitholder has Units entered against his name in the said Depository Register and registered in his name in the Register of Unitholders, he should insert the aggregate number of Units. If no number is inserted, this form of proxy will be deemed to relate to all the Units held by the Unitholder.
5. The instrument appointing a proxy or proxies or the power of attorney or other authority under which it is signed or a notarially certified copy of such power of attorney must be deposited at the office of the Unit Registrar at 50 Raffles Place, #32-01 Singapore Land Tower, Singapore 048623 not less than 48 hours before the time set for the Extraordinary General Meeting.
6. The instrument appointing a proxy or proxies must be under the hand of the appointor or of his attorney duly authorised in writing. Where the instrument appointing a proxy or proxies is executed by a corporation, it must be executed either under its common seal or under the hand of its attorney or a duly authorised officer.

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Affix
Postage
Stamp

The Unit Registrar of First REIT
Boardroom Corporate & Advisory Services Pte. Ltd.
50 Raffles Place
#32-01 Singapore Land Tower
Singapore 048623

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7. Where an instrument appointing a proxy is signed on behalf of the appointor by an attorney, the power of attorney or a duly certified copy thereof must (failing previous registration with the Manager) be lodged with the instrument of proxy; failing which the instrument may be treated as invalid.
8. A corporation which is a Unitholder may authorise by resolution of its directors or other governing body such person as it thinks fit to act as its representative at the Extraordinary General Meeting and the person so authorised shall upon production of a copy of such resolution certified by a director of the corporation to be a true copy, be entitled to exercise the powers on behalf of the corporation so represented as the corporation could exercise in person if it were an individual.
9. The Manager shall be entitled to reject the instrument appointing a proxy or proxies or a Proxy Form which is incomplete, improperly completed or illegible or where the true intentions of the appointor are not ascertainable from the instructions of the appointor specified on the instrument of proxy or the Proxy Form. In addition, in the case of Units entered in the Depository Register, the Manager may reject any instrument of proxy or Proxy Form if the Unitholder, being the appointor, is not shown to have Units entered against his name in the Depository Register as at 48 hours before the time appointed for holding the Extraordinary General Meeting, as certified by CDP to the Manager.
10. All Unitholders will be bound by the outcome of the Extraordinary General Meeting regardless of whether they have attended or voted at the Extraordinary General Meeting.
11. At any meeting, a resolution put to the vote of the meeting shall be decided on a show of hands unless a poll is (before or on the declaration of the result of the show of hands) demanded by the Chairman or by five or more Unitholders present in person or by proxy, or holding or representing one-tenth in value of the Units represented at the meeting. Unless a poll is so demanded, a declaration by the Chairman that such a resolution has been carried or carried unanimously or by a particular majority or lost shall be conclusive evidence of the fact without proof of the number or proportion of the votes recorded in favour of or against such resolution.
12. On a show of hands, every Unitholder who (being an individual) is present in person or by proxy or (being a corporation) is present by one of its officers as its proxy shall have one vote. On a poll, every Unitholder who is present in person or by proxy shall have one vote for every Unit of which he is the Unitholder. A person entitled to more than one vote need not use all his votes or cast them the same way.
13. CPF Approved Nominees acting on the request of the CPF investors who wish to attend the Extraordinary General Meeting as observers are requested to submit in writing, a list with details of the CPF Investors' names, NRIC/Passport numbers, addresses and number of Units held. The list, signed by an authorised signatory of the relevant CPF Approved Nominees, should reach the office of the Unit Registrar, Boardroom Corporate & Advisory Services Pte. Ltd. at 50 Raffles Place #32-01, Singapore Land Tower, Singapore 048623, at least 48 hours before the time appointed for holding the Extraordinary General Meeting.

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FIRST REIT

FIRST REAL ESTATE INVESTMENT TRUST

Managed By:

Bowsprit Capital

BOWSPRIT CAPITAL CORPORATION LIMITED
1 Phillip Street, #15-00, Singapore 048692
Tel: (65) 6435 0168 Fax: (65) 6435 0167

Website: www.first-reit.com