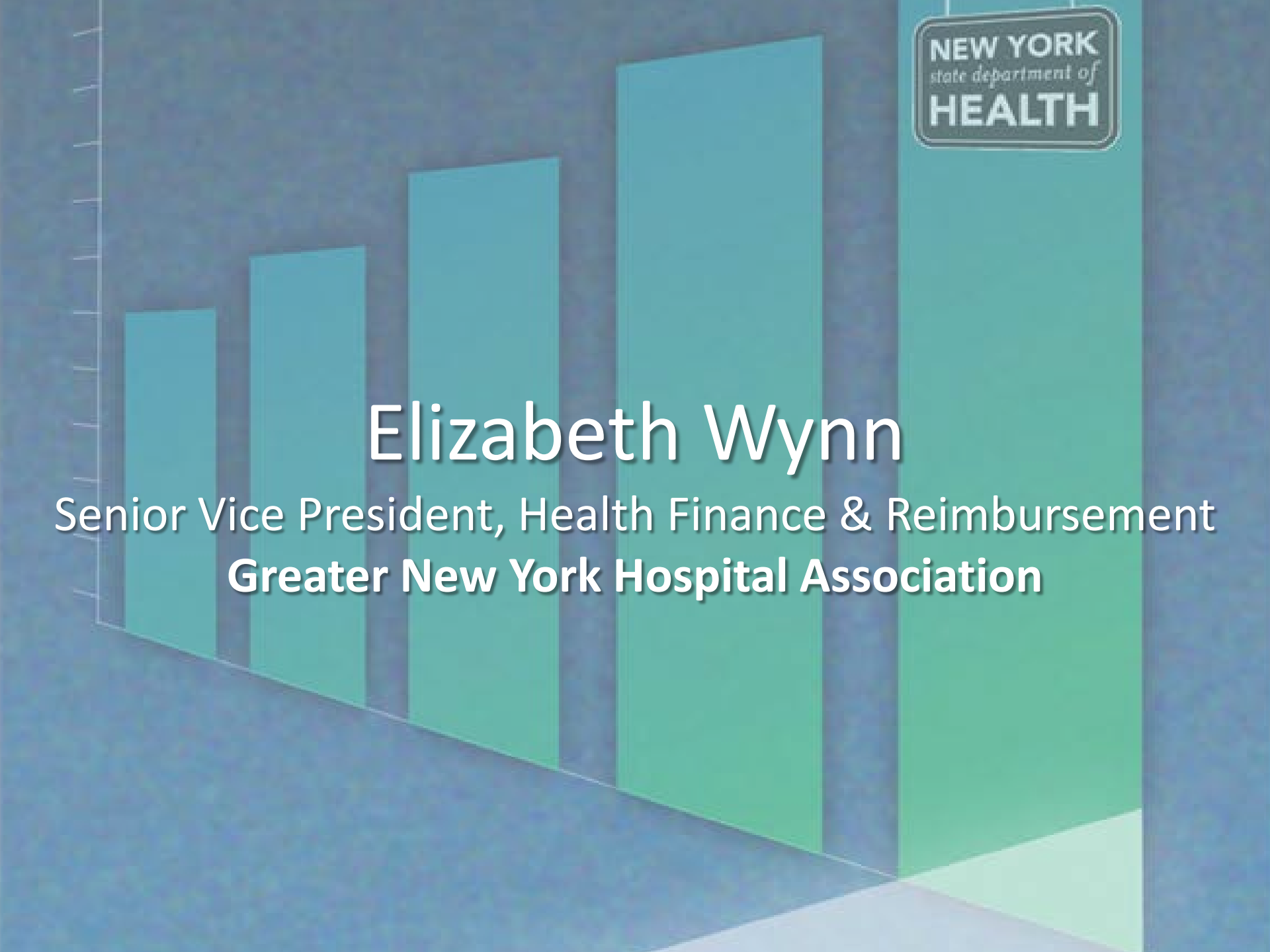
Improving Capital Access

for Health Care Providers in New York State

Nirav R. Shah, M.D., M.P.H.

Commissioner of Health

New York State Department of Health



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Senior Vice President, Health Finance & Reimbursement

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LeadingAge New York

Improving Capital Access for Health Care Providers in New York State:

A Long Term Care and Senior Services Perspective

Dan Heim
LeadingAge New York
October 2, 2012

LeadingAge™ New York
formerly NYAHSA

Need for Capital in LTC

- Aging facilities, many built in 1970s
- New development costs high
- Lagging in HIT and other infrastructure
- Lack of access a barrier to entry to new service lines/business models
- Critical shortages of affordable senior housing and assisted living in many areas
  - HUD funding for new development disappearing

Access to Capital for LTC

- Most LTC providers are not investment grade rated borrowers
  - Typically need credit enhancement (mortgage insurance, LOCs, etc.)
- More stringent underwriting by lenders and insurers
- Fewer lenders and insurers in general
- Medicaid managed care is a concern
  - No assurance of capital cost reimbursement

Access to Capital for LTC

- Recommendations:
  - Gap financing/funding for supportive senior housing
  - Rationalize Medicaid capital reimbursement
    - Carve out of managed care payments to nursing homes
    - Enhance for assisted living programs
  - Facilitate access to small loans for technology and building projects
  - Consider social impact bonds
  - Reauthorize IDA financing authority for senior living facilities

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President and Chief Executive Officer

New York State Health Facilities Association, Inc.

Capital Access for Healthcare Providers in NY State

From the Skilled Nursing and Assisted Living Perspective

Richard J. Herrick
President & CEO, NYSHFA

October 2, 2012

Barriers to Capital Formation

- Timeliness of Regulatory Approvals
- NY "Risks" seem higher…are they?
- Capital Investment faces Road Blocks
- "Perception / Reality"

NEW YORK STATE NYSHFA HEALTH FACILITIES ASSOCIATION, INC.

Let's Talk

- Public Companies
- Private Equity
- Withdrawal of Equity
- Master Leases
- Cross Collateralization
- 25% Equity
- Management Companies
- Tort Reform

Meeting Tomorrow's Needs

- Facility Replacement & Upgrade
- Health Information Technology
- Assisted Living Program Capital
- Program Change

How Can NY Attract Capital?

- Create Capital Friendly Environment
- Create a New York Capital Forum
- Ask, "What Would Make NY More Attractive to Capital Investors?"
- How do we encourage "sweat equity"? (The value of expertise and contribution of effort.)

SEIZE THE OPPORTUNITY

- Large Amounts of Capital are waiting to go to work in New York
- Cost of Capital - historically low

NEW YORK STATE
NYSHFA
HEALTH FACILITIES ASSOCIATION, INC.

To further the Discussion:

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CHCANYS

Community Health Care Association of New York State

PRIMARY CARE CAPITAL

Opportunities and Challenges

Improving Capital Access for Health Care Providers in New York State

A Forum Sponsored by NYS Department of Health
October 2, 2012

Elizabeth Swain
President & CEO
Community Health Care Association of New York State

Defining New Directions

Overview

- Historically, investment in primary and preventive care has been secondary to investment in institutional care.
- New York State is leading our health system transformation with a new focus on primary care and the triple aim of better care, better health, and lower costs
- Federal investment in primary care expansion through Medicaid expansions in states and through doubling of the FQHC system nationally
- Significant payer shifts to recognize the importance of primary care
  - Medicare to penalize hospitals for hospital admissions and readmissions, inappropriate ER utilization
  - Commercial payers and employers implementing carrot and stick programs to encourage primary care, disease management, wellness and preventive services, and to discourage harmful behaviors
  - NYS Medicaid 1115 Waiver: Would invest $1.25 B specifically to increase access to primary care

New York's Reform Efforts:
Focus on Primary Care

New York's efforts to rebalance the health care system requires a shift of capital resources toward community based primary care, and collaboration with other providers.

This means:

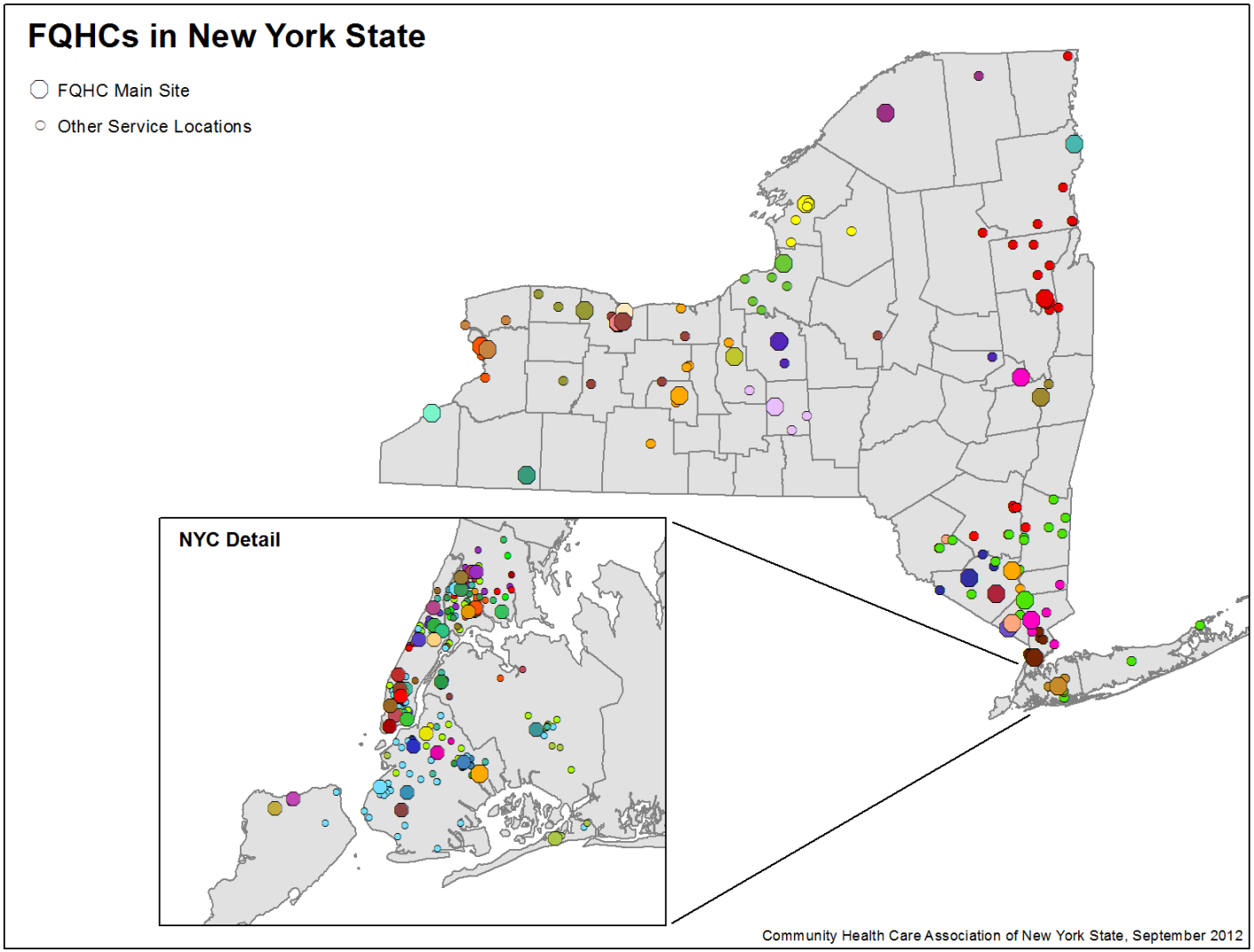
- Expansion
- Renovation
- Re-engineering
- HIT

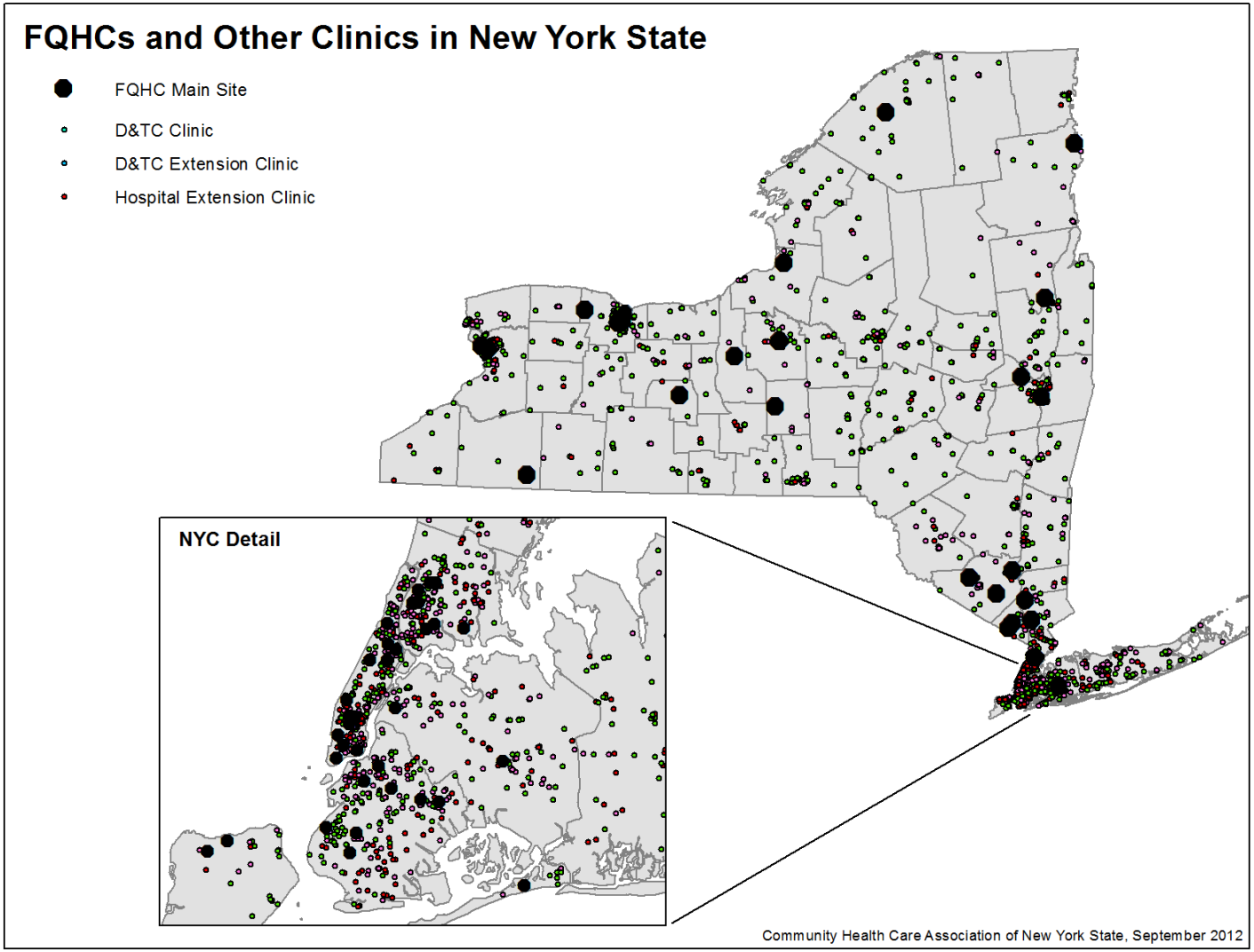
Primary Care Providers

- Federally Qualified Health Centers
- FQHC “Look-Alikes”
- Free-standing Diagnostic & Treatment Centers and Extension Clinics
- Primary Care Physician practices
- EDs and Hospitals
- Other

FQHCs in NYS

- 61 organizations operating over 500 sites
- Staffed by over 10,500 FTEs in 2011
- Serving 1.5 million patients, with 6.9 million visits
- One in four are uninsured; half covered by Medicaid or CHPlus
- 115,000 homeless or migrant/seasonal workers
- 1/5th best served in language other than English
- NYS exceeded nation on quality measures for timely prenatal care, PAP tests, diabetes control, documenting & counseling on BMI


FQHCs in New York State
FQHC Main Site
Other Service Locations
NYC Detail
Community Health Care Association of New York State, September 2012


FQHCs and Other Clinics in New York State
FQHC Main Site
D&TC Clinic
D&TC Extension Clinic
Hospital Extension Clinic
NYC Detail
Community Health Care Association of New York State, September 2012

FQHCs Capital Needs

- Address primary care “deserts” across the State of NY through targeted capital development based upon planning research
- Goal to increase capacity across the state to serve 3 million people by 2015 in partnership with NYS and to leverage national Affordable Care Act FQHC provisions
- At least $1 billion in capital investment needed to finance existing projects
- New projects will be in the $5 - $20 million range, with some much smaller

Other Considerations

- "Capital" needs are broader than bricks and mortar
- Health Information Technology
- Telehealth
- Mobile health

Challenges for FQHCs Primary Care Providers

- Many will be borrowing for the first time
- Assistance needed in capital financing process including TA in construction, commencement of operations, ongoing operations
- Standard lenders will need credit enhancement to be willing to lend to many of these projects
- Lending process will need to be simple and straightforward

CHCANYS Capital Development Program

CHCANYS and our partners are taking several steps to improve access to capital:

- statewide canvassing of needs and opportunities for collaboration with behavioral health, other social determinants of health
- development of a program to educate providers about available sources of capital
- working with CDFI's and private lenders
- identifying sources of grant capital
- brainstorming about the most effective uses of potential 1115 waiver funds for PC expansion

Traditional Primary Care Capital Sources

- Federal grants
- State grants
- Philanthropy
- Debt

BUT . . .

Pressures on Existing Sources

- ***Philanthropy*** is down due to the economy
- ***Existing funds*** are reduced due to thinner bottom lines
- ***Grants*** are shrinking because of governmental deficits and philanthropy issues.
- Availability of ***debt*** also has diminished in NYS
  - Recession
  - Conservatism from the banking crisis
  - Smaller margins
  - Fewer sources of credit enhancement
  - Uncertainty about future revenue streams from widespread payment reforms
  - Ability of management to adapt to unprecedented reform efforts

Thank You

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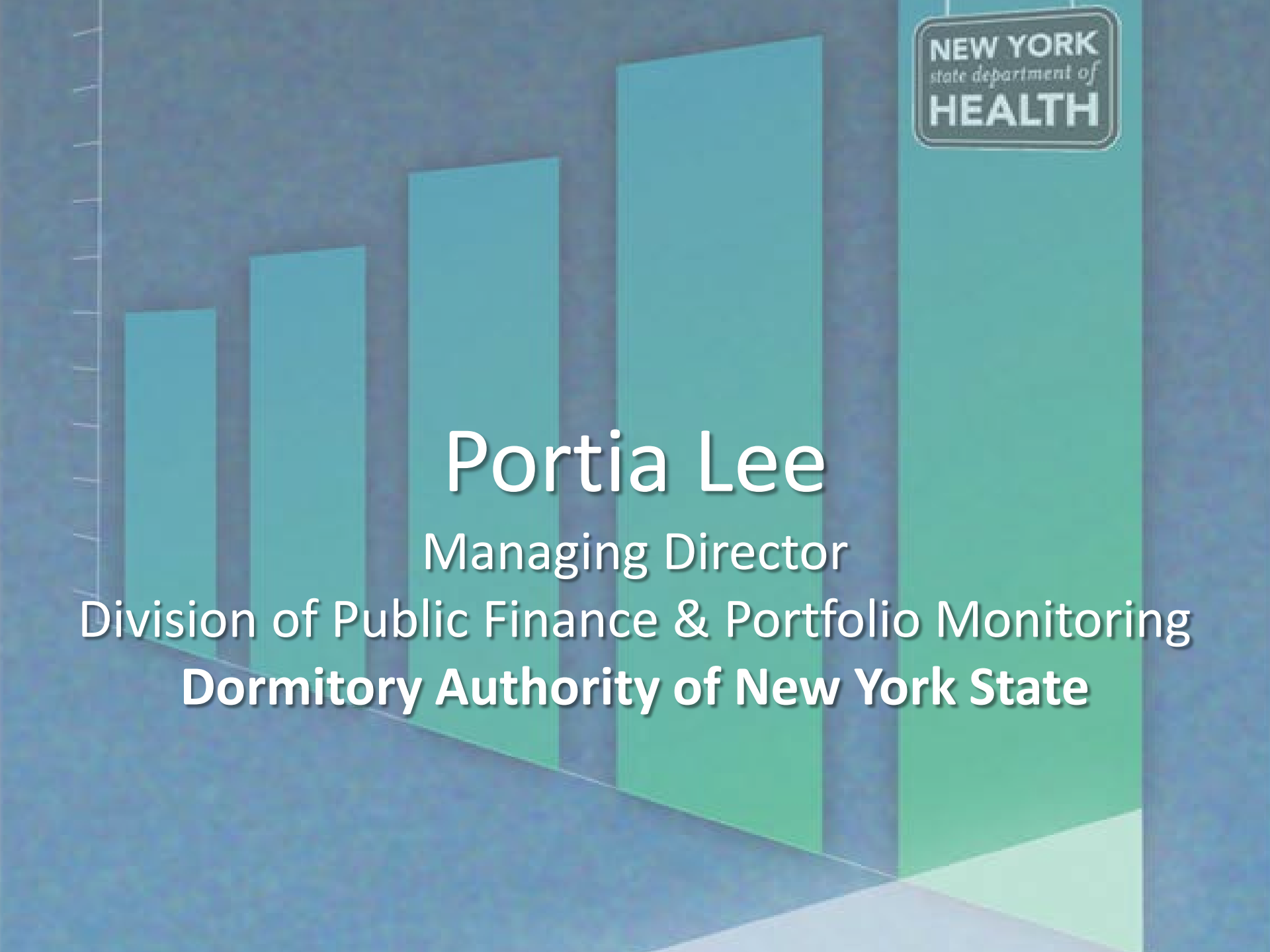

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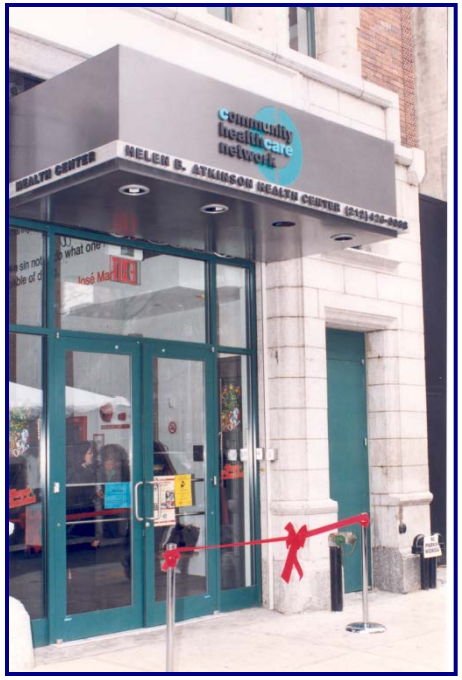
The Primary Care Investment Imperative



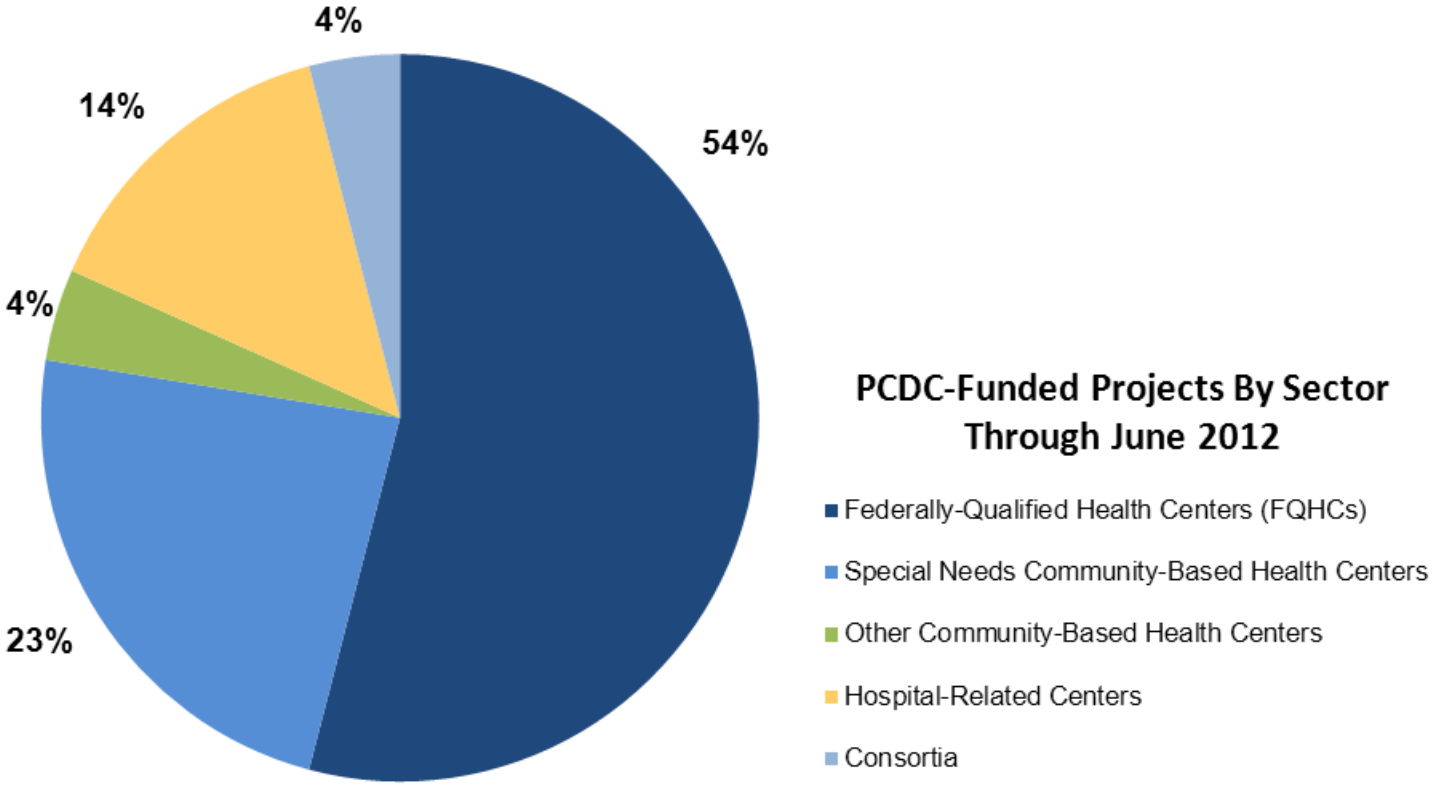
NYS Dept. of Health Capital Access Forum
October 2, 2012

PCDC Background

- **Mission – To expand & transform primary care in underserved communities**
- **Three mutually supporting strategies:**
  - **Capital Investment**: Expands primary care capacity
  - **Performance Improvement**: TA to transform the model of care
  - **Policy & Advocacy**: Assures resources & sustainability
- **Nonprofit CDFI:**
  - **CARS™ rated:** AAA+2
  - **20 Years of Experience**

Historical Condition:
Primary Care: under-resourced & under-developed

- PCDC created to address this market failure
- PCDC invests in FQHCs & other critical community providers



PCDC has a very strong track record in this market

- **Access Created:**
  - For 845,000 underserved New Yorkers annually
- **Economic Development in Low-Income Communities:**
  - 4,200 jobs created/preserved
  - 100 completed projects valued at $400 million
  - 790,000 square feet improved
- **Transformation of Operations:**
  - TA to >500 teams in 35 states to transform operations & delivery models
- **Spread:**
  - PCDC is Financial Advisor to HRSA for federal loan guarantee;
  - Underwrites and manages $100MM multi-state portfolio

New Condition #1:
Effective Primary Care is being widely recognized as key ingredient to achieving Triple Aim

- **Central to federal ACA & NYS MRT strategies**
- **Strategies call for:**
  - **Expansion**:
    - 2.3 million New Yorkers lack access to primary care
    - $1 billion+ in capital needed
  - **Practice Transformation**
    - To advanced primary care or “medical home” model

New Condition #2: The Primary Care Sector is Changing

- **Growth:**
  - FQHCs are slated to double per ACA strategies & funding
  - Hospitals are buying & creating physicians practices
- **Disruption:**
  - Hospitals at risk in underserved communities = primary care at risk
- **New Capital Needs:**
  - New, expanded & modernized facilities
  - HIT – critical to new care models
  - Acquisitions & business financing
  - Debt relief in some cases

New Condition #3:
The traditional Investment Model is Going, Going...

- **Traditional model:**
  - Predictable FFS payments support long-term, fixed-rate, fully-amortizing debt to stand-alone entity
- **Emerging revenue streams include:**
  - PCMH bonuses, blended rates, bundled rates, shared savings, risk-sharing—all models that are untried—imposed on an already financially fragile sector.
- **Long-term, fixed-rate debt already rare:**
  - Refinancing & downstream interest rate risk are already here

New Conditions Require: #1 - Public/Private Collaboration

- **Waiver includes Grants, Debt Relief & Revolving Capital Fund:**
  - **Public sector investment:**
    - Demonstrates policy commitment to health system reconfiguration during a period of transition, giving confidence to both lenders & borrowers;
    - Creates credit enhancement for lenders, inducing better terms
    - Reduces cost of capital for borrowers
  - **Revolving Fund creates perpetual low-cost resource for sector**
    - Repayments are re-lent

New Conditions Require:

#2 - New Financial Players, New Types of Capital, New Loan Types

- **Financing for primary care will more like the rest of the sector & world**
- **Private investment must involve all sources--foundations, tax credits, CDFIs like PCDC, tax-exempt issuers like DASNY, as well as banks**
- **New Loans:**
  - Acquisition;
  - Temporary bridges to new capital sources;
  - Equipment
  - Interest-only loans supported by tax credits

New Conditions Require:
#3 - Development and Operational Planning & Assistance

- Short expansion timeframe demands coordination among provider organizations, planners & regulators
- New revenue streams demand concurrent performance improvement
- Primary care preservation and expansion must accompany hospital restructuring
- Provider organizations need support as they expand – The biggest risk occurs when construction is done

PRIMARY CARE DEVELOPMENT CORPORATION

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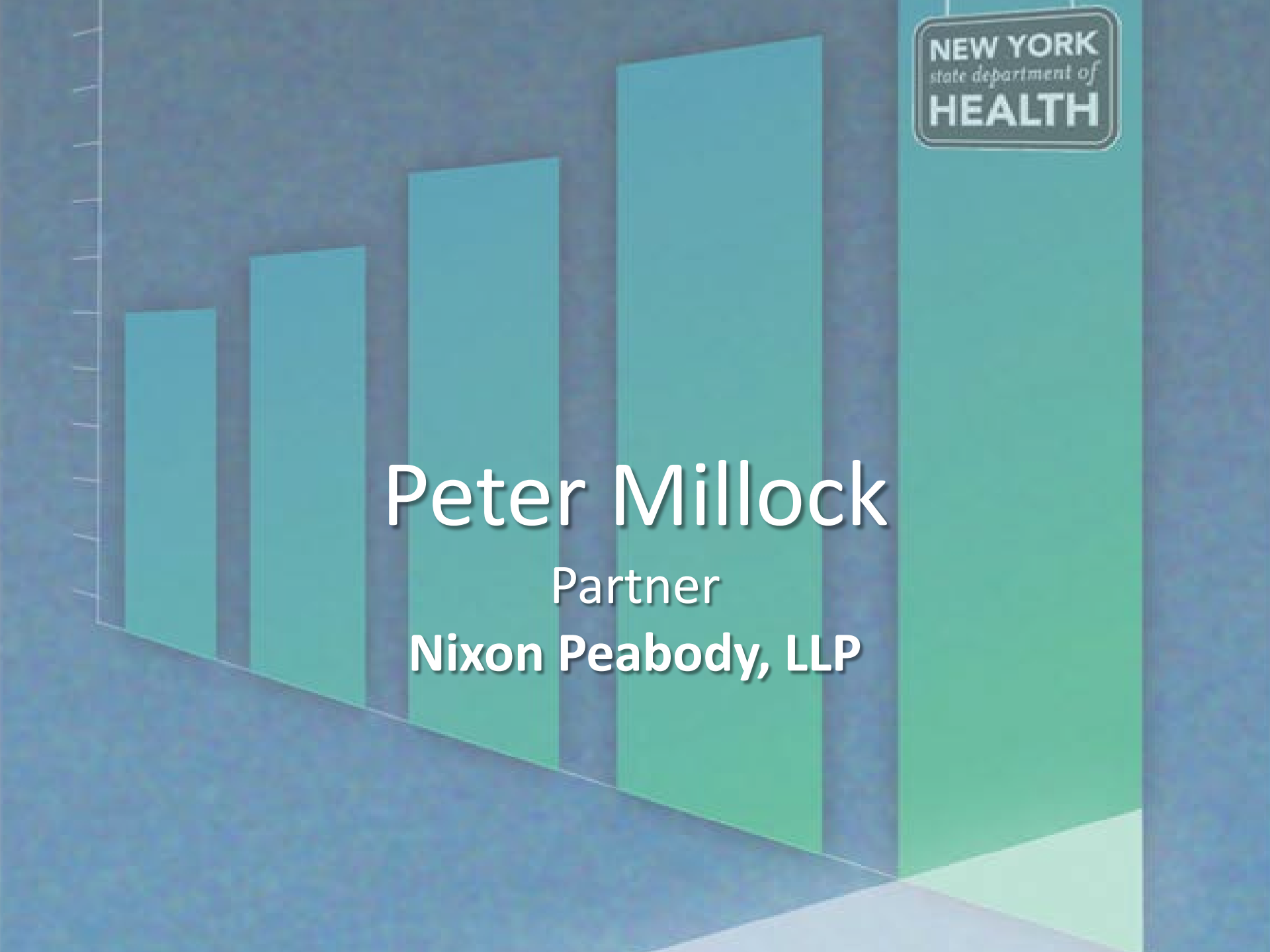

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Dormitory Authority State of New York

IMPROVING CAPITAL ACCESS FOR HEALTHCARE PROVIDERS IN NY STATE

Profile of the Healthcare Landscape in NY and the Nation
October 2, 2012

David Burik, Managing Director – Navigant Healthcare
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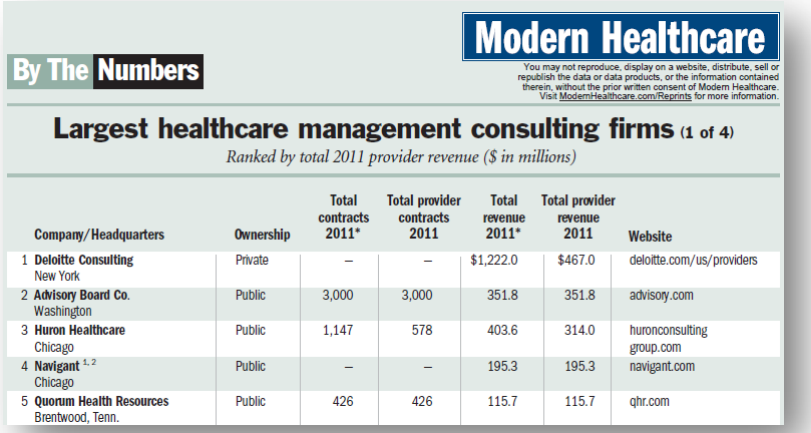
NAVIGANT
HEALTHCARE

DISPUTES & INVESTIGATIONS • ECONOMICS • FINANCIAL ADVISORY • MANAGEMENT CONSULTING

A BRIEF INTRODUCTION

- Navigant Healthcare
  - Among nation's largest healthcare consultancies
  - Full complement of healthcare services across all industry sectors
- David Burik
  - Leader, Navigant Healthcare Strategy Division
  - 30+ years of experience
  - Current NY experience, including ongoing projects in NYC and Upstate



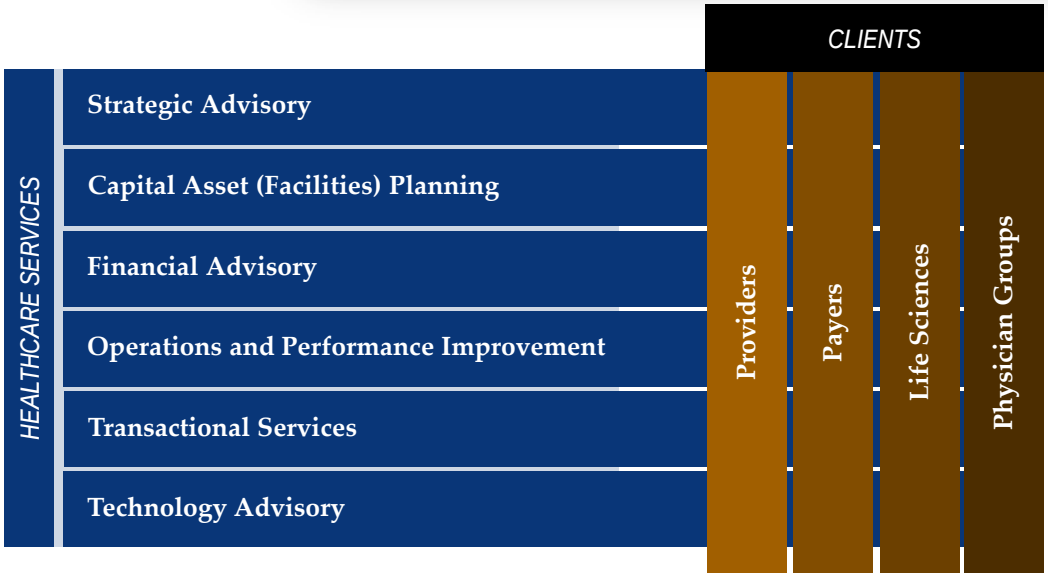
By The Numbers

Modern Healthcare

Largest healthcare management consulting firms (1 of 4)

Ranked by total 2011 provider revenue ($ in millions)

	Company/Headquarters	Ownership	Total contracts 2011*	Total provider contracts 2011	Total revenue 2011*	Total provider revenue 2011	Website
1	**Deloitte Consulting** New York	Private	–	–	$1,222.0	$467.0	deloitte.com/us/providers
2	**Advisory Board Co.** Washington	Public	3,000	3,000	351.8	351.8	advisory.com
3	**Huron Healthcare** Chicago	Public	1,147	578	403.6	314.0	huronconsulting group.com
4	**Navigant** [1,2] Chicago	Public	–	–	195.3	195.3	navigant.com
5	**Quorum Health Resources** Brentwood, Tenn.	Public	426	426	115.7	115.7	qhr.com



AGENDA

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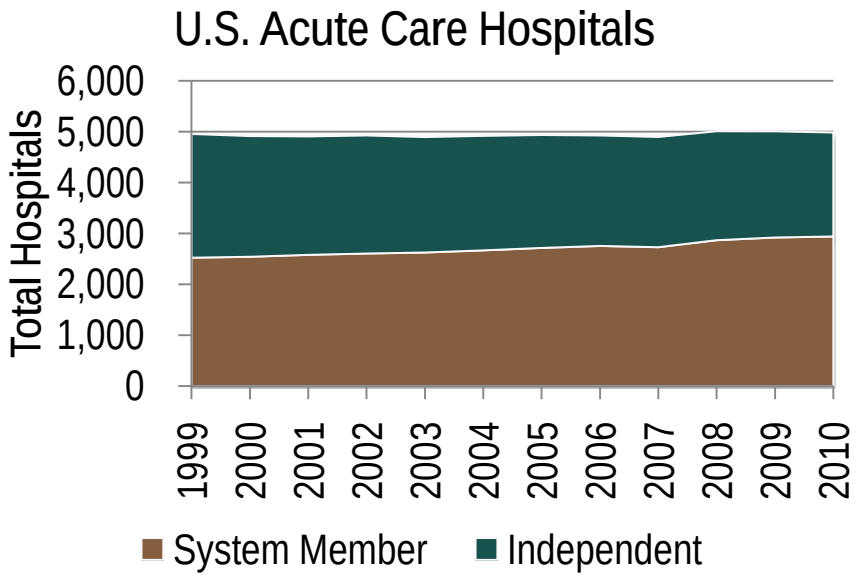
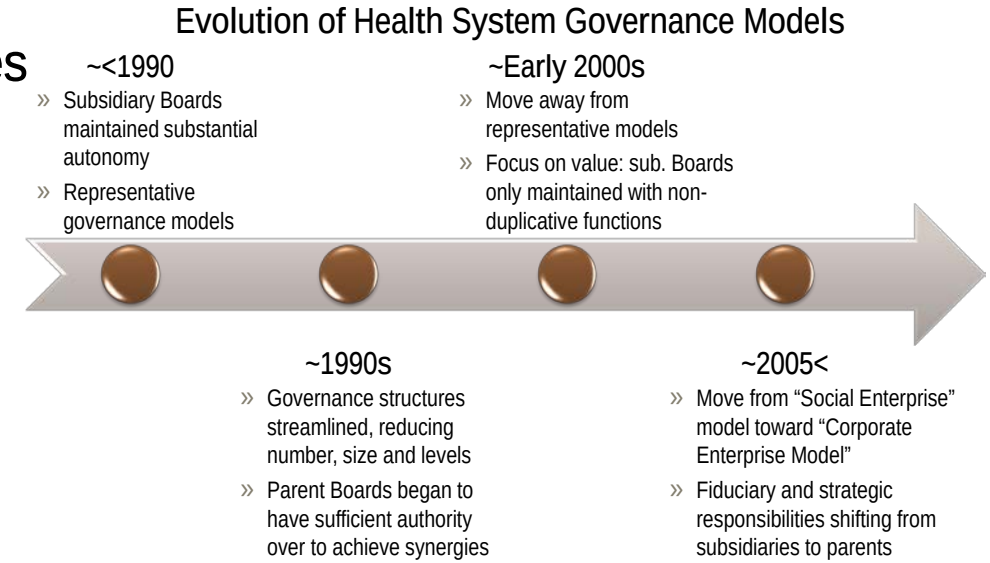
Reconfiguration of U.S. Healthcare Underway	» Translate environmental changes in hospital actions	5 mins
NY's Unique Pattern of Reconfiguration	» Identify unique facets of NY's healthcare delivery system » Discuss potential drivers of NY's uniqueness	10 mins
Recapitalization Strategies in NY v. the U.S.	» Discuss current approaches to recapitalization underway nationally	10 mins
Challenges Created by NY's Unique Trajectory	» Identify implications of the current NY landscape	5 mins

JOURNEY OF HEALTHCARE RECONFIGURATION

- Recent years have witnessed dramatic consolidation of hospitals into systems
  - Independent hospitals joining systems
  - National systems (taxables) growing rapidly
  - Regional (tax-exempt) systems expanding across traditional boundaries to form super-regional systems
- And, systems have increasingly centralized functions and authorities
  - Evolution from hospital systems as holding companies to operating companies





Source: American Hospital Association (2012), The Governance Institute (2005) and NCI analysis

NOW, HOSPITAL SYSTEMS FOCUSING ON 3 IMPERATIVES

Since the PPACA's passing in 2010, Navigant has intentionally invested in assisting clients in Massachusetts, the nations' laboratory of healthcare reform. Navigant has now completed over 250 post-reform engagements with a wide range of physicians, payors, health systems, and suppliers. Based on our experience, we believe *reform has been the catalyst for the following market forces and trends which are reshaping the healthcare landscape.*

#1. Increased Provider Consolidation is Coming (Recapitalization)

- Thinly capitalized and distressed hospitals & physician groups increasingly will seek partnerships, resulting in some transactions that could not have been predicted two years ago

#2. A New Payment Model is Emerging

- Managed care contracts, offering incentives to use accountable care tools such as more generics, less high-end imaging and ED avoidance are being embraced by primary care physicians, triggering acceptance by specialists and hospitals

#3. Government Fiscal Pressures are Forcing Payment Cuts that Demand Provider Cost Reductions & Performance Improvement

- Large federal and state budget deficits have exacerbated Medicare and Medicaid solvency issues, pressuring provider payment
- The cuts are large enough to require an integrated performance improvement / strategy/ financial approach

Note: PPACA = Patient Protection and Affordable Care Act of 2010

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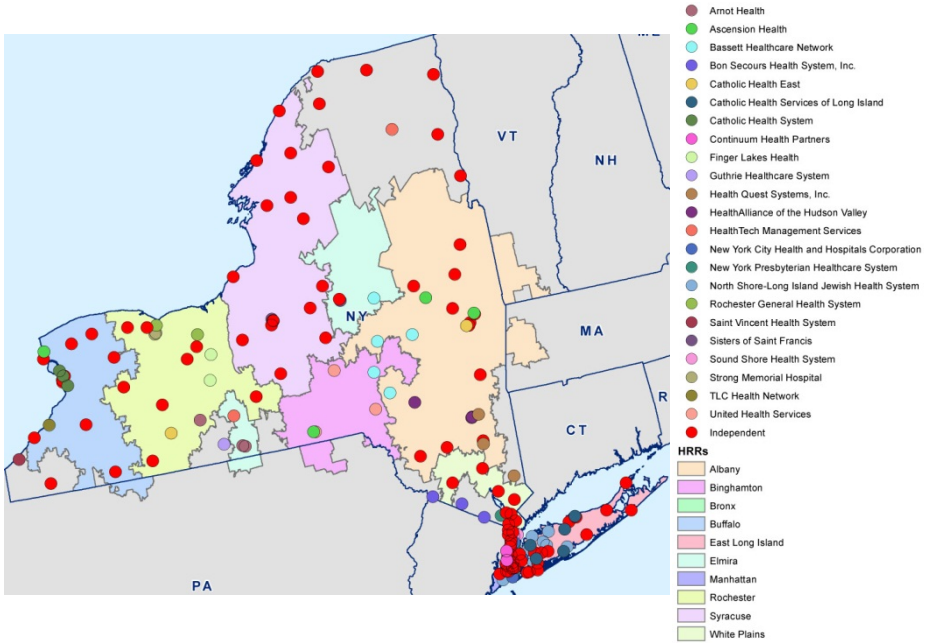
HOWEVER, NY HOSPITALS HAVE FOLLOWED A UNIQUE RECONFIGURATION PATTERN

- NY landscape is dominated by independent hospitals or small systems, focused on a single referral region
- Unique pattern may reflect five unique factors
  1) Restrictive CON regulations
  2) Character & Competence Review
  3) Berger Commission
  4) High presence of public hospitals
  5) The long shadow of rate-review through 1996

Delivery System Characteristics

	NY	U.S.
Hospitals in Systems	46%	59%
Number of Health Systems (per State)	20	6.5>
Average System Size	4	7.8



Source: American Hospital Association (2012) NCI analysis.

1) CON REGULATIONS ARE ALIVE & WELL IN NY

- CON regulations in NY are among the nation's most restrictive
- Regulations keep hospital systems locally focused by restricting abilities to:
  - Invest in greenfield inpatient expansion
  - Support hospitals with profitable, surrounding destination ambulatory centers
  - Widen hospitals' draw areas by adding more advanced tertiary/quaternary services
- New entrants must demonstrate need – difficult when population is stable

State	# of Regulated Services	% of Services Regulated	Rank (from Most to Least Restrictive)
VT	30	100%	1
HI	27	90%	2
NC	25	83%	3
ME	24	80%	4
RI	21	70%	5
WV	21	70%	5
AL	20	67%	7
SC	20	67%	7
AK	19	63%	9
TN	19	63%	9
VA	19	63%	9
NY	18	60%	12
KY	18	60%	12
MI	18	60%	12
MS	18	60%	12

Source: National Conference of State Legislatures (January 2011) and Navigant analysis

2) CHARACTER AND COMPETENCY REVIEW IMPEDES SYSTEM FORMATION

- Driven by Character and Competence Review, NY is one of only a few states with minimal taxable presence:
  - RI – Amended state's conversion law in June 2012 to enable for-profit Steward to purchase Landmark (pending)
  - HI – Last remaining taxables restructured under bankruptcy and subsequently closed (circa 2010)
  - VT – Single payor landscape continues to be dominated by tax-exempt systems
- In many other states, taxable systems have been an organizing force, aggregating disparate, struggling community hospitals into regional systems

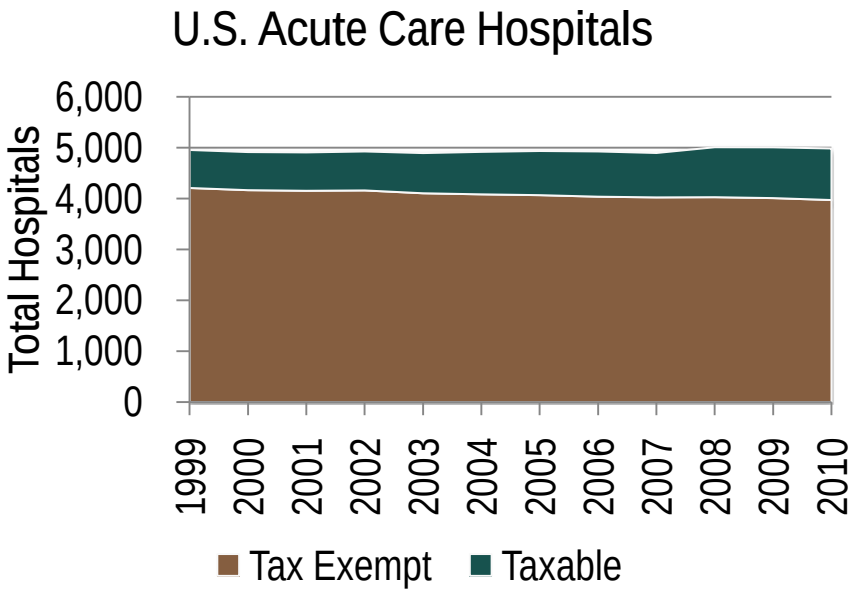
NEW YORK STATE BAR ASSOCIATION

INSTITUTIONAL LISCENSING IN NEW YORK STATE

OWNERSHIP BY PUBLIC COMPANIES

Hospitals and Nursing Homes

Hospitals and nursing homes licensed under Article 20 of the Public Health law may not be publically owned for the reasons already discussed and described, i.e., (i) each shareholder must go through a character and competence review . . . (ii) no parent/subsidiary relationship is permitted.



Source: NY State Bar Association, Kaiser Family Foundation (2010), and Navigant analysis

3) BERGER COMMISSION DIRECTED RECONFIGURATION

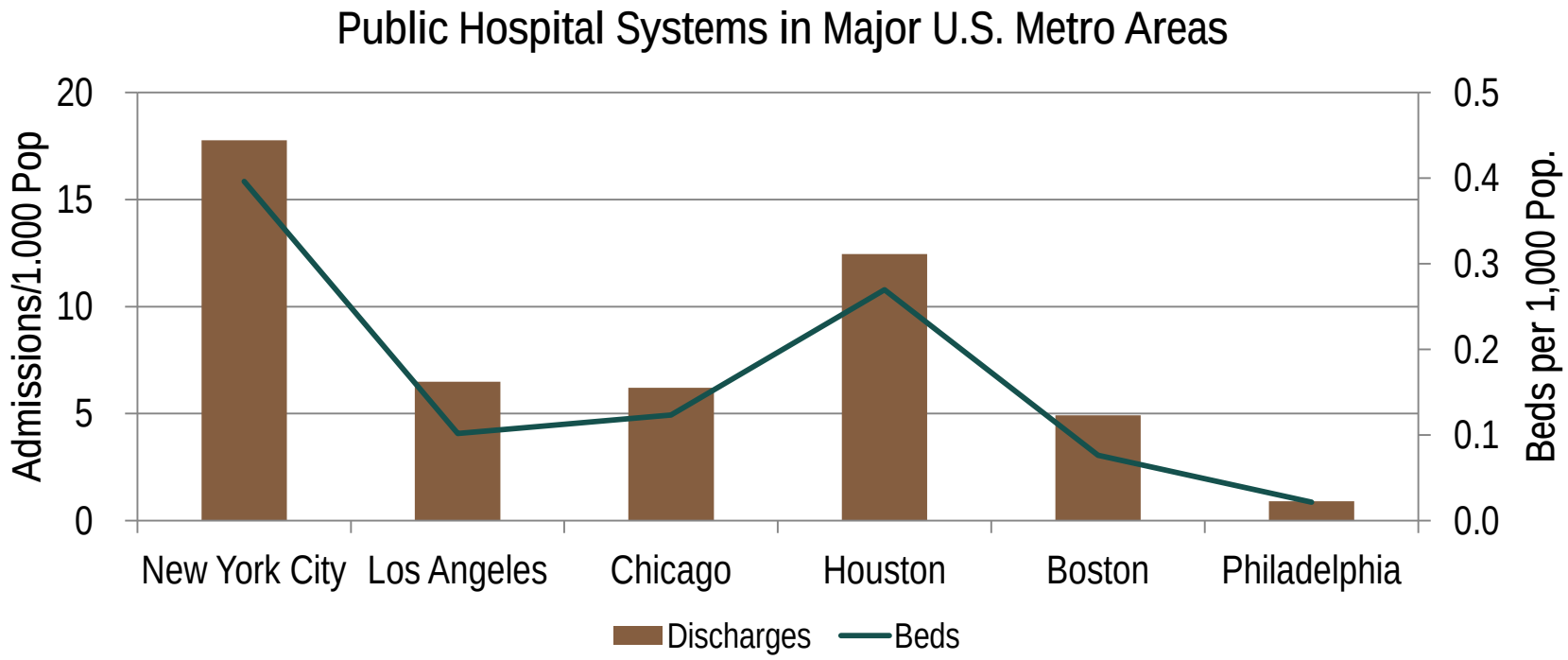
» NY is one of the few states that has made specific, systemic recommendations regarding state-wide hospital configuration

Commission	Purpose	Results
 **New York** Commission on Health Care Facilities in the 21st Century, 2006	» Eliminate excess bed capacity and duplication of services » Provide residents with greater access to primary and preventative care	» 9 hospitals were recommended for closure, eliminating about 1,700 beds » 48 hospitals were restructured, eliminating another 1,700 beds
Restructuring the Healthcare Delivery System in Brooklyn, 2011	» Address struggling healthcare system in Brooklyn » Reform Medicaid to reduce waste	» Recommended integrations amongst specific hospitals, including bed reductions » Suggested for-profit systems be allowed a greater role in the State
 **New Jersey** Multiple Commissions 1992, 1999, and 2008	» 1992 – Extend state oversight in multiple capacities	» 6 hospitals recommended for closure
	» 1999 – Improve declining financial health of hospitals	» Performance studies at stressed hospitals; no recommended closures
	» 2008 – Evaluate forces leading to financial difficulties at State hospitals	» No closure recommendations » Authorizes DHSS to intervene in management of distressed hospitals
 **Maryland** The Governor's Task Force on Health Care Cost Containment, 1984	» Address the rapid rise of healthcare costs	» Created the Maryland Hospital Bond Program to promote <u>voluntary</u> consolidations, mergers, conversions, and closings

Source: Business Council (2006), Urban Health Institute (2006), American Health Lawyers Association (2009) , Modern Healthcare (2011) and NCI analysis

4) GOVERNMENT HOSPITALS HAVE HISTORICALLY BEEN SHIELDED FROM NATIONAL CHALLENGES

- Compared to other major U.S. population centers, NY has a high concentration of public hospitals
- Government support may have insulated NY hospitals (e.g., SUNY, Westchester) from forces driving consolidation and change
  - But, how long will this continue?



Source: American Hospital Association (2012) and NCI analysis

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UNDER THE SHADOW OF REFORM, RECONFIGURATION HAS BECOME RECAPITALIZATION

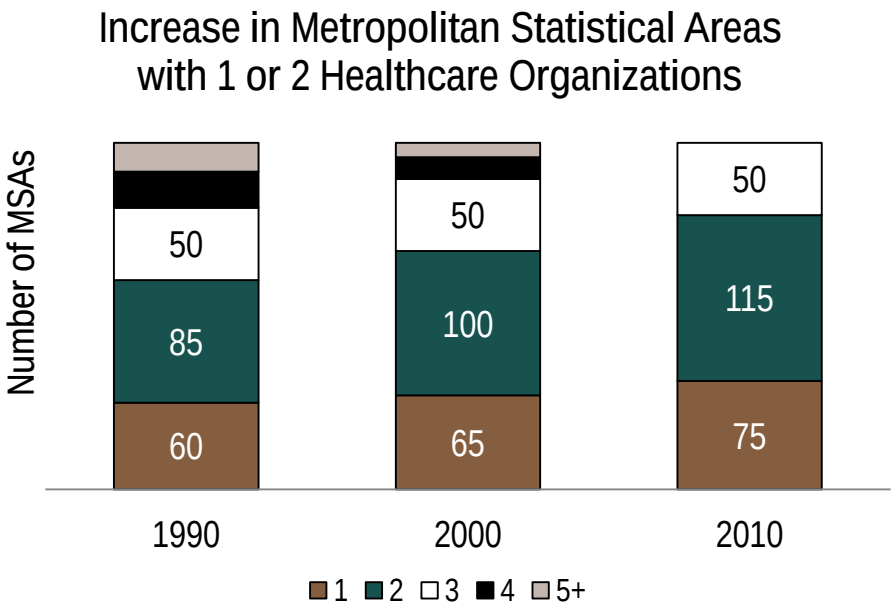
LARGER organizations are better positioned to respond to the challenges of the current landscape than smaller ones

- Efficiencies of staff – its someone's 'day job' to worry about implementing changes
- Best practice learnings from around the system
- Processes and communication systems in place that allow for rapid roll out
- Can try small scale pilots more readily
- Capital and cash to fund investments in new programs

The result: multiple national approaches to reconfiguration/recapitalization

OPTION A: MERGE WITH NEIGHBORS

- Over the last 20 years, historically competing hospitals have frequently consolidated within local markets
  - Potential Benefits: Scale, access to capital, service rationalization, failing hospitals saved
  - Trend is alive in NY, though somewhat driven by regulation (Berger), instead of the market
- However, the anticompetitive concerns restricting mergers in other industries seem to be gaining traction in healthcare



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HEALTH INDUSTRY | March 18, 2012, 6:11 p.m. ET

Regulators Seek to Cool Hospital-Deal Fever

By BRENT KENDALL

Government antitrust enforcers have tackled AT&T Inc. T +0.20% and Intel Corp. INTC +0.07% in recent years. Now the question is whether regulators can conquer an even tougher foe: the hospital industry.

Enlarge Image

Associated Press

To control costs, 'you have to challenge anticompetitive hospital mergers,' says FTC Chairman Jon Leibowitz.

From Rockford, Ill., to Albany, Ga., hospitals are merging. A 10-year high of 86 deals, valued at $7.94 billion in total, were announced last year, according to research firm Irving Levin Associates Inc. The hospitals say they are trying to cut costs and deliver care more efficiently, a goal of the 2010 federal health-care overhaul.

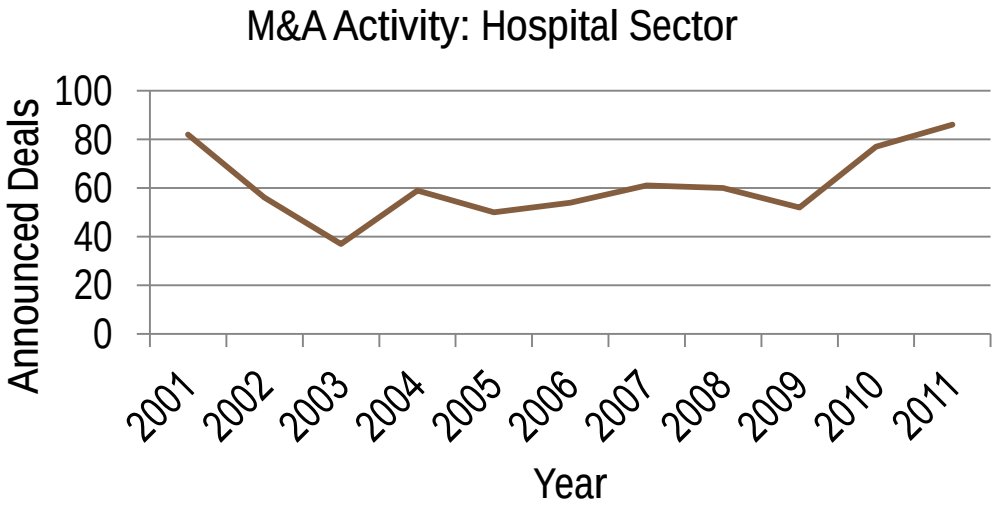
But Federal Trade Commission Chairman Jon Leibowitz says some mergers can lock up local markets, leading to higher prices for patients and insurance companies with few other places to turn.

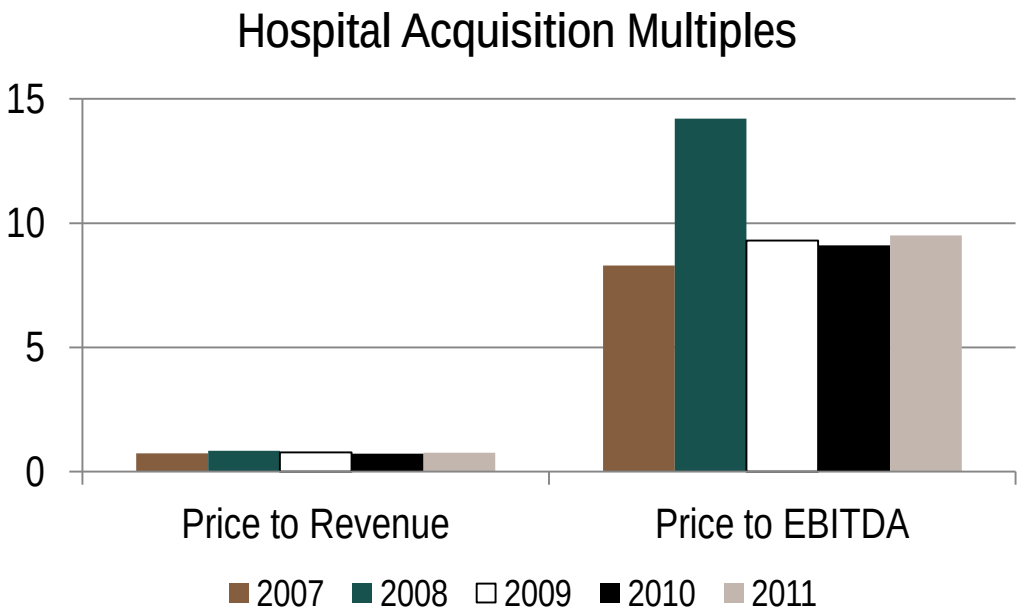
"If you want to do something about controlling costs in health care, you have to challenge anticompetitive hospital mergers," he says in an interview.

Source: *Trustee Magazine* (2011) and NCI analysis

OPTION B: CONVERT TO TAXABLE

- Increased M&A activity
  - Capital markets valuing scale
  - Concerns about facing value-based competition alone
  - Needs to achieve scale economies/efficiency
  - Investors pressuring taxable chains to grow
- Hospitals are increasingly seeing the capital infusion offered by taxables as a palatable trade for lost control
  - Competition for targets placing upward pressure on multiples
- For obvious reasons, NY has not experienced this trend

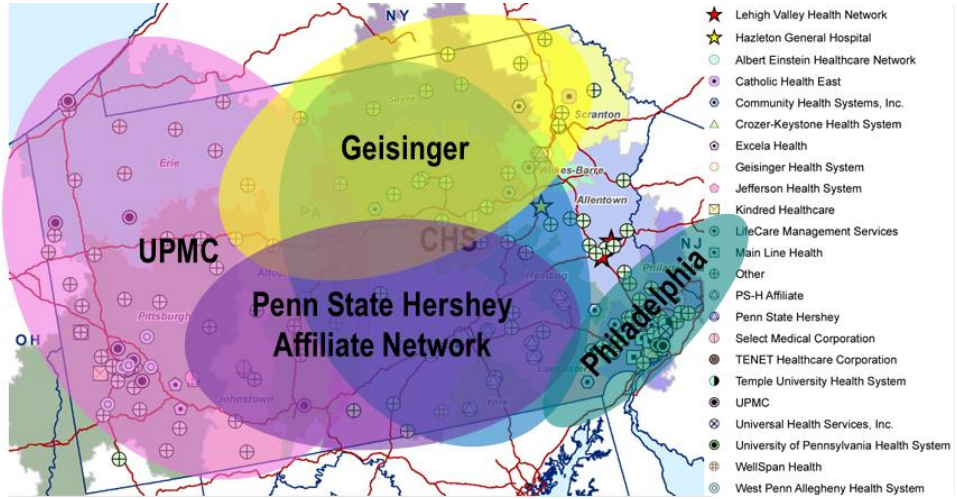




Source: Levin Associates (2012) and NCI analysis

OPTION C: FORM/JOIN A SUPER-REGIONAL SYSTEM

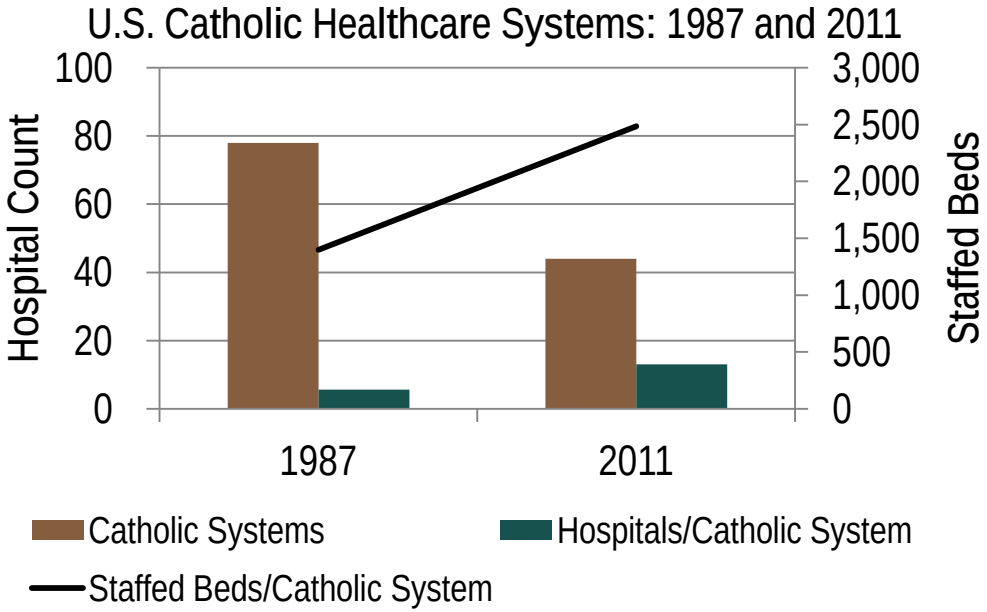
- Not to be left out, tax exempt systems are achieving super-regional scale
- UPMC – One of several examples from a neighboring state
  - Growth to 20+ hospitals from 3 hospitals that joined to form the system in 1986
  - 33% market share in W PA, with owned asset presence in 4 hospital referral regions
  - 1.6 M covered lives via UPMC health plan
- Defining Super Regionals
  - Governance and operating model that improves performance
  - Strong balance sheet, access to capital
  - Scale & skill economies
  - Commitment to success over broad geography (multiple referral regions)
  - Sustainable physician alignment

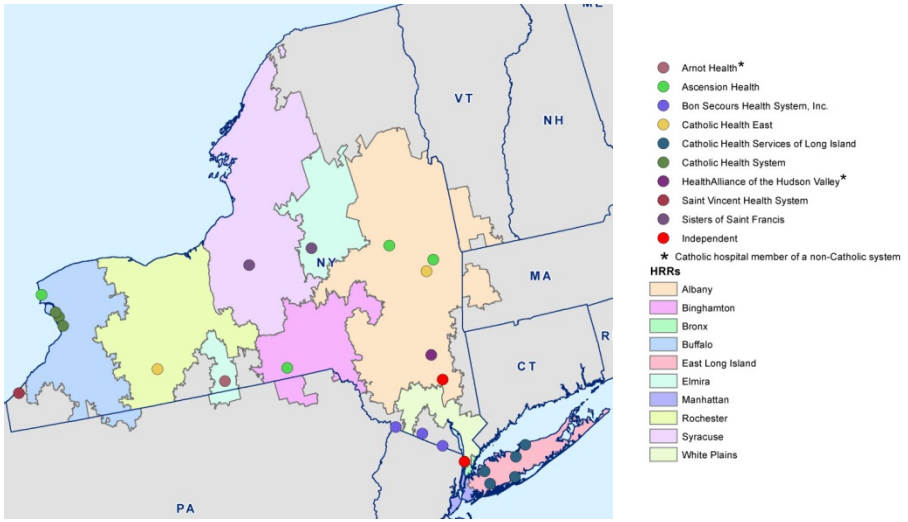


- At best, NY has arguably one super regional – LIJ

OPTION D: CHANGE SPONSORS (IF YOU'RE CATHOLIC)

- Nationally, Catholic systems have undergone sponsorship changes, consolidating into larger systems
  - Historically, Catholic systems formed based on call-based geographies
  - More recently, call-based systems are integrating into national systems
    - In response to same pressures being faced by secular systems nationally
- Yet, the national Catholic systems have limited NY presence
  - Many of the state's Catholic systems continue to be local/regional systems
  - National systems with presence (e.g., Ascension, CHE, Bon Secours) lack critical mass across referral regions





Source: AHA (1989 and 2012) and NCI analysis

OPTION E: CRAFT AN INNOVATIVE PARTNERSHIP

» 3 innovative reconfiguration strategies that have not yet surfaced in NY

Example	Model	Description & Considerations
Duke LifePoint Healthcare	Hybrid (taxable: tax-exempt) partnership	» Duke & LifePoint partnering to acquire community hospitals » Acquisition targets benefit from access to Duke's clinical expertise & brand and LifePoint's capital » Allows Duke to expand without draining its balance sheet » Model being widely replicated – national Navigant study identified 7 similar, emergent models
Summa Health System	Whole hospital JV	» Summa offering minority interest in exchange for capital infusion » Partner to have governance representation and reserve powers » Potential for margin sharing to align incentives » Summa to gain access to skill & scale economies of investing system » Examples emerging in other states (e.g., Mid-Michigan)
quality health solutions, inc.	Arm's length	» JV of 7 health systems and MCW to compete with Aurora » Partners contractually share investments (and associated returns) in intellectual capital and support services » Shared investments "free up" capital for investment in physical plants » Examples emerging in other states

Source: Queries of hospital websites, NCI interviews and NCI analysis

AGENDA

Topic	Focus	Time
Reconfiguration of U.S. Healthcare Underway	» Translate environmental changes in hospital actions	5 mins
NY's Unique Pattern of Reconfiguration	» Identify unique facets of NY's healthcare delivery system » Discuss potential drivers of NY's uniqueness	10 mins
Recapitalization Strategies in NY v. the U.S.	» Discuss current approaches to recapitalization underway nationally	10 mins
Challenges Created by NY's Unique Trajectory	» Identify implications of the current NY landscape	5 mins

NY HOSPITALS HAVE LIMITED OPTIONS TO RECAPITALIZE

	Option	Comments
A.	Merge with neighbors	» Present in NY state, though largely driven by regulations v. the market » In future, strategy may be less tenable, due to federal regulatory environment
B.	Convert to taxable	» Effectively prevented by Character and Competence
C.	Form super regional system	» One example, at best, in NY state
D.	Change sponsors (if Catholic)	» State's Catholics remain fragmented, locally focused » National Catholics are either not present or have not organized across referral regions
E.	Craft innovative partnership	» Models have yet to emerge in NY » Some models (e.g., hybrid) face regulatory challenges

NY HOSPITALS HAVE LIMITED OPTIONS TO RECAPITALIZE

» Key question: If only option A is on the table (and it's under federal scrutiny), how long can NY afford to proceed without other recapitalization options?

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IMPLICATIONS OF THE CURRENT LANDSCAPE

- Absent recapitalization strategies available nationally, creditor relief is the main option for distressed NY hospitals
  - The public burden borne by hospital bankruptcies/restructuring is more acute than in other parts of the country, as hospital debt is more often publically backed

FierceHealthcare

Filing bankruptcy the newest hospital business strategy

August 22, 2011 | By Karen Cheung-Larivee

It may be a desperate measure, but hospitals' filing bankruptcy may be the latest strategy to avoid lawsuits and payments, compensate top execs, or sell the hospital to another company. Hospitals that have recently filed for Chapter 11 are under the watchful eye of the public, who speculate on the reasons for filing bankruptcy papers.

New York's St. Vincent Hospital, which closed in April 2010, is under investigation for fraud, as the New York District Attorney accuses the Catholic charity hospital of purposely sinking finances, according to the *New York Post*. The bankruptcy cleared the way for St. Vincent's to sell the hospital to a private developer who plans to build luxury housing on the site.

- Many NY hospitals are mired in year-over-year operational struggles, unable to make requisite strategic investments for value-based competition
  - Many NY hospitals are probably underfunding performance improvement (cost reduction) and population health management (payor) capabilities
- Will insurance companies help fill the capital gap? How will this impact providers?

Lunch

The forum will reconvene at 12:30pm

Michael Irwin

Managing Director

Citi Corp Global Markets, Inc.

Overview: Private Capital & Not-For-Profit Hospitals

October 2, 2012

1. Discussion Outline

Discussion Outline

- Environmental Trends
- Bond Market Update
- Alternative Sources of Capital

2. Environmental Assessment

Environmental Trends

- Uncertainty around health care reform and longevity of current health care business models
- Accelerating consolidation throughout health care services
- Changing competitive landscape
  - Private equity playing a direct role in health care transformation
  - Managed care organizations: Diversification of business with acquisitions in areas of healthcare information technology, provider consulting, MSO services, physician groups and ambulatory clinics
- Non-traditional partnerships emerge as a response to environmental forces

Environmental Factors Create a “Push” and “Pull” That Drive Hospital Transactions

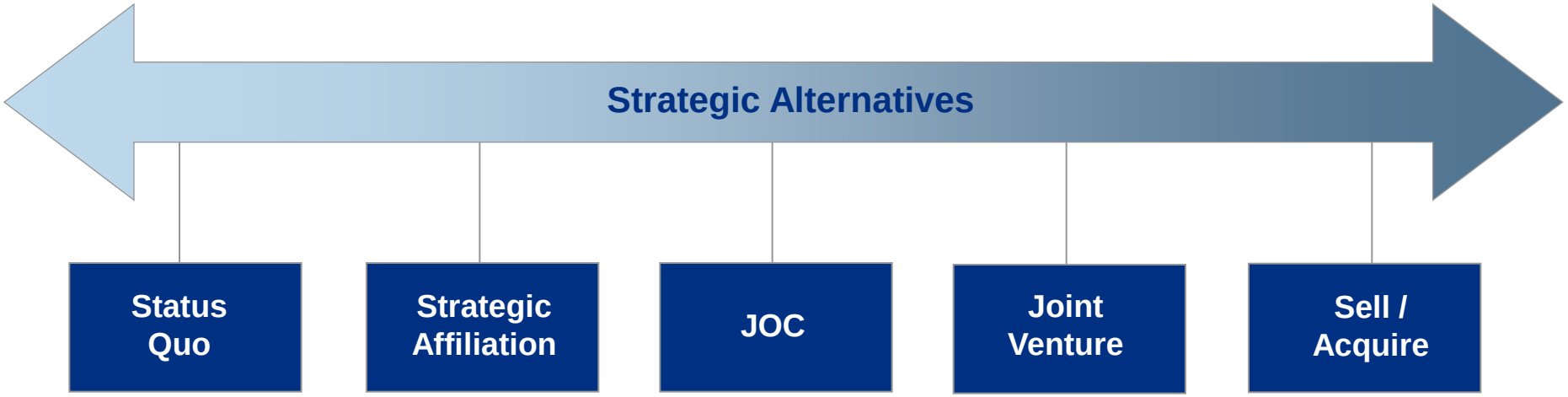
Push Factors

- Distressed financials
- Uncertain capital access
- Aging plants
- Limited payor leverage
- Market specific economic conditions
- Need for IT investment
- Physician recruitment / alignment demands

Health care reform increases the need for efficiencies and may emphasize the split between “haves” and “have-nots”

Pull Factors

- Increased market share
- Expanded geographic reach
- Creation of economies of scale
- Equity investor pressure for revenue growth
- Growing appetite from strategic and financial buyers
- Availability of capital to strong FP and NFP aggregators

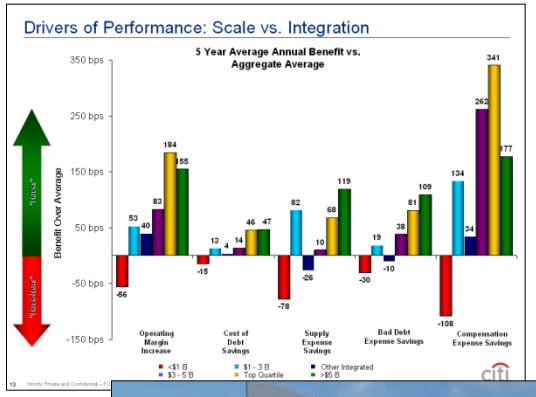


Future Success Factors

The emerging success model requires:

- Scale and integration
- Market essentiality
- Reasonable capital access
- Leading quality and patient safety
- Aligned physicians
- Sophisticated IT with high adoption rates
- Highly efficient cost structures
- Post-acute linkages
- Progressive governance and leadership

Maintain Organizational Sustainability



3. Bond Market Update

Bond Market Update

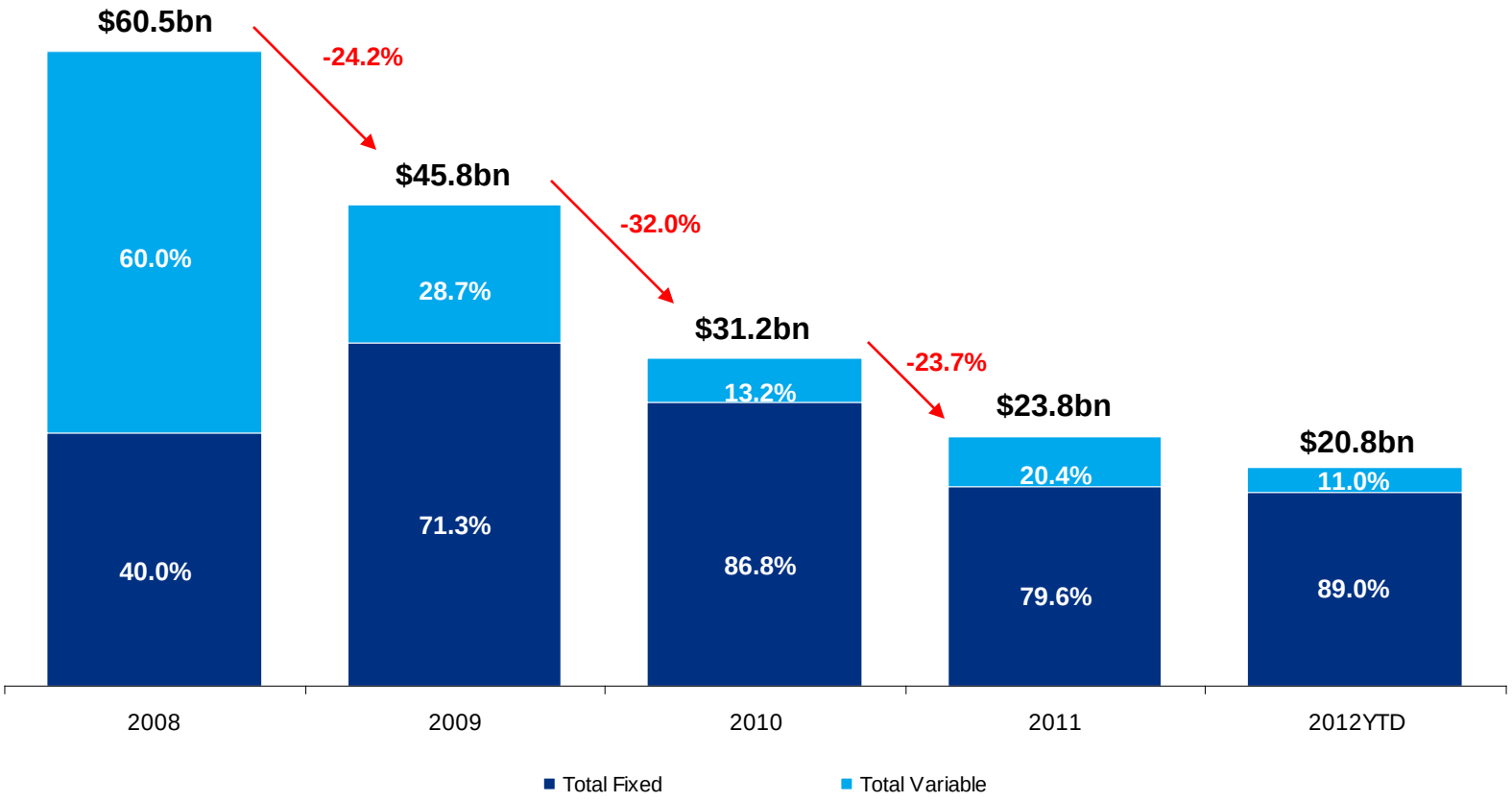
- Interest rates are attractive
- Obligated group options expand
- Highly rated credits explore taxable market
- Bank direct placement offers value

Health Care Interest Rates Are Attractive

Historical Statistics (9/14/2002 - 9/14/2012)			
	'AA' Average	'A' Average	'BBB' Average
Maximum:	6.87%	7.58%	9.19%
Average:	5.01%	5.42%	6.32%
Minimum:	4.27%	4.35%	4.44%
Current:	4.46%	4.75%	5.10%

Source: Bloomberg Health Care Revenue Bond Indices.
Rates as of September 14, 2012. For illustration purposes only. Past results do not indicate future performance.

Health Care Issuance has Fallen Dramatically



Source: SDC by Thompson Reuters. 2012 YTD issuance through September 7, 2012. Includes both taxable and tax-exempt transactions. Excludes private placements.

Obligated Group Options Expand

- Intrastate obligated groups grow
- Limited co-establishment opens door to out-of-state obligated groups
  - Stronger capital platform to facilitate expansion in New York State

Highly Rated Credits Explore Taxable Market

North Shore LIJ
North Shore-Long Island Jewish Health System

$135mm
Pricing Date: 9/8/2012
A3 / A- / A-

- General corporate purposes
- 30-year bullet maturity / spread: +185 bps to 30yr UST (4.84% yield)
- Gross receipts pledge
- Corporate – 3a4

NYU Langone MEDICAL CENTER

$250mm
Pricing Date: 7/31/2012
A3 / A- / A-

- General corporate purposes
- 30-year bullet maturity / spread: +187.5bps to 30yr UST (4.43% yield)
- Gross receipts pledge
- Corporate – 3a4

Memorial Sloan-Kettering Cancer Center

$150mm
Pricing Date: 1/6/2012

$250mm
Pricing Date: 12/1/2011

Aa2 / AA- / AA

- Finance capital projects to expand clinical service network
- 30-year bullet maturity / spread: +188bps to 30yr UST (4.90%) on 01/06/12
- 30-year bullet maturity / spread: +188bps to 30yr UST (5.00%) on 12/01/11
- General unsecured obligation
- Corporate – 3a4

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4. Beyond Bonds

Beyond Bonds

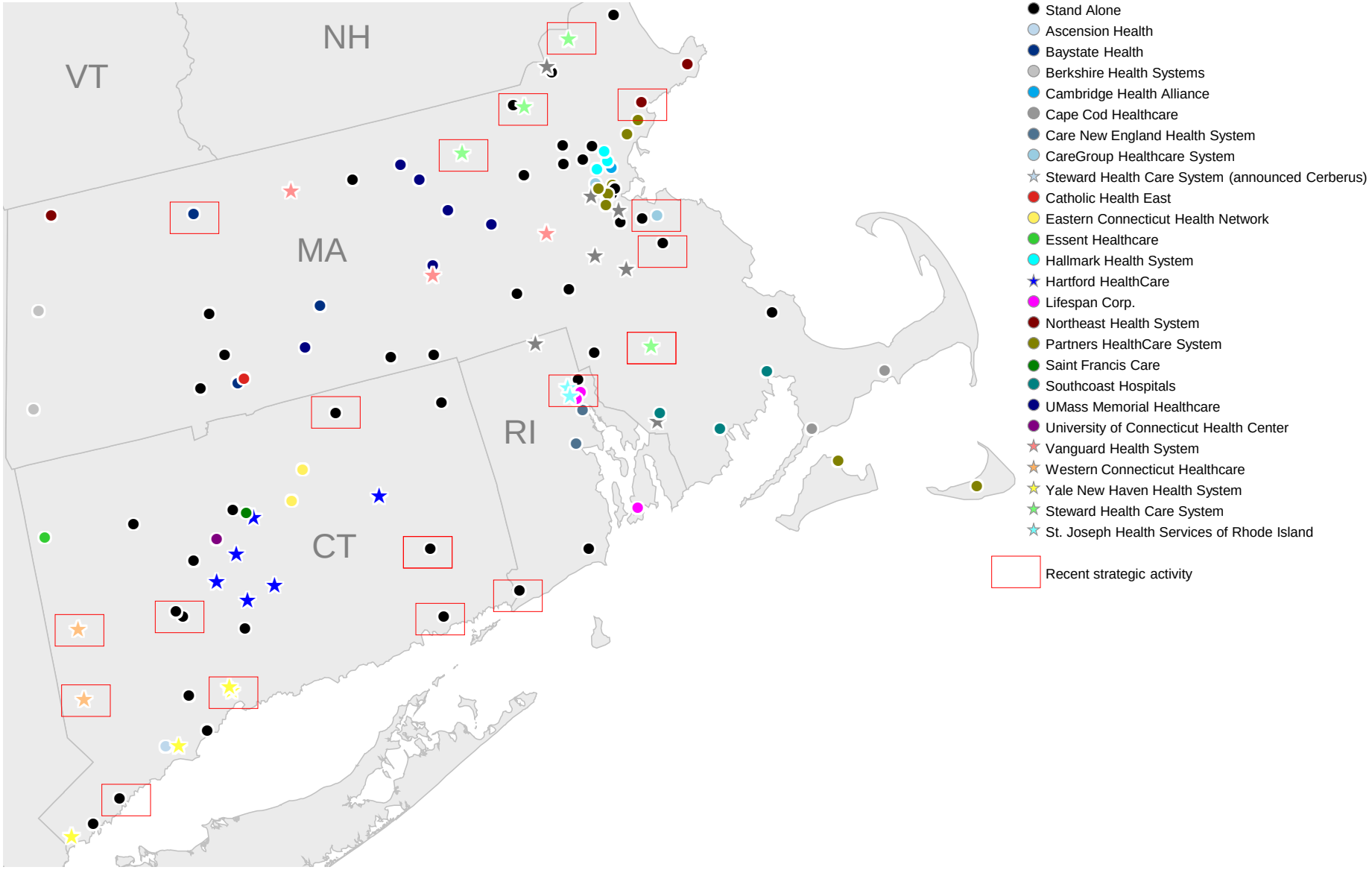
- Private equity expands options
  - New hospital management companies emerge
  - Ambulatory services and post-acute care providers as well
- Publicly traded companies offer outsource solutions
- Horizontal and vertical expansion strategies abound
  - Increases competition
  - Opportunities for collaboration

Why NFP Hospital Investment?

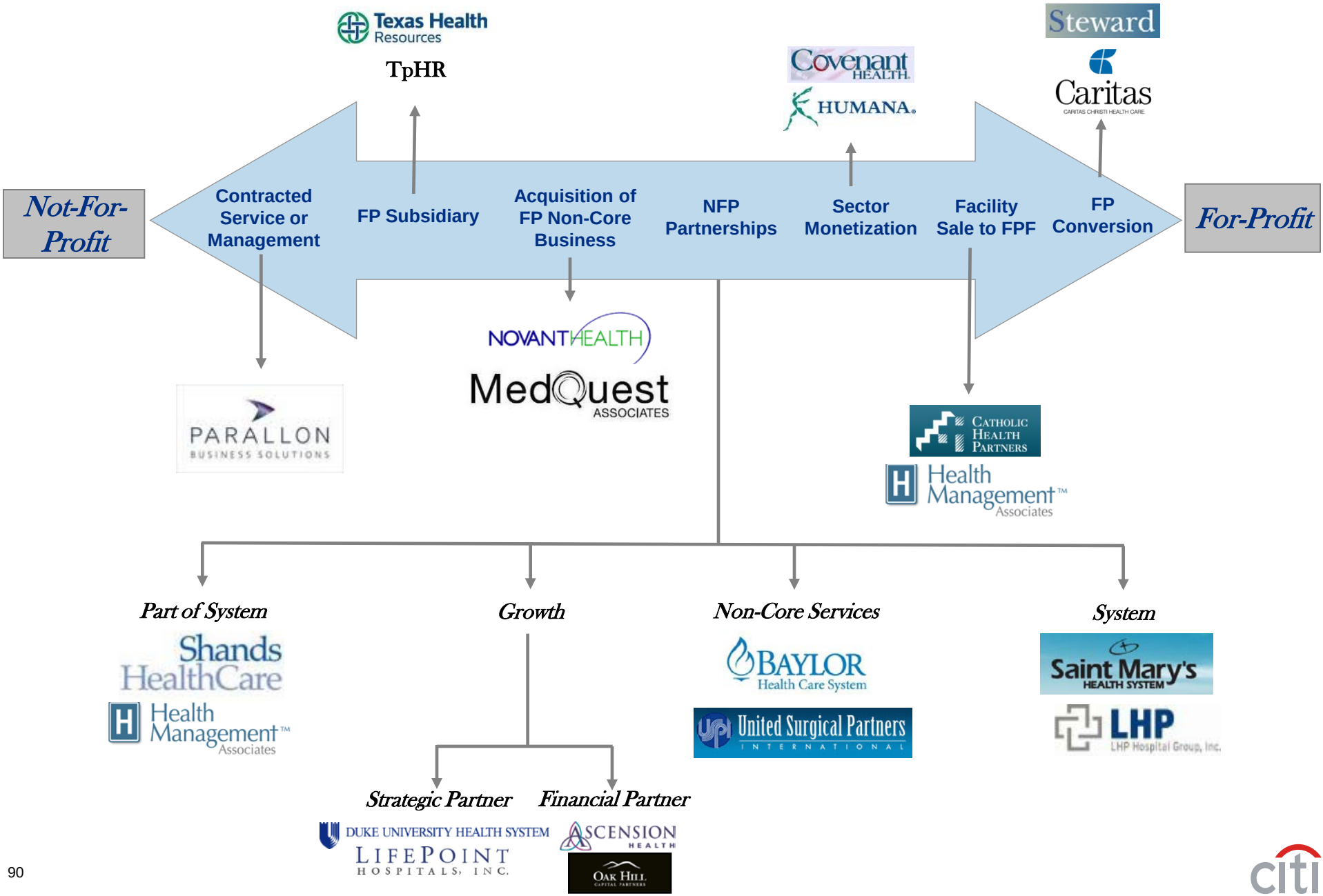
- Opportunity for Operating Efficiencies
- Industry Stability
- High Barriers to Entry
- HCA Success Story
- Favorable Demographic Trends
- Brand Recognition
- Affordable Assets
- Fragmentation
- Leveragable Assets
- Defensive Strategy

Private Equity

Dramatic Changes Underway in New England



It's Not "All or Nothing"



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- We will not require you to provide property or services to Citibank or any affiliate of Citibank as a condition to the extension of a commercial loan to you by Citibank or any of its subsidiaries, unless such a requirement is reasonably required to protect the safety and soundness of the loan.
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Neil Faden

Partner

Manatt, Phelps & Phillips, LLP

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NEW MARKETS TAX CREDITS

Improving Capital Access for Health Care Providers in New York State

Neil S. Faden
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October 2, 2012

NMTC PROGRAM BACKGROUND

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- Established by Congress in 2000 as part of the Community Renewal Tax Relief Act of 2000
- Goal: encourage economic and community development and job creation in low-income communities by attracting private capital
- Codified in Section 45D of the Internal Revenue Code
- Administered by the Community Development Financial Institutions Fund (the "CDFI Fund") of the U.S. Treasury Department

HOW DO NMTCS WORK?

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- NMTCs are available for qualified investments in Low Income Communities
- "Low Income Community": census tract with
  - poverty rate greater than 20%
    or
  - median family income less than 80% of applicable area median family income*

    *if tract not in metropolitan area, statewide median family income; if tract in metropolitan area, greater of statewide median family income or metropolitan area median family income
- CDFI Fund encourages investments in areas of higher distress
  - Many CDEs are required in their allocation agreements to provide NMTCs only for investments in "highly distressed" census tracts (e.g., poverty rate > 30%; median family income < 60% of applicable area median income; unemployment > 1.5x national average; etc.)

HOW DO NMTCS WORK?

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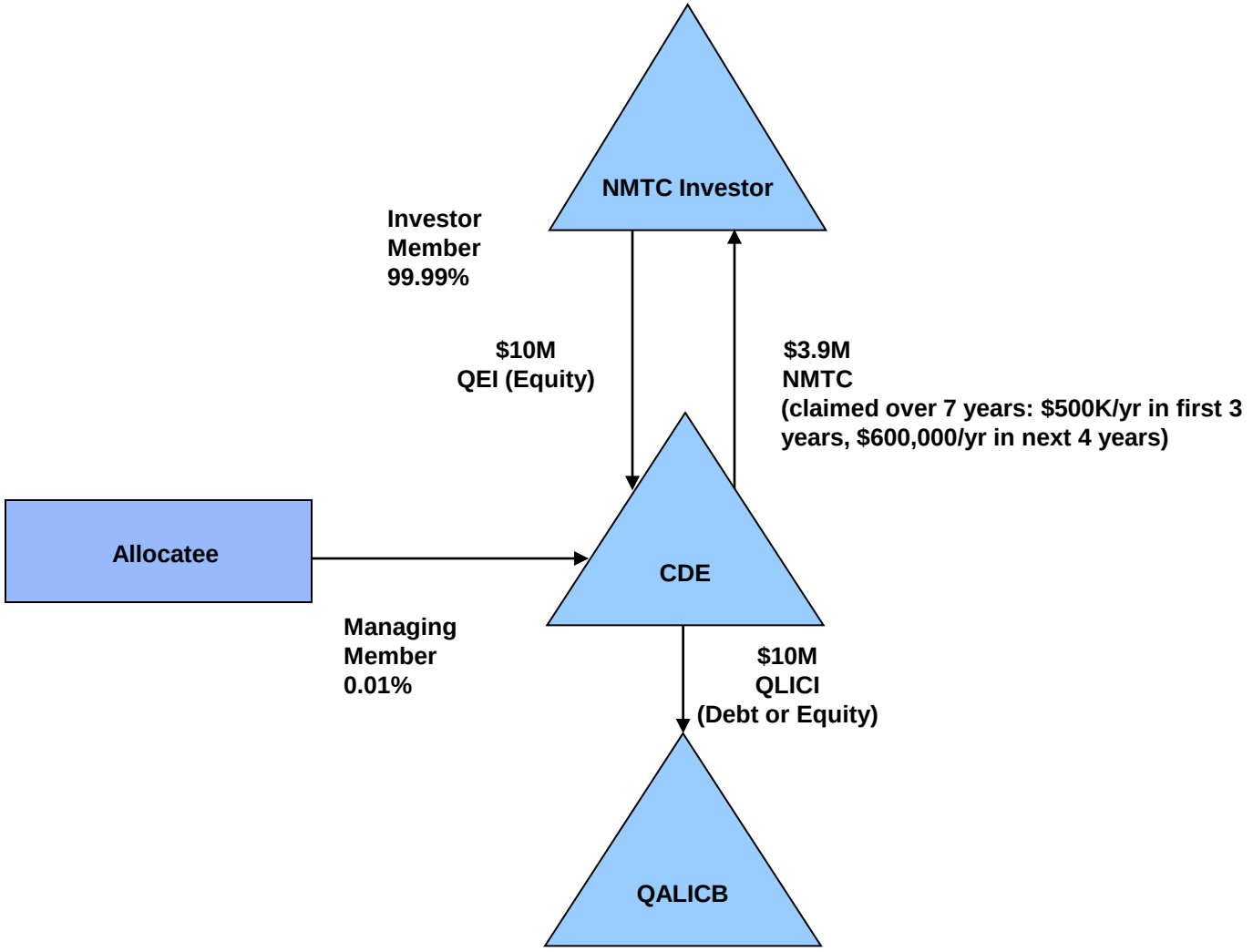
Overview

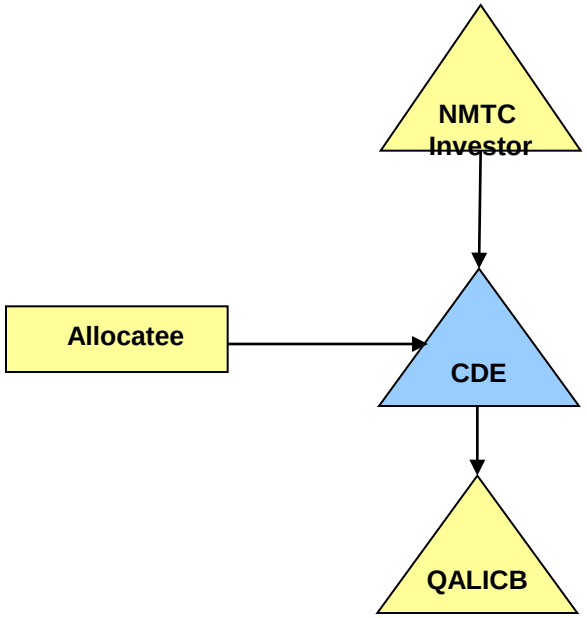
- Taxpayer makes "qualified equity investment" ("QEI") in an eligible "community development entity" ("CDE")
- Within 12 months, CDE must use "substantially all" (more than 85%) of the QEI to make loans or investments ("QLICIs") in qualified borrowers ("QALICBs")
- QEI must remain invested or be reinvested for 7 years (NMTCs encourage patient investment)
- Taxpayer claims credit against Federal income taxes: 39% of the QEI, claimed over seven years (5%, 5%, 5%, 6%, 6%, 6%, 6%)

HOW DO NMTCS WORK?



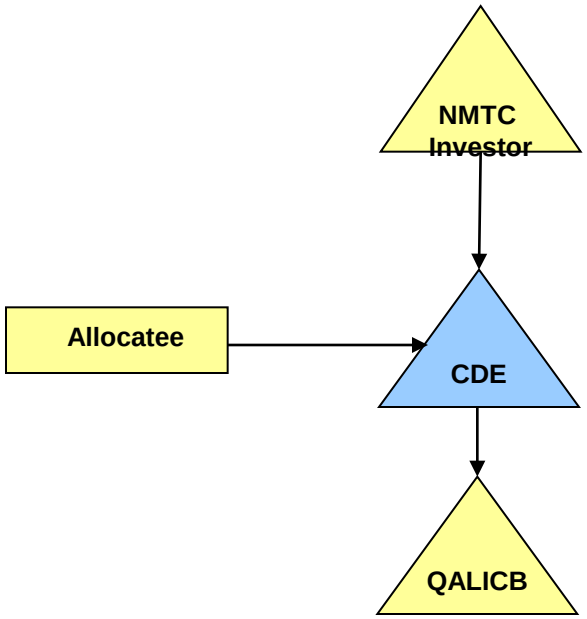
WHAT IS A CDE?

- Entity that is a **corporation or partnership for tax purposes** (corporation, partnership or LLC) and **certified by CDFI Fund**
- **Primary mission:** serve or provide investment capital for LICs or low-income persons



- **Accountable to LICs** through representation (at least 20%) on governing or advisory boards
- CDFIs can automatically qualify

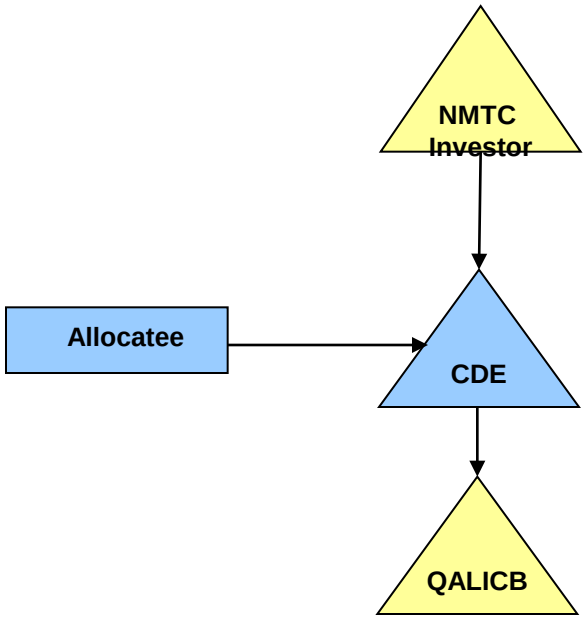
- **Accountability through advisory (or governing) board:**
  - At least 20% must be residents of or otherwise representative of LIC (e.g., board member of LIC-focused organization)



  - If large service area, need reps from cross-section of LICs
  - Must meet at least 1x/yr (more often is preferable); input and views must be given consideration by governing board

WHAT IS A CDE? (continued)

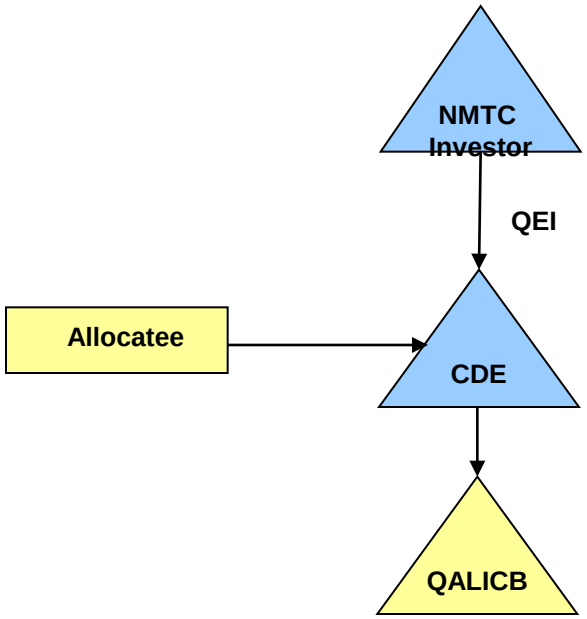
- A CDE that receives an allocation of NMTCs (the "Allocatee") will often form subsidiary CDEs and use different subsidiary CDEs for each transaction



- CDE must be a for-profit entity that can receive equity investments
- Nonprofit CDE can form for-profit subsidiary CDE and use for-profit subsidiary for transaction

WHAT IS A QEI?

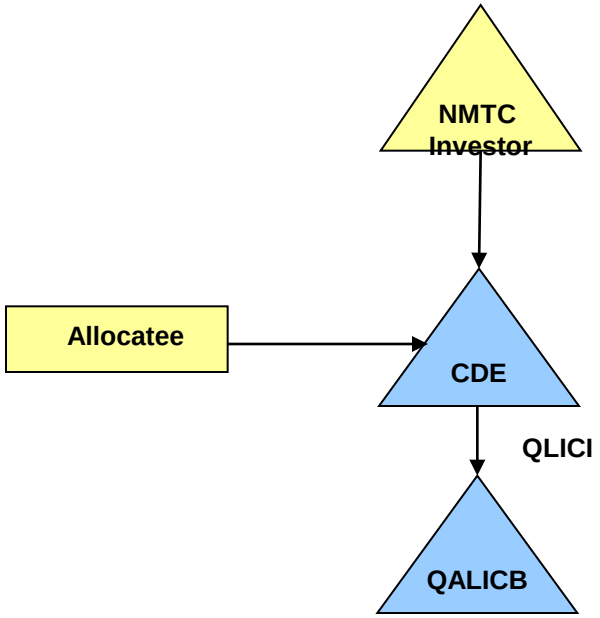
- A **Qualified Equity Investment** is a cash investment for stock or capital interest in a CDE (i.e., an equity investment)



- By virtue of making QEI, taxpayer may claim credits (39% of the QEI, claimed over seven years)
- Within 12 months, CDE must use substantially all of QEI proceeds to make QLICIs

WHAT IS A QLICI?

- Loan to, or equity investment in, a QALICB
- Loan to, or equity investment in, another CDE (that CDE must then make a loan to or equity investment in a QALICB)

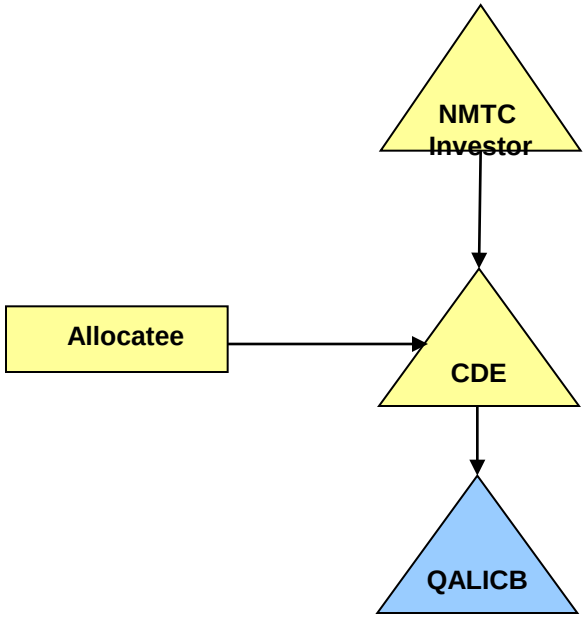


- Purchase of QLICI loan originated by another CDE
- Financial counseling and other services

WHAT IS A QALICB?

A **Qualified Active Low Income Community Business** is:

- corporation or partnership (including nonprofit corporations)
- engaged in the ***active**** conduct of a qualified business
- meets 5 threshold tests
- not engaged in an excluded business or activity:



active** = reasonably expect the business to ***generate revenues within 3 years after QLICI is made

if nonprofit corporation, must engage in an activity that ***furthers its charitable purpose***

WHAT IS A QALICB? (continued)

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5 Threshold Tests:

1. **Tangible Property** – at least 40% of tangible property of the business is used in a LIC
2. **Services** – at least 40% of services performed for the business by its employees are in a LIC (measured by amount paid)
3. **Gross Income** – at least 50% of total gross income must be derived from active conduct of qualified business in a LIC
   - deemed satisfied if Tangible Property or Services test met at 50% instead of 40%
   - **No Employees?** A business without employees can meet the Gross Income and Services tests if it meets the Tangible Property test at 85% (e.g., SPE with no employees formed to hold real estate)

WHAT IS A QALICB? (continued)

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5 Threshold Tests:

4. Nonqualified Financial Property

Less than 5% of the average unadjusted basis of the QALICB's property can be attributable to "nonqualified financial property"

- Includes cash, debt, stock, partnership interests, options, futures contracts, forward contracts, warrants, notional principal contracts, annuities and other similar property
- Excludes reasonable amounts of working capital
- Policy: discourage passive/intangible investments, encourage investments in tangible assets (buildings, equipment) that contribute directly to growth and employment in a LIC

5. Collectibles

- Less than 5% of the average of the aggregate unadjusted basis of the property of the QALICB can be attributable to collectibles (i.e., antiques, stamps, etc.)
- Excludes collectibles held primarily for sale to customers in the ordinary course of business

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Excluded Businesses

- QALICBs **and** their tenants can not operate a:
  - Private or commercial golf course
  - Country club
  - Massage parlor
  - Hot tub facility
  - Suntan facility
  - Racetrack or other gambling facility
  - Store the principal business of which is the sale of alcoholic beverages for consumption off premises
    - (bars, supermarkets and convenience stores selling liquor are generally OK)

WHAT IS A QALICB? (continued)

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- **Other excluded businesses:**
  - Businesses in which the predominant business is developing or holding intangibles for sale or license (e.g., intellectual property portfolio)
  - Certain farming businesses
  - Residential rental
    - less than 80% of gross rental revenue can be from residential rental units
    - i.e., **mixed-use projects are allowed so long as at least 20% commercial**
  - Rental of unimproved real property
    - Substantial improvements must be built on the property

WHAT IS A QALICB? (continued)

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- **Portion of the Business**
  - A portion of a business may qualify as a QALICB if that portion of the business (i) would meet the QALICB requirements if separately incorporated and (ii) has a completely separate set of books and records.
  - Useful for businesses that are not located exclusively in low income census tracts.
  - **Example:** multi-site hospital system uses NMTC financing to build a new community health facility in a low-income community. The POB consists of the operation of that facility.

WHAT ARE THE RISKS?

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Tax Credit Recapture

If, at any time during the 7-year credit allowance period:

- CDE ceases to be qualified as a CDE
- CDE redeems or "cashes out" any portion of the QEI (although operating income may be distributed)
- the "substantially all" test is not met (i.e. at least 85% of the QEI is not invested by CDE in QLICIs)

then, the tax credit investor suffers **complete recapture** of tax credits.

Indemnification

- Investors will require an **indemnity from the CDE** for recapture caused by the CDE
- A CDE may cease to meet the "substantially all" test if the QALICB to whom it has made a QLICI ceases to be a QALICB. Therefore, investors will also require an **indemnity from borrowers** for recapture resulting from failure to remain a QALICB during the 7-year credit period

HOW ARE FEES STRUCTURED?

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CDE Fees

- CDEs generally receive upfront fees and ongoing asset management fees for life of 7-year NMTC investment
- Upfront fees: generally range from 2% to 5% of QEI
- Ongoing fees: generally range from 2.45% to 5.25% of QEI
- Exit fees: some CDEs structure exit or success fees, often equal to 1% of the investment

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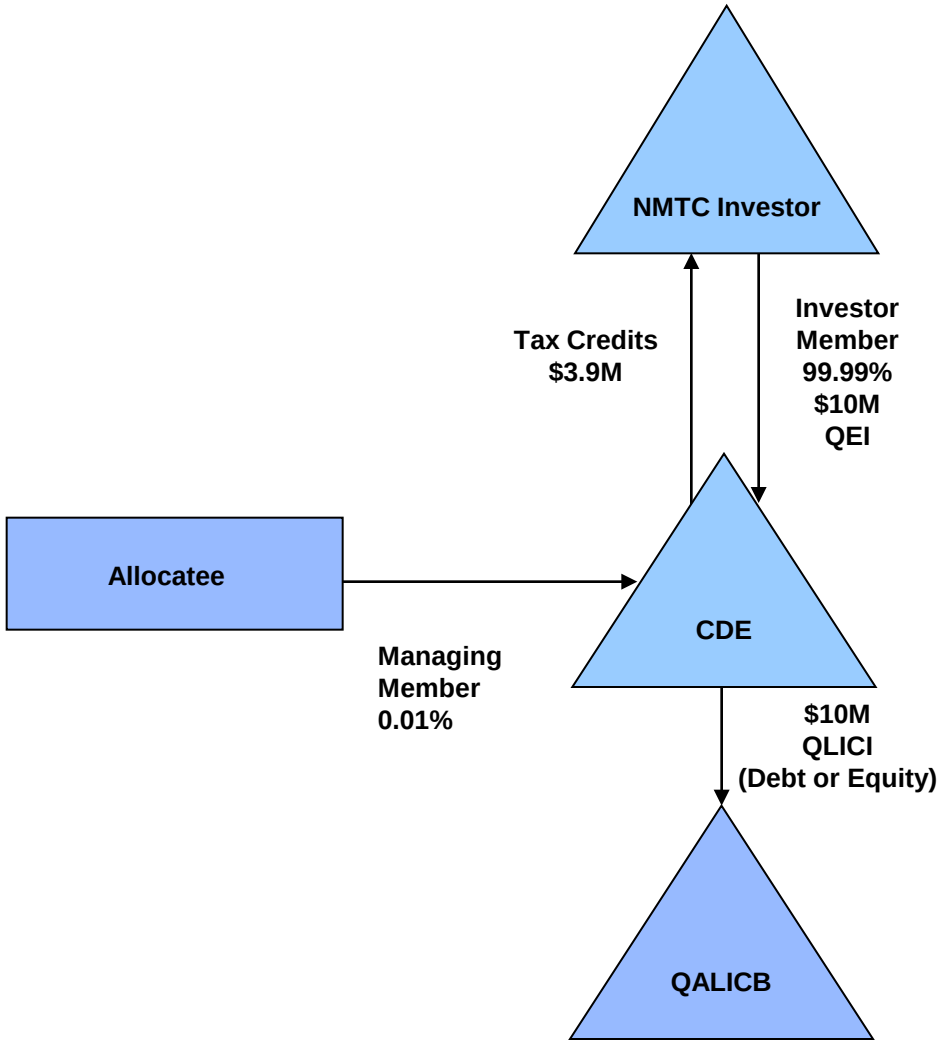
Direct Investment Model v. Leverage Model

HOW IS A TRANSACTION STRUCTURED?
Direct Investment Model



- Taxpayer makes a QEI in the CDE, for which it receives tax credits equal to 39% of the amount of the investment
- CDE uses at least 85% (i.e., *substantially all*) of the QEI to make QLICIs in QALICBs, typically in the form of loans or direct equity investments

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Direct Model v. Leverage Model

- Direct investment not as common due to limited return on investment

- Leverage model makes the program more attractive by increasing the rate of return on the equity investment

HOW IS A TRANSACTION STRUCTURED?
Leverage Model

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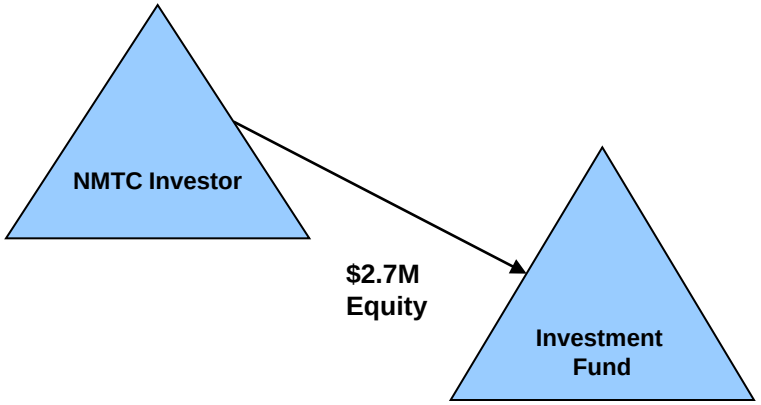
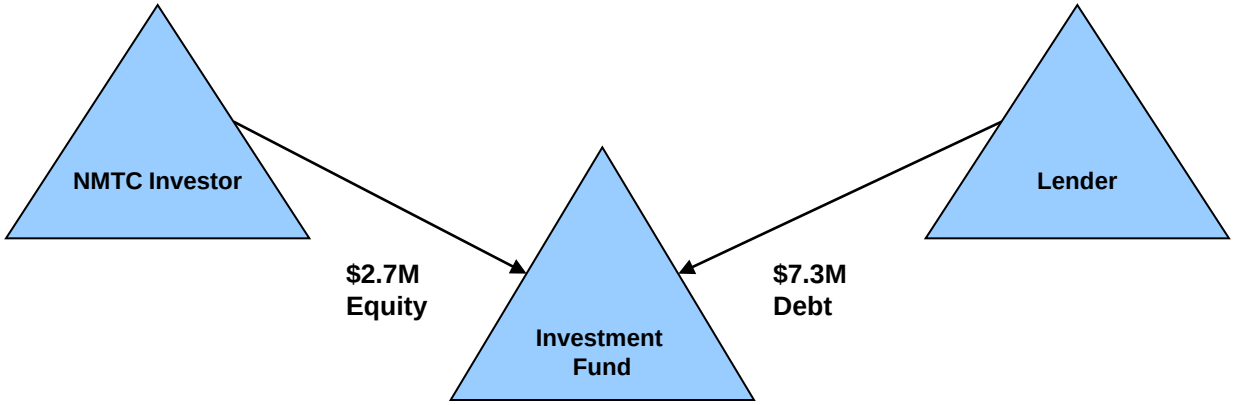
- Taxpayer makes an equity investment in a special purpose entity (the "Investment Fund")



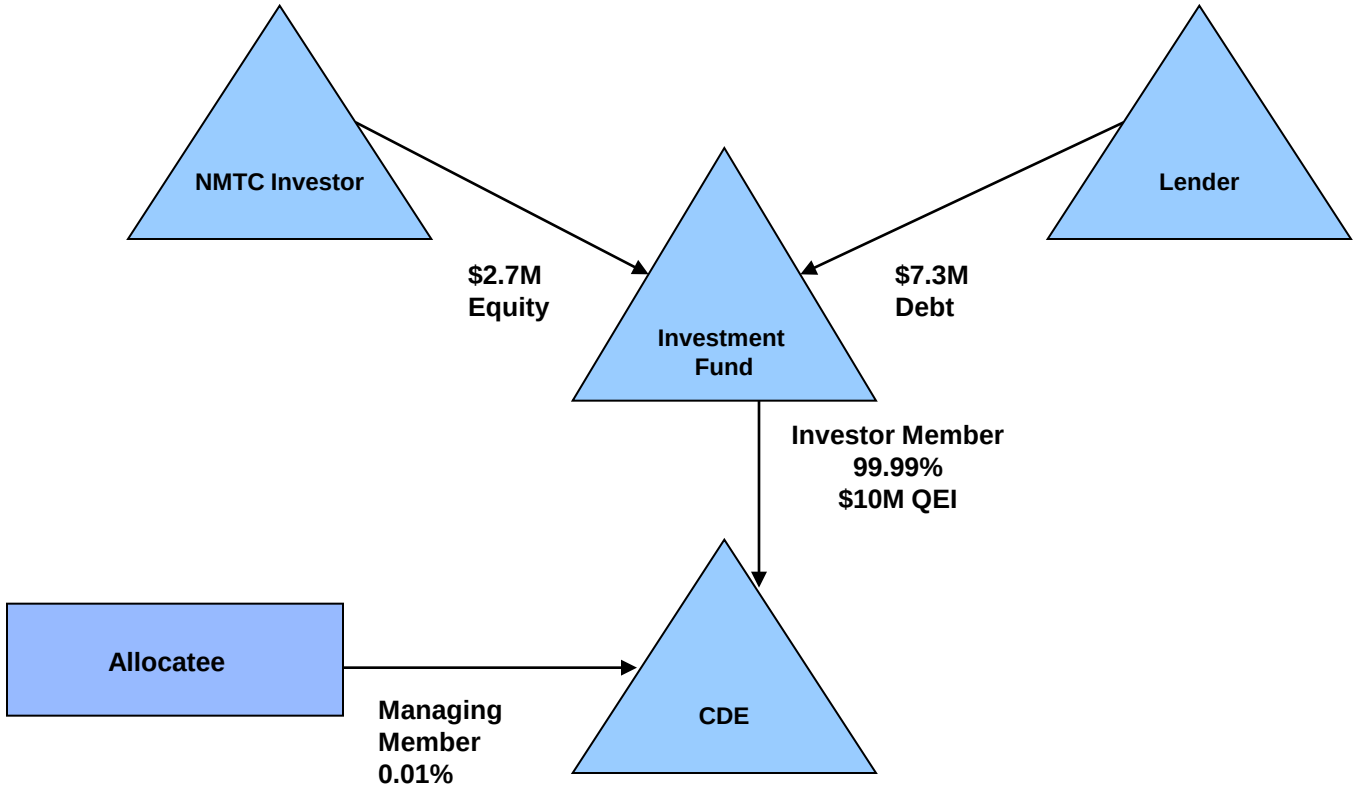
HOW IS A TRANSACTION STRUCTURED?
Leverage Model

- A lender provides a loan to the Investment Fund



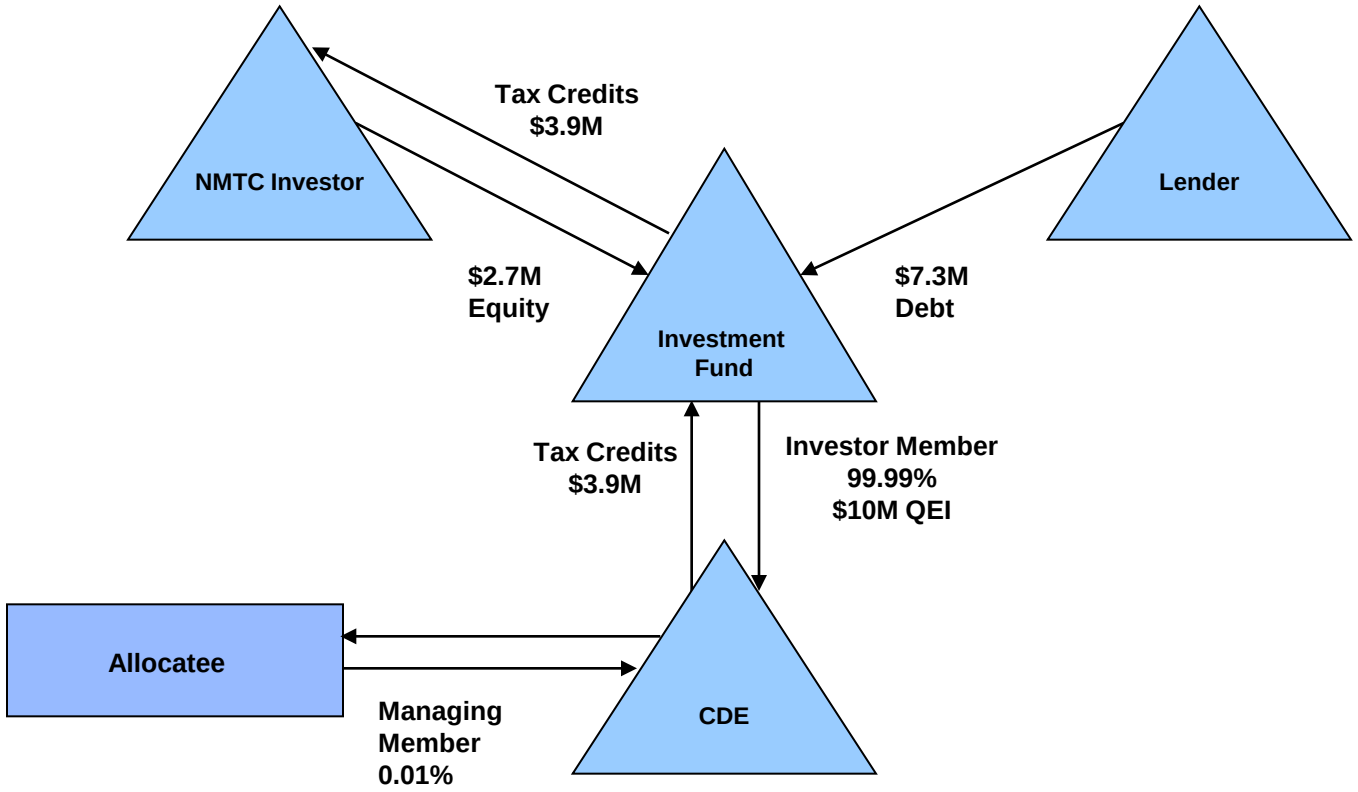
HOW IS A TRANSACTION STRUCTURED?
Leverage Model

- Investment Fund makes a QEI in the CDE using the proceeds of both the equity investment and the loan

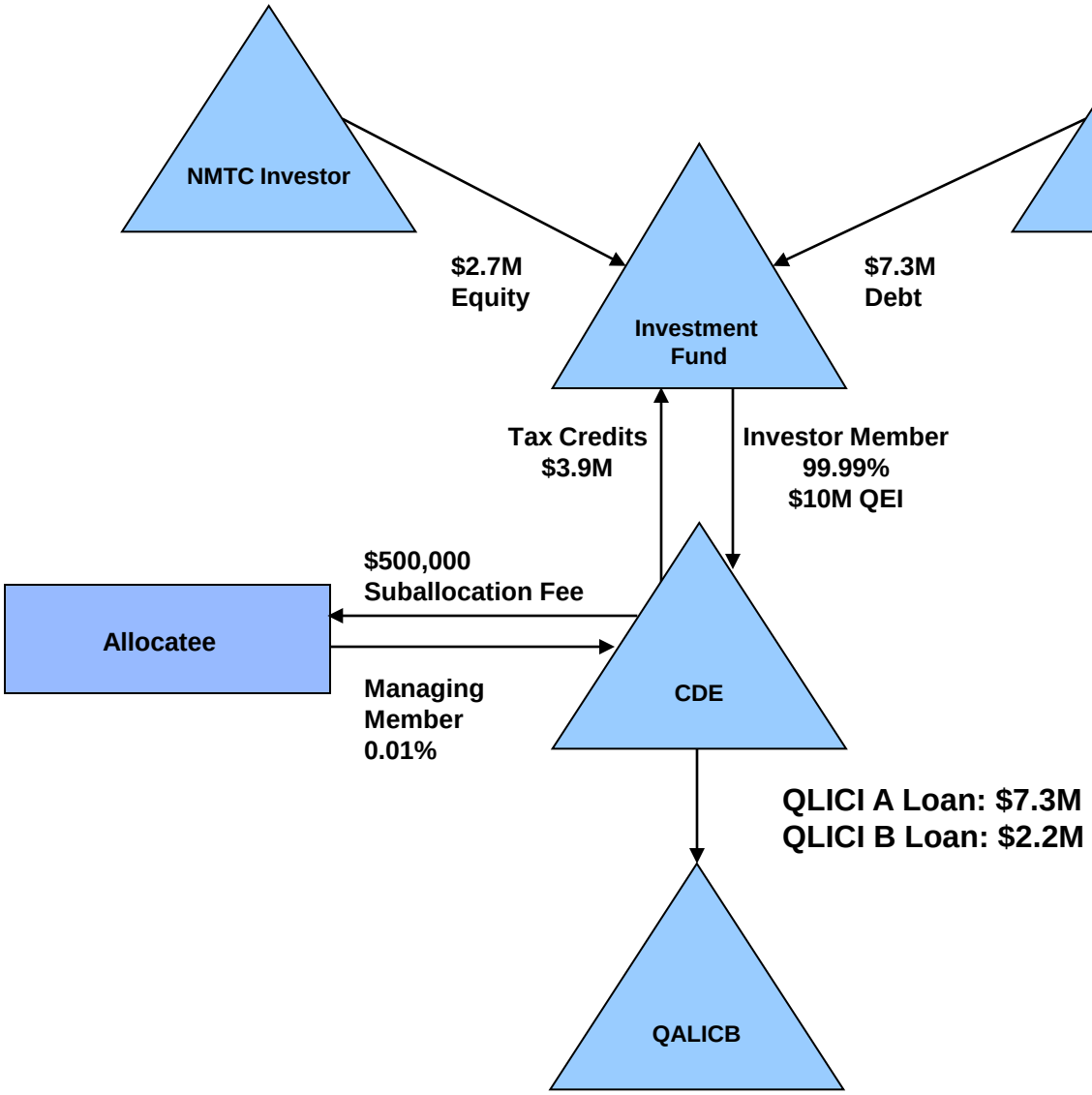


HOW IS A TRANSACTION STRUCTURED?
Leverage Model

- Investment Fund receives tax credits equal to 39% of the amount of the entire investment (debt and equity)
- Tax credit investor (as sole member of investment fund) receives 100% of the tax credits



HOW IS A TRANSACTION STRUCTURED?
Leverage Model



- Rest of transaction is same: CDE uses at least 85% (substantially all) of QEI to make QLICIs in QALICBs
- QLICIs typically track Investment Fund capitalization: “A” loan equal to leverage loan amount and “B” loan equal to NMTC equity net of fees and expenses
- Structure approved by the IRS but the leverage lender can **not** have a collateral interest in the QALICB or its assets

HOW IS A TRANSACTION STRUCTURED?
Leverage Model

manatt

Who is the Leverage Lender?

- Affiliate of the Taxpayer
- Affiliate of the Borrower
- Unaffiliated third party such as a bank, a CDFI or a governmental entity
  - Third party leverage lenders provide needed capital but increase complexity of negotiations
  - Third party leverage lender will want control over reinvestments if there is a “sub-all” failure and the QLICI needs to be redeployed
- Leverage lenders can sell participations in leverage loans

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Multiple CDE Transactions

- Large transactions often involve more than one CDE because a CDE may lack sufficient allocation authority or may be unwilling to allocate too much of its allocation to any one project
- Multiple CDE transactions can get complicated and expensive quickly

NMTCS AND COMMUNITY IMPACT

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- Need to show benefit to low-income community, such as:
  - Job creation/retention
  - Job training/targeted hiring
  - Needed community services (healthcare, child care, education)
  - Needed goods and services (pharmacy, grocery store)
- CDEs report community impact to CDFI Fund; impacts consideration for future allocations

NMTCS AND THE "BUT FOR" TEST

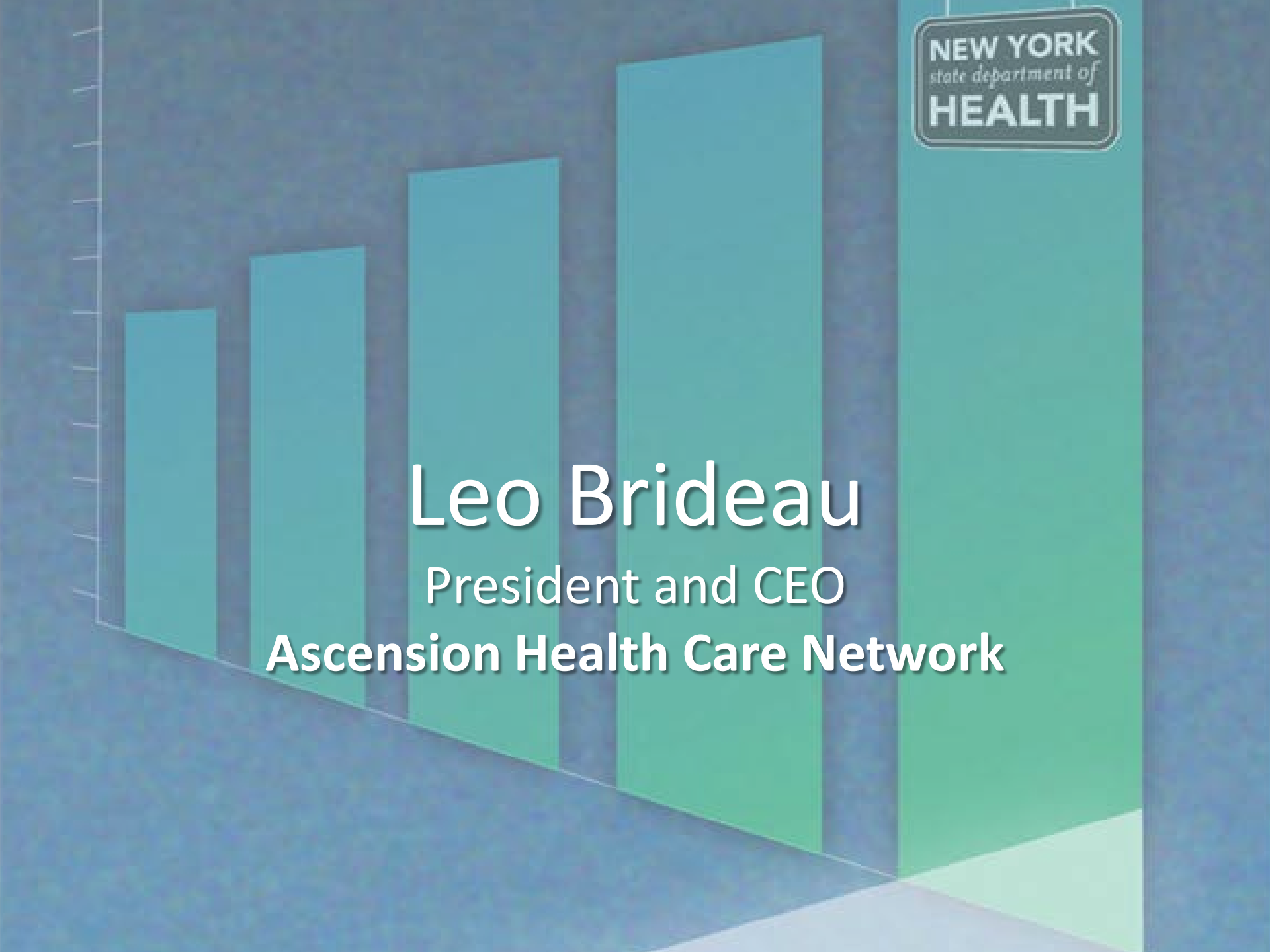
manatt

- Need to show project could not proceed "but for" NMTC
  - Market-rate financing has been maximized
  - All sources of "soft funds" tapped
  - Project still has a funding gap
- Goal: efficient use of taxpayer money

QUESTIONS?

manatt

- Questions?


NEW YORK
state department of
HEALTH
Leo Brideau
President and CEO
Ascension Health Care Network

ASCENSION HEALTH
CARE NETWORK

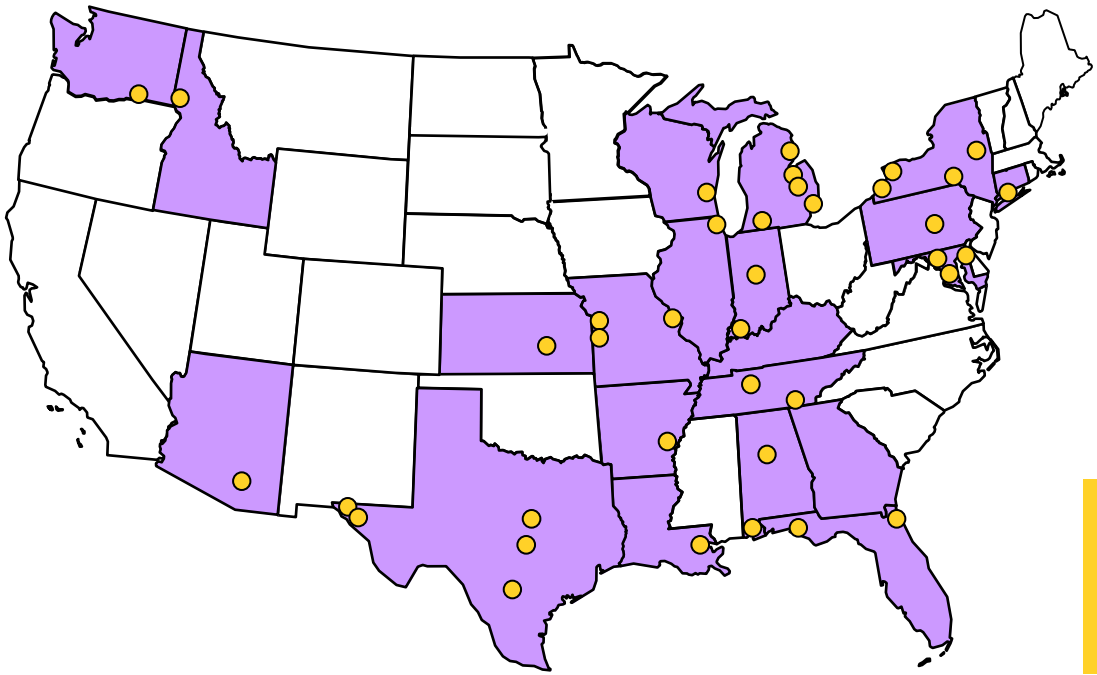
New York State Health Care Capital Access Forum

October 2, 2012

Ascension Health Alliance

Ascension Health Alliance is the largest Catholic health system, the largest private non-profit system and the third largest system (based on revenues) in the United States, operating in 21 states and the District of Columbia.

Care of Persons Living in Poverty and Community Benefit Programs $1.3 Billion

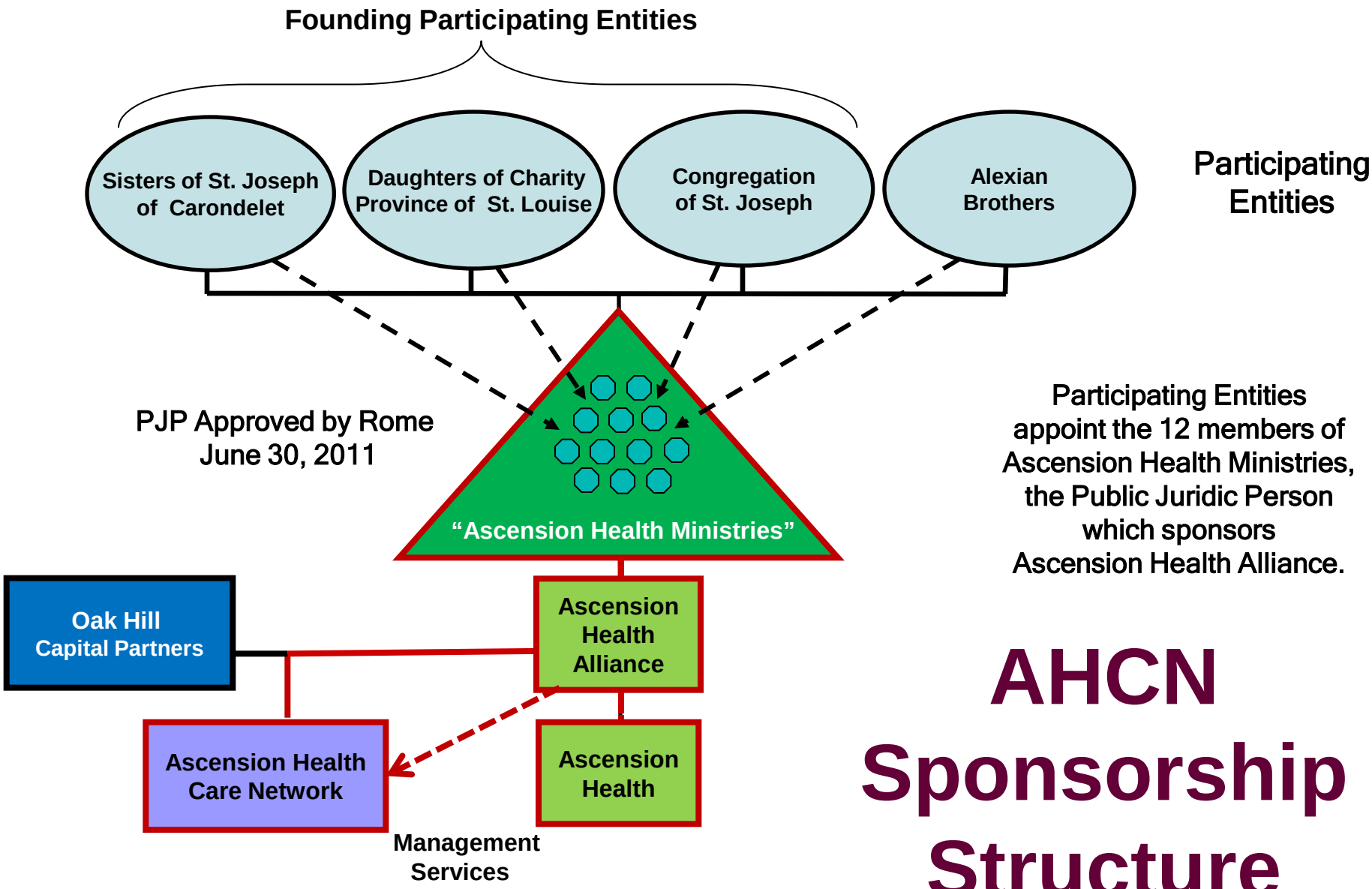


Facilities and Staff

Locations	1,400+
Acute Care Hospitals	70
Long-term Acute Care Hospitals	3
Rehabilitation Hospitals	3
Psychiatric Hospitals	6
Available Beds	18,450
Associates	122,000
Physicians	30,000
Nurses	23,000

Financial Information (FY12)

Total Assets	$23.8 Billion
Operating Revenue	$16.6 Billion



AHCN Sponsorship Structure

Pressures Facing The “Have-Not” Hospitals

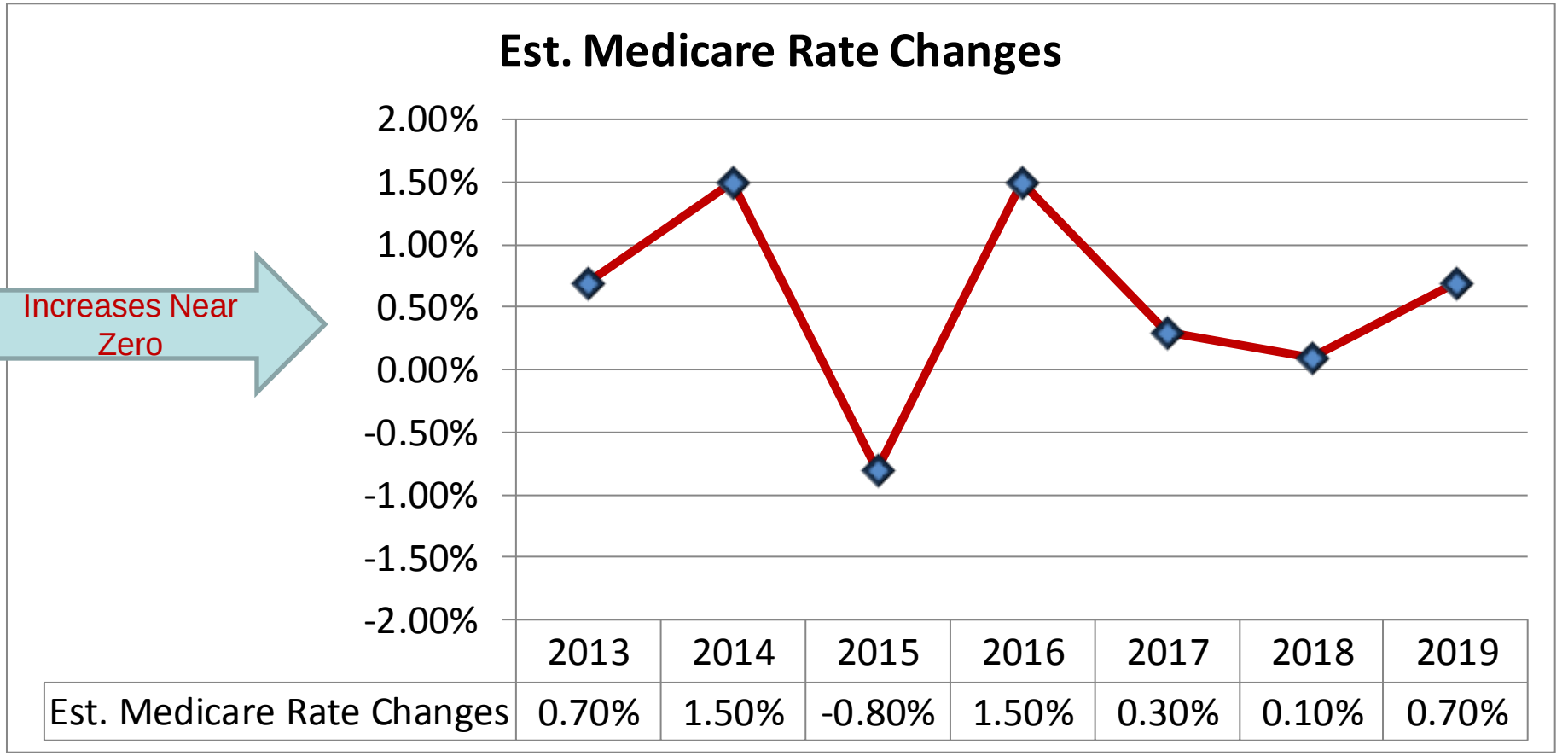
The Same Old Problems

- Flat or declining Medicare and Medicaid payments
- Shift of care away from hospital settings
- Chronic underinvestment in physical plant and equipment
- High debt loads
- Unfunded pension liabilities

The New Challenges - The Imperative to Transform

- Need to evolve away from pure fee-for-service to payment for value
- New demands for capital:
- Infrastructure required to manage care of populations
- Electronic health records
- Creating aligned/integrated health care systems

Future Medicare payments will fall far short of historical healthcare inflation rates

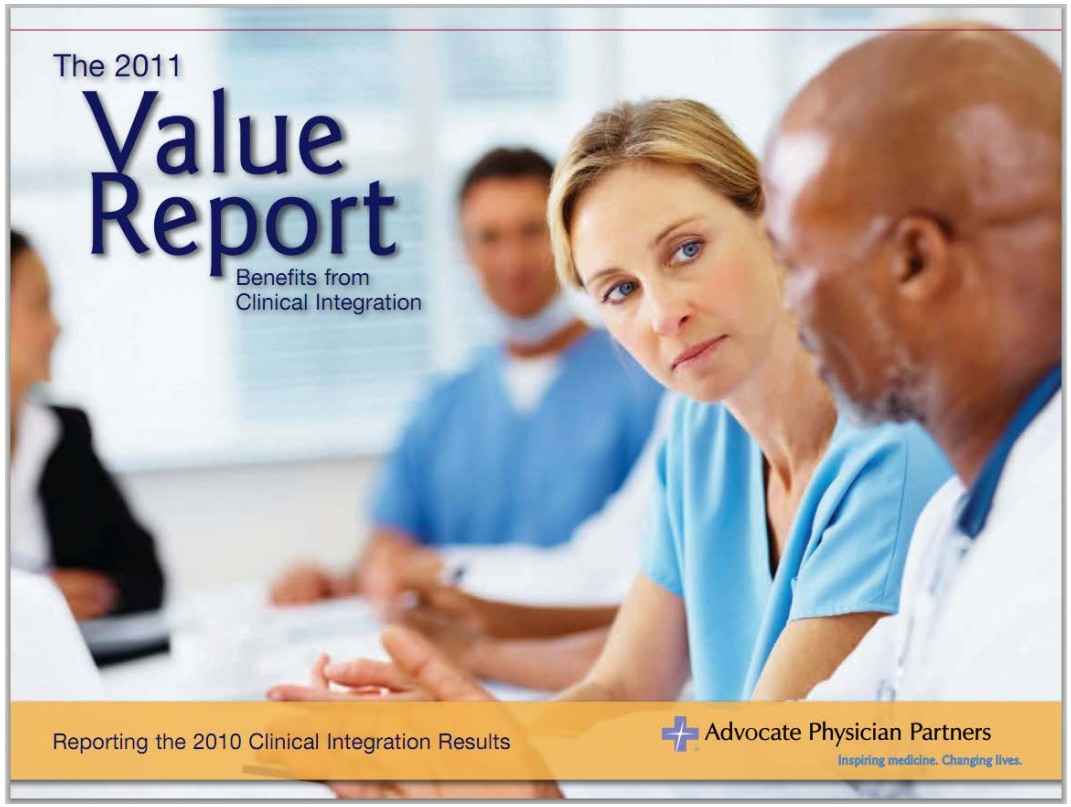


	2013	2014	2015	2016	2017	2018	2019
Est. Medicare Rate Changes	0.70%	1.50%	-0.80%	1.50%	0.30%	0.10%	0.70%

Source: Barclays Equity Research
March 2012

New Value-Based Payment Models are Being Driven by Clinically Integrated Regional Market Leaders

Payment mechanisms are focusing on value and driving providers toward taking accountability for costs and quality…and they are starting to deliver



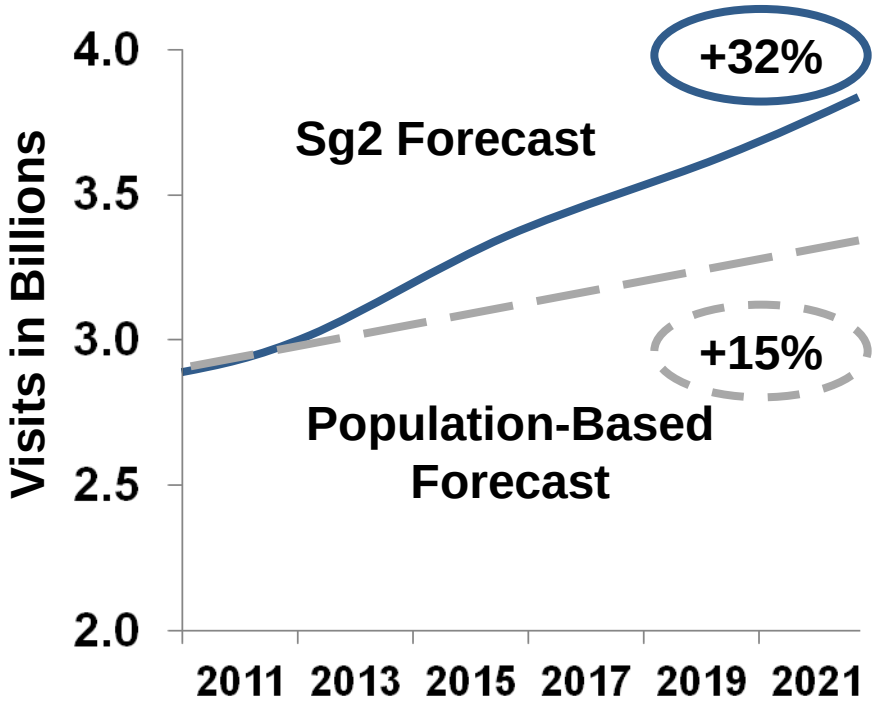
Advocate's performance under the value-based contract with BCBS-IL

- Admissions/1,000: <11.1%>
- Length of Stay: 1.2%
- Days/1,000 <9.9%>
- O/P Surgery/1,000 <11.0%>
- Advanced Imaging <7.5%>
- Scripts/1,000 2.3%

Source: Kaufman Hall

Care Will Continue to Shift to the Outpatient Settings
And
Not to the same competitors as in the past

Adult Outpatient Forecast in U.S. Market 2011 - 2021



The Market Will See New Entrants

Walgreens
The Pharmacy America Trusts

Walmart

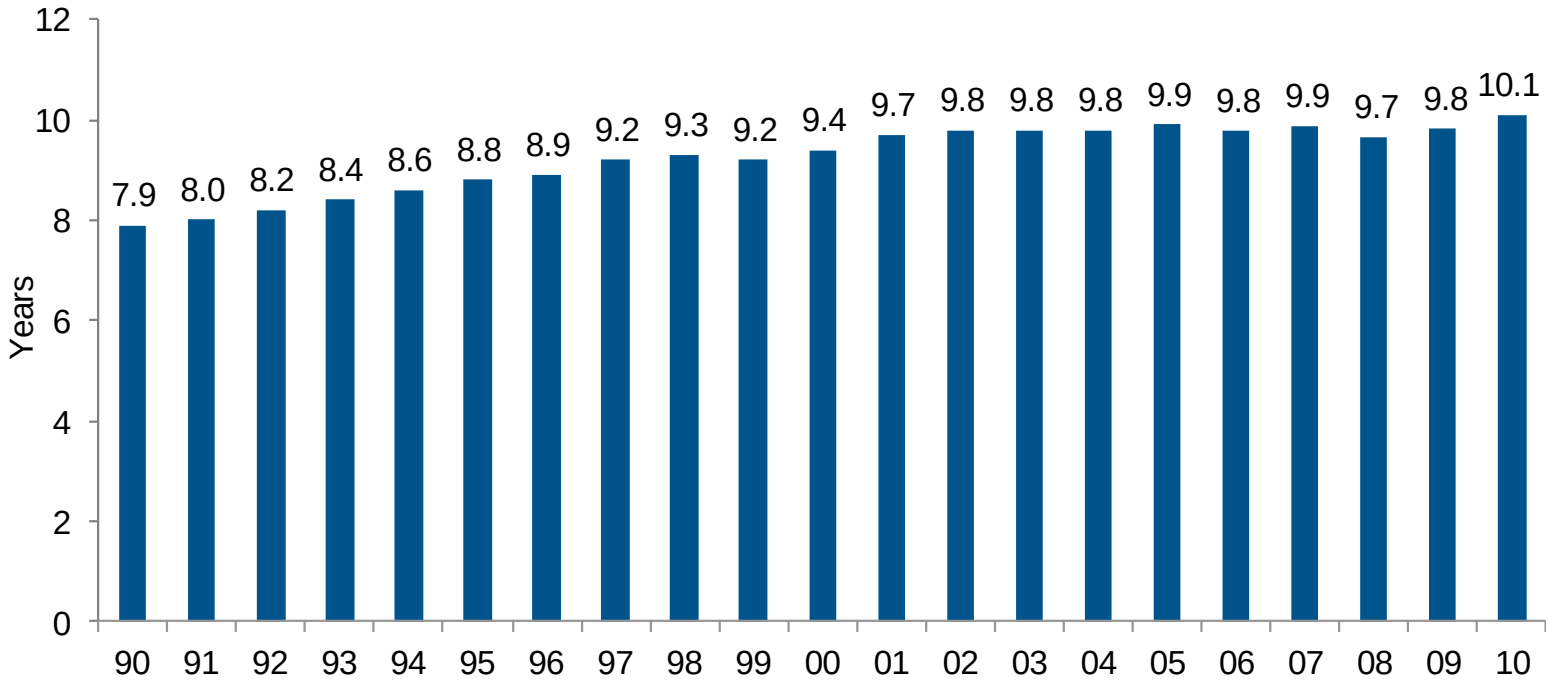
NIKE

Ascension Health Care Network

Source: Impact of Change v10.0; NIS; Pharmetrics; CMS; Sg2 Analysis, 2011

Chronic Underinvestment in Physical Plant and Equipment

Average Age of Plant has increased more than 25 percent over the past 20 years.



ASCENSION HEALTH CARE NETWORK

Source: Ingenix, *Almanac of Hospital Financial and Operating Indicators,* 2005, 2008, 2009, 2010, 2011, and 2012 and CHIPS, *The Almanac of Hospital and Financial Operating Indicators*, 1994 and 1996-7.

Vision

AHCN's Point of View on the Future of Health Care

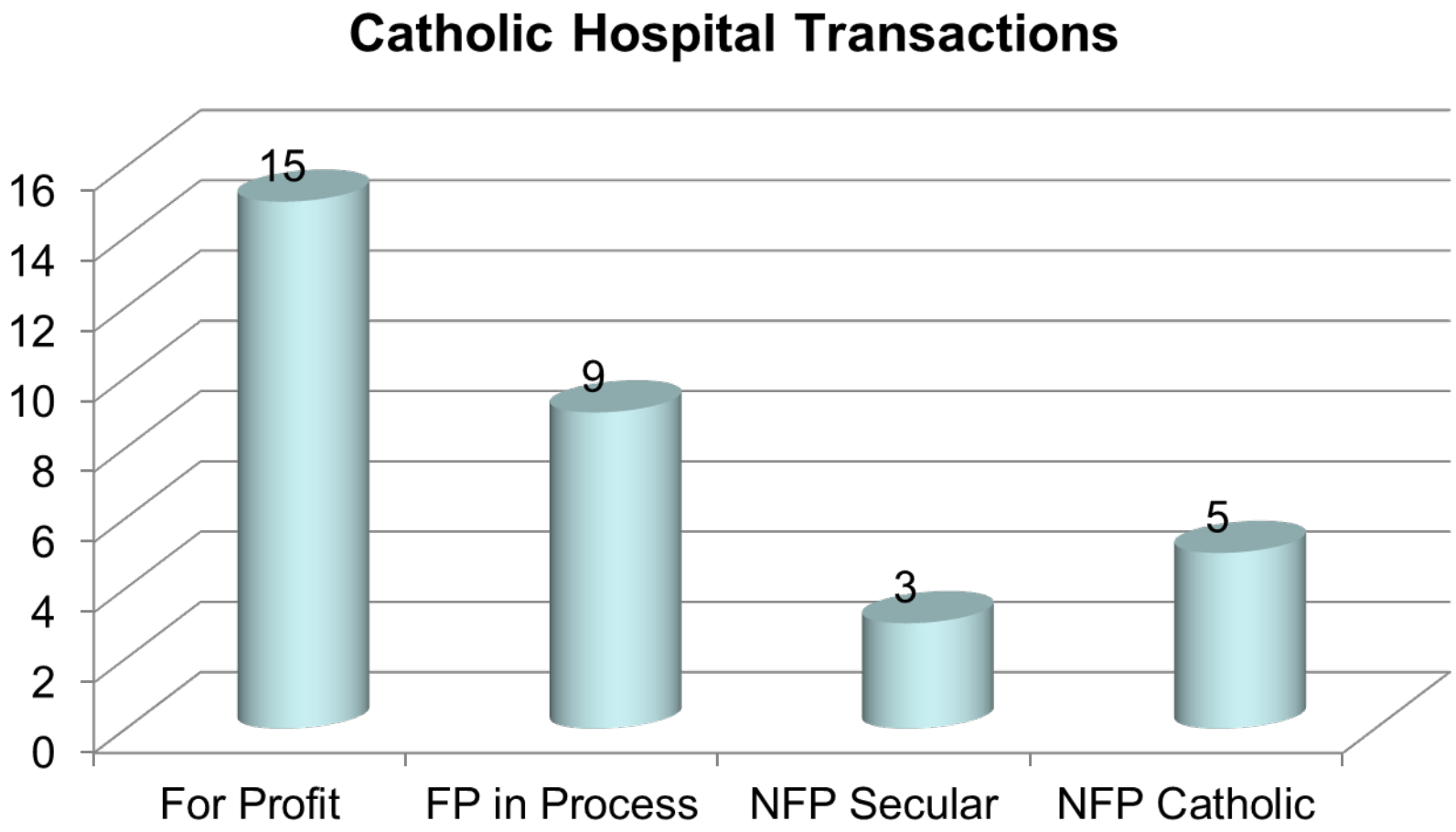
Forces

- Unsustainable economic model creates huge financial pressure.
- Demand for **value** (quality/safety/experience with lower total cost of care) requires integrated care.

Response

- Create sufficient scale nationally and locally.
- Consolidate, integrate, collaborate to create optimal value.

Since 2009 most changes in ownership of Catholic hospitals have been to for-profit companies



Source: Citi Private Analysis

AHCN: Key Structural Elements

- Joint venture between Ascension Health Alliance (20% owner) and Oak Hill Capital Partners (80% owner).
- 11 member board of directors: 4 appointed by Ascension Health Alliance, 6 appointed by Oak Hill and the AHCN CEO is an ex officio member with vote.
- Formed as a Delaware for-profit corporation.
- **Ascension Health Alliance has sole authority in perpetuity over compliance with, changes in, and interpretation of:**
  - Elements of Catholic identity and related programs
  - Charity care and community benefit policies of AHCN
  - Adherence to Ethical and Religious Directives

Oak Hill Capital Partners

- Oak Hill Capital Partners (OHCP) is a leading private equity firm with a track record of successful investments in the healthcare industry.
- OHCP is committed to helping AHCN hospitals deliver the same level of quality, charity care and community benefit as Ascension Health hospitals.
- OHCP sees a path to value creation in the way Ascension Health builds financial strength and serves communities today:
  1) Focus on partnering with **outstanding management teams** and building **best-in-class hospitals**.
  2) Valuing the **benefits of scale** that Ascension Health will provide to AHCN hospitals.
  3) Belief that successful hospitals **engage the local community,** including through charity care and community benefit.

“For profit” describes AHCN’s tax status; not its purpose.

A not-for-profit hospital meets its capital needs in three ways:

- By making a profit on care it provides
- By borrowing money
- By investing in stocks, bonds, and other investment vehicles

A not-for-profit hospital uses its capital for four purposes

- To support its charitable mission
- To maintain its physical plants and replace equipment
- To invest in strategic initiatives that grow and sustain the health system
- To provide a return on investment to its bondholders

An AHCN hospital meets its capital needs in three ways:

- By making a profit on care it provides
- By borrowing money
- By receiving equity capital from its shareholders

An AHCN hospital uses its capital for four purposes

- To support its charitable mission
- To maintain its physical plants and replace equipment
- To invest in strategic initiatives that grow and sustain the health system
- To provide a return on investment to its bondholders and shareholders

Purpose & Identity

- We believe Catholic Identity goes beyond an agreement to adhere to the Ethical and Religious Directives.
- We use an integrated, comprehensive approach to express and to sustain our Catholic Identity. Key Elements include:
  - Promoting and Defending Human Life and Human Dignity
  - Promoting the Common Good and Justice
  - Promoting and Maintaining Holistic Care
  - Promoting a Participatory Community of Work and Mutual Respect
  - Living our mission in Solidarity with those who live in Poverty
  - Stewarding our resources on behalf of the ministry
  - Acting in Communion with the Church

How Can AHCN Add Value?

Improving economic performance

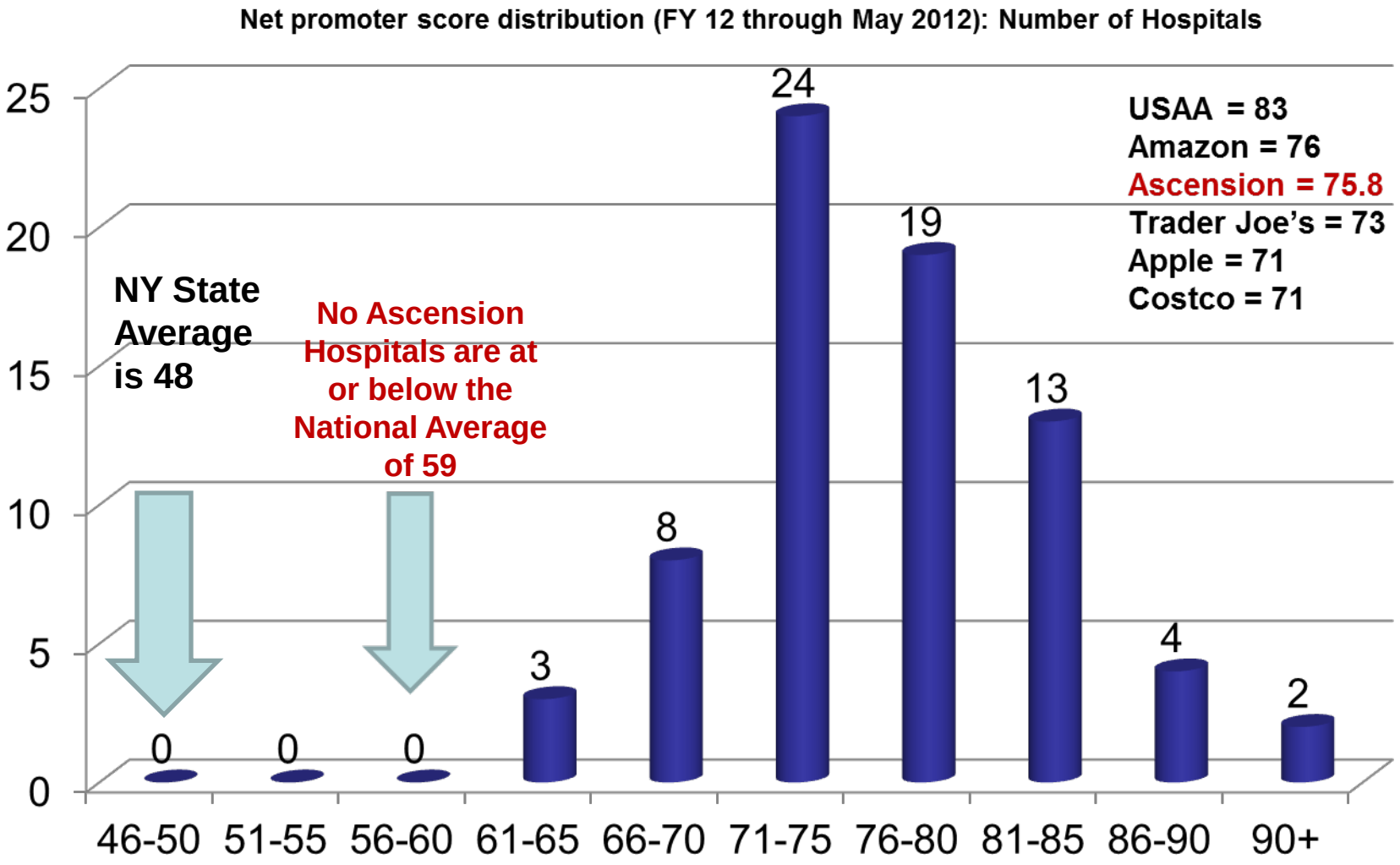
Improving quality and safety

Improving the patient experience

Providing access to capital

An Exceptional Patient Experience

Ascension Health Alliance has learned how to provide consistently exceptional patient experiences.



Source: The Joint Commission and Satmetrix

Ascension Health Care Network Provides value through:

- Management support services from the nation's largest Catholic and largest not-for-profit health system
- Maintaining hospitals as sponsored works of the Catholic Church while strengthening all elements of Catholic identity
- Commitment to serve the poor and vulnerable
- Proven track record of quality improvement and patient safety
- Proven track record of providing an excellent patient experience
- Proven track record of creating great workplaces
- Source of capital to ensure long term viability and success of critically needed hospitals and health systems

Questions?

Ralph de la Torre

Chairman and CEO

Steward Health Care System, LLC

Keith Pitts

Vice Chairman

Vanguard Health Systesm

VANGUARD
HEALTH SYSTEMS

Improving Capital Access for Health Care Providers in New York State

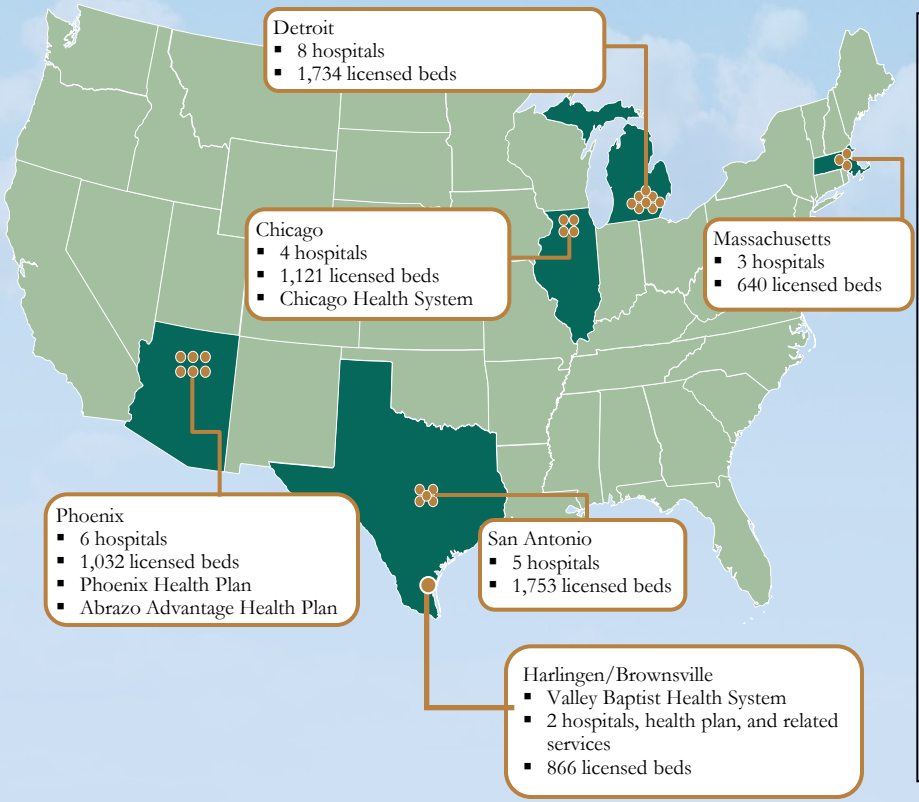
Detroit Medical Center

October 2, 2012

Health for Life

VANGUARD
HEALTH SYSTEMS

Overview of Company



- **Fortune 500 company publically traded on the New York Stock Exchange (NYSE: VHS)**
- **28 hospitals in 5 states**
- **Currently own 3 health plans and a risk MSO platform with over $1B in risk-based revenue**
- **Annualized revenues of $6.0 billion**
- **Committed to health system reform**
  - 3 approved ACOs
  - ACE Demonstration Project
  - CMS bundled payment awards
  - CMMI Award

Health for Life

VANGUARD HEALTH SYSTEMS

Our Strategic Focus

- **Build and support regionally scaled, high-performance patient-centered integrated care networks**
  - Focus on safety, quality and value
  - Clinically coordinated, integrated and evidenced-based care
  - Establish the standard of care for positive experiences for our patients, their families and our physicians
- **Fully engage in health and wellness**
  - Create an organization where our employees and their families are some of the healthiest and most productive in the markets we serve
  - Lead efforts to measure and directly improve the health of our communities as payments move from fee-for-service to fee-for-value, including risk sharing platforms
- **Strengthen our growth and reputation through local trust, national scale and sustained access to capital markets**
  - Innovate and share best practices
  - Find, invest in and retain talented people
  - Create a great place to work and a most admired company
  - Develop strategic partnerships with regional and national organizations

Health for Life

VANGUARD HEALTH SYSTEMS

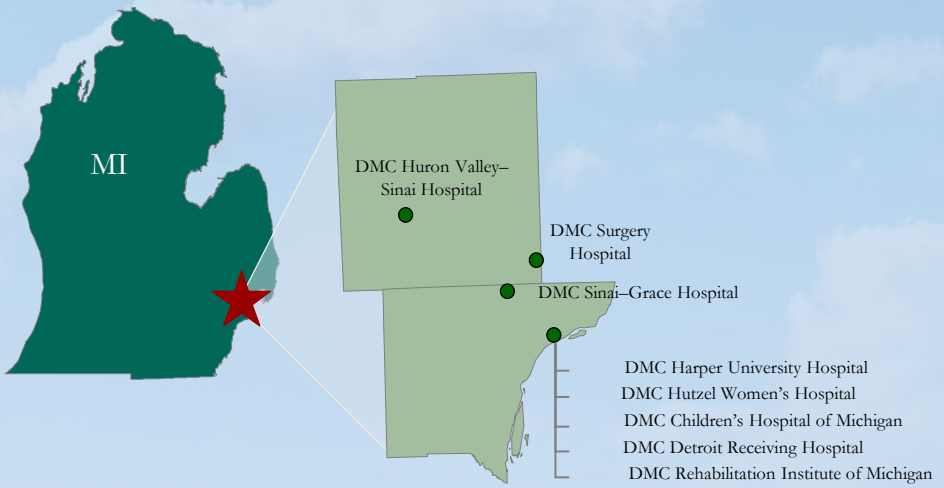
DMC Transaction Overview

- **On March 19, 2010 entered into LOI**
- **On June 10, 2010 entered into Definitive Agreement**
- **Closed transaction on January 1, 2011**
- **Summary of Financial Consideration:**
  - Debt: $360.3 million to repay DMC outstanding debt (includes $416.6 million of debt and $56.3 million of acquired unrestricted cash)
  - Pension Liability: $184 million assumption of DMC pension plan liability
  - Capital Commitment:
    - Maintain routine capital expenditures averaging $70 million per year or $350 million over the five year period after closing, then adequate levels thereafter; no “guarantees” on these expenditures
    - Construct specific capital projects totaling $500 million over the five year period after closing

DMC Background

- **DMC is comprised of eight hospitals in Southeast Michigan, with an additional 50 outpatient sites**
- **December 31, 2009 financial statistics [(1)]**
  - Revenue: ~$2.0 billion
  - Income from operations before impairment charge and unrealized gain on investments: $11.1 million
  - Depreciation & Amortization: $81.5 million
  - Interest: $32.0 million
  - Pension Plan Expense: $31.0 million
  - Discharges: 75,000
  - ER visits: 370,000

[(1)] Publically reported on EMMA



Investment Thesis

- **The transaction creates a unique opportunity in a new market with a large system in a major metropolitan area**
- **Highly sophisticated, community-based Board of Directors and a strong, experienced senior management team remaining with the Company**
- **DMC is recognized as a technology innovator and a leader in the delivery of high quality medicine**
- **Over the past two decades, 21 hospitals consolidated to 8 hospitals in Detroit**
  - 6 of these are owned by the DMC
  - 3 of the 6 DMC hospitals were regional specialty hospitals
- **The Detroit economy appeared to be at a historical low point**
- **Uninsured percentage one of the lowest in the Vanguard system**

Facilities Overview

	Licensed Beds	Comments
 **Children's Hospital of Michigan**	228	▪ SE Michigan's only pediatric Level One Trauma Center ▪ More than 40 specialties
 **Detroit Receiving Hospital**	273	▪ Michigan's first Level One Trauma Center ▪ Trains a large number of Michigan's emergency physicians
 **Harper University / Hutzel Women's Hospital**	567	▪ Hutzel is Michigan's first and only hospital for women ▪ Harper, established in 1863, is a highly regarded teaching institution
 **DMC Surgery Hospital**	36	▪ Sports medicine ▪ Back Pain Clinic
 **Rehabilitation Institute of Michigan**	94	▪ Center of excellence for treatment of strokes, spinal cord and brain injuries
 **Sinai-Grace Hospital**	383	▪ Level Two Emergency Department ▪ Top 1% in heart failure outcomes
 **Huron Valley-Sinai Hospital**	153	▪ Located in suburban Oakland county ▪ One of nation's top hospitals for patient satisfaction
Total	1,734	

Potential Opportunities

- **Healthcare Reform: Medicaid provisions in the Healthcare Reform Bill could add a significant number of covered lives to the Medicaid rolls in Detroit**
- **Further Consolidation in the Market: While Detroit has consolidated, the suburban areas had a building boom over the past 20 years**
- **Outmigration: Inpatient discharges within DMC's primary service area, principally Medicare and Managed Care, are going to hospitals outside the primary service area (capital projects targeted to address outmigration opportunity)**
- **Opportunity to further develop regional service lines**
  - Cardiovascular services
  - Neurosciences
  - Maternal fetal medicine
  - Pediatric (specialties)
  - Complex rehabilitation

Potential Opportunities cont'd

- **Capitalizing on larger scope for successes DMC has already had within its own market**
  - 29 minute ER guarantee
  - 3 Magnet certified hospitals
  - 3 hospitals nationally ranked in 2011 U.S. News Best Hospitals List
  - All hospitals recently received "A" safety ratings from Leapfrog
- **Cardiovascular Institute**
- **Neurosciences Institute**
- **Karmanos Cancer Institute**

What the DMC Transaction Wasn't

- Acquisition of unneeded hospitals
- A turn-around of poor performing hospitals
- A bailout of management or the Board

What the DMC Transaction Represented

- Recapitalization of a needed community resource
- Opportunity to grow by serving more patients in the its primary service area
- Opportunity to take a leadership role in transitioning from fee-for-service to fee-for-health

DMC: 18 Months Later

- **Growth in inpatient admissions and outpatient visits**
- **Completion of several projects**
  - Children's Hospital of Michigan ambulatory tower
- **Major projects underway**
  - DMC cardiovascular institute
  - Sinai-Grace ER and ICU project
- **Over 1000 physician PHO formed**
- **1 of 32 Medicare Pioneer ACOs**
- **Recently signed a definitive agreement to purchase a Medicaid HMO plan**

Paul T. Williams
Dormitory Authority of New York State

Ian Wootton
PwC

Jason Radford
Ashurst

Public/ Private Partnerships (P3s) in Healthcare: "Why Not New York?"

Paul T. Williams, Jr.
Dormitory Authority of the State of New York (DASNY)

Ian Wootton
PwC

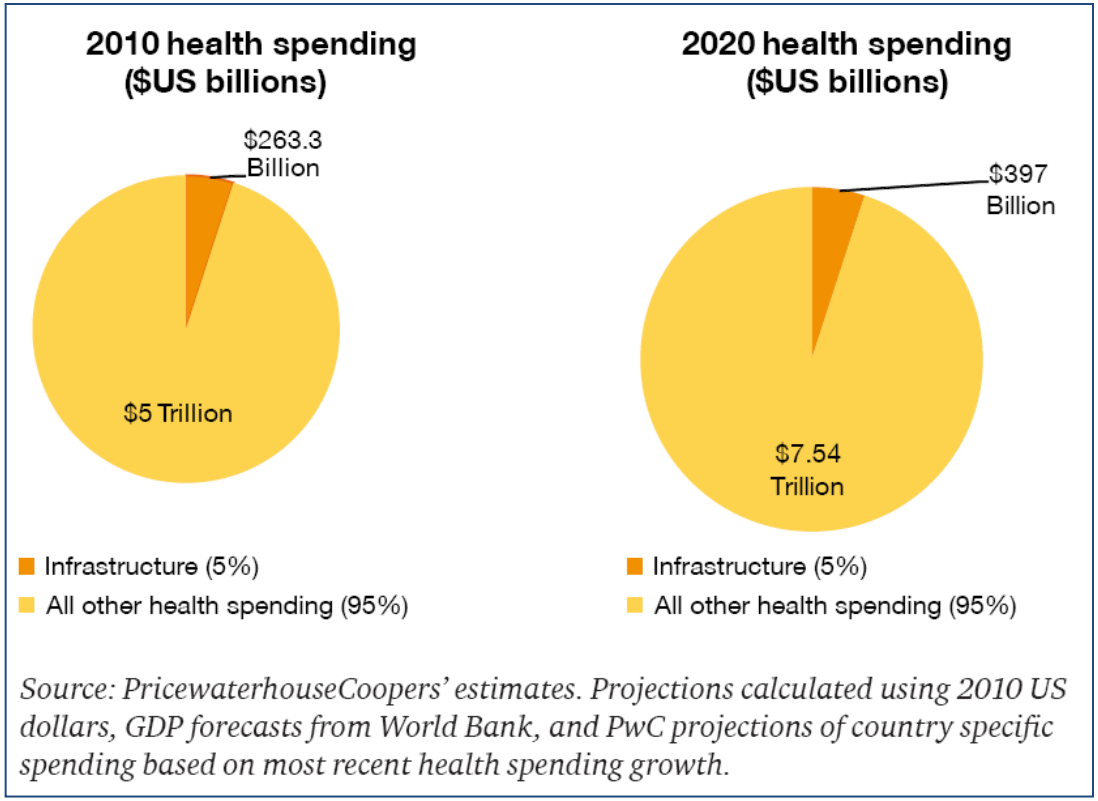
Jason Radford
Ashurst

October 2, 2012

DASNY pwc ashurst

Sizing the market: Health spending is expected to increase by 65.5% between 2010 and 2020

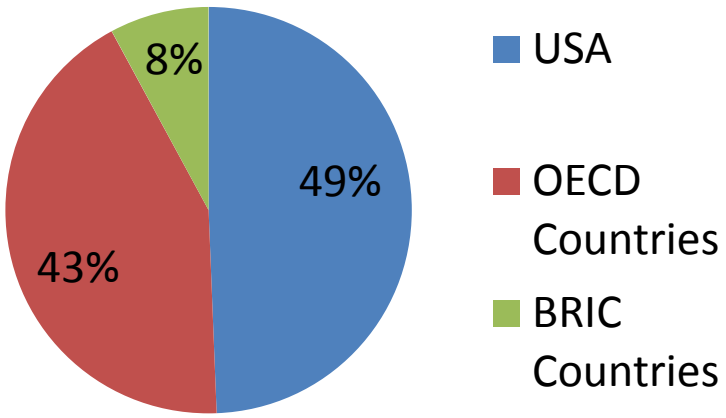
- As health spending in OECD and BRIC nations grows, so will the need for alternative methods of financing and care delivery
- P3s will revolutionize traditional approaches toward cutting costs and improving efficiencies



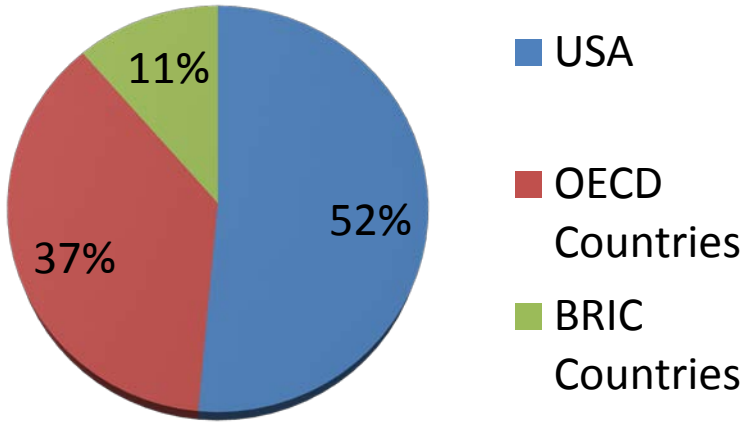
Source: PricewaterhouseCoopers' estimates. Projections calculated using 2010 US dollars, GDP forecasts from World Bank, and PwC projections of country specific spending based on most recent health spending growth.

The USA accounts for over half of health care expenditure

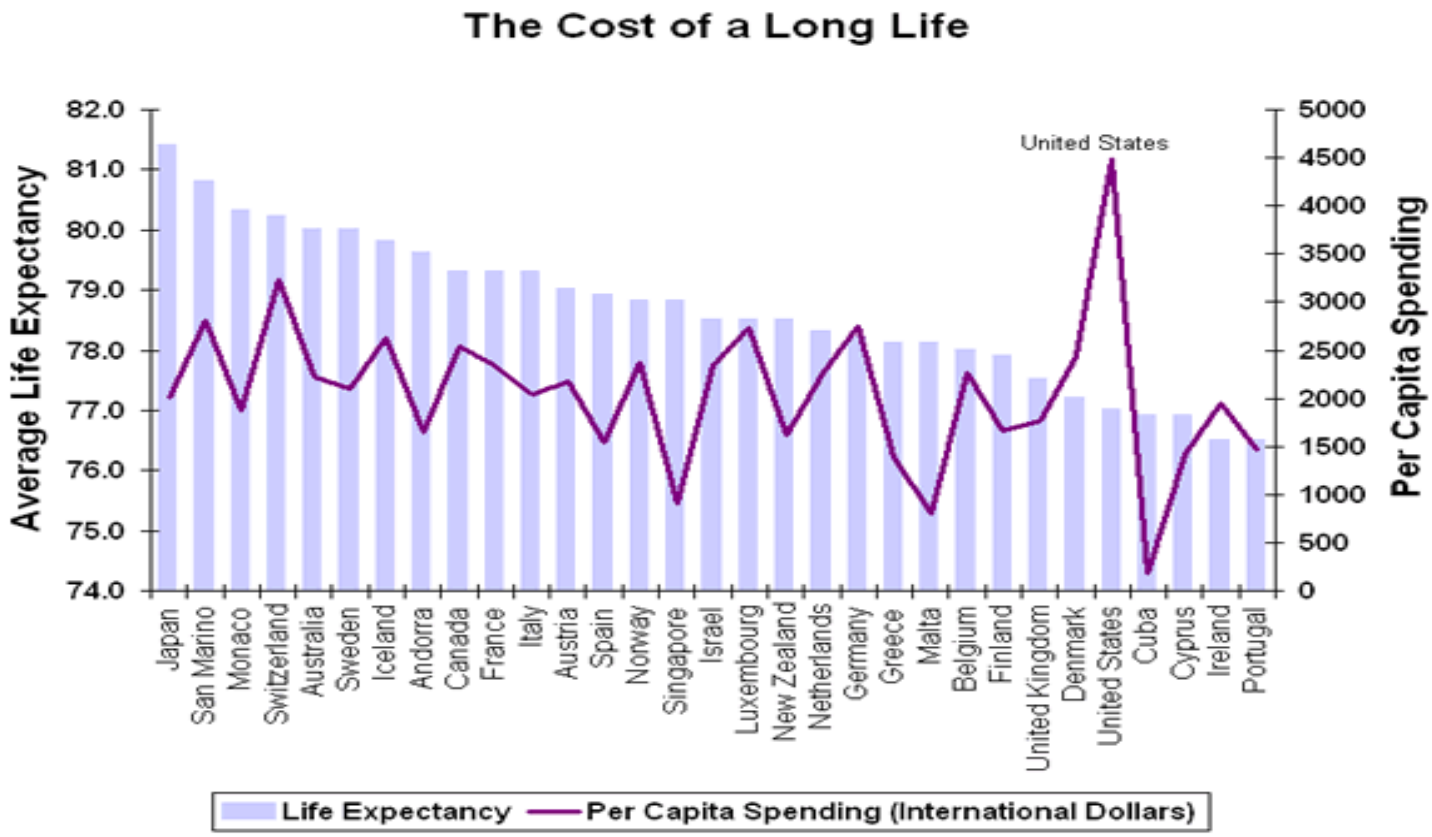
Health Spend 2010
$8.6 Trillion



Health Spend 2020
$12.8 Trillion



Linking health spending to improved outcomes



DASNY pwc ashurst

Healthcare PPPs are taking on a broader scope…in response to broader problems

- The sustainability of health systems around the globe is threatened by growing spending and challenging demographic and epidemiological trends.
- More efficient, value-based models of infrastructure development and care delivery are needed now more than ever.
- PPPs have evolved over time from a primarily infrastructure-oriented model to a clinical services delivery model, increasing in complexity. Some PPPs include both.

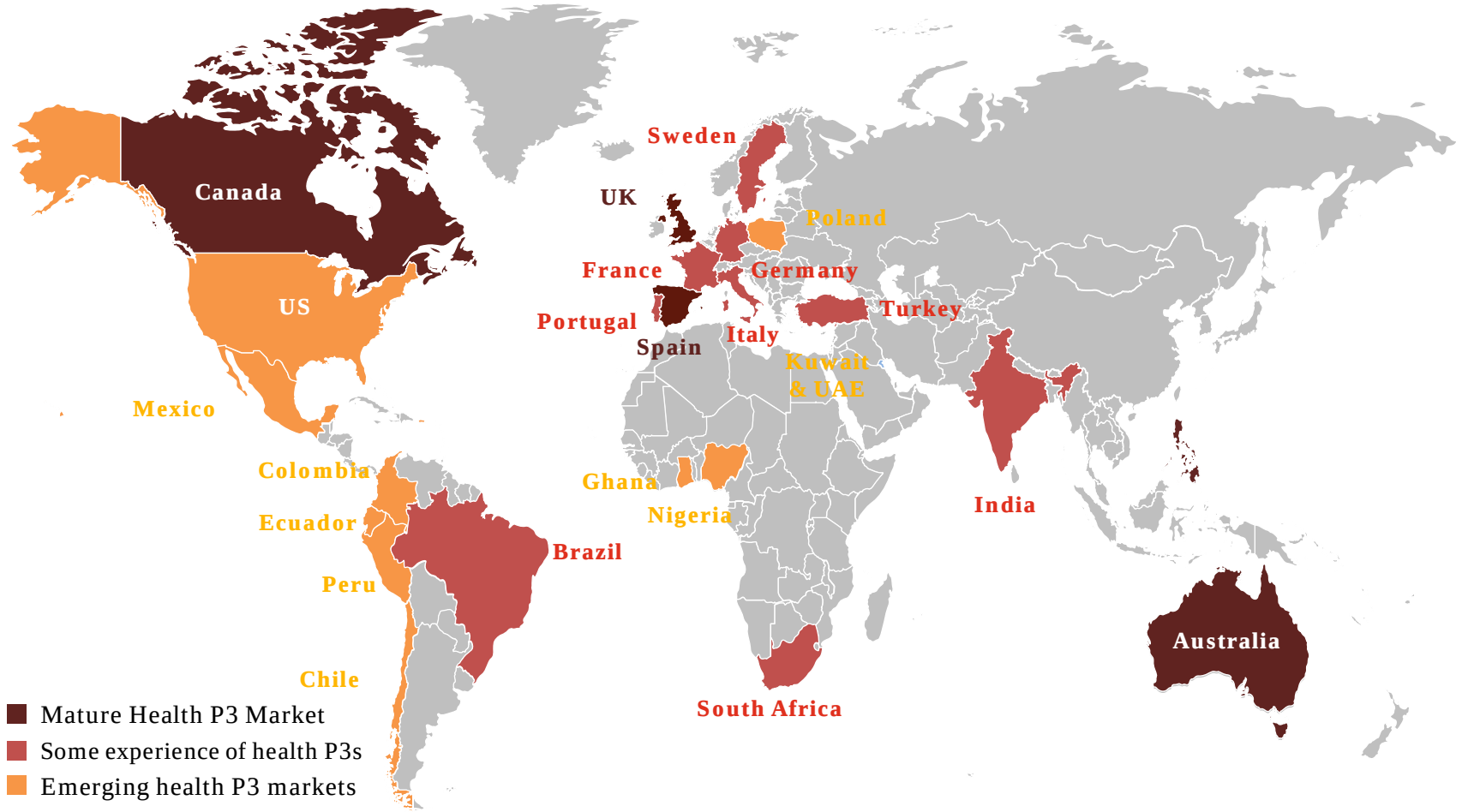
Evolution

Traditional infrastructure–based model

Clinical services–based model

Integrated model–combines both infra & clinical service

A selection of the health P3 markets



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Examples of health PPP projects

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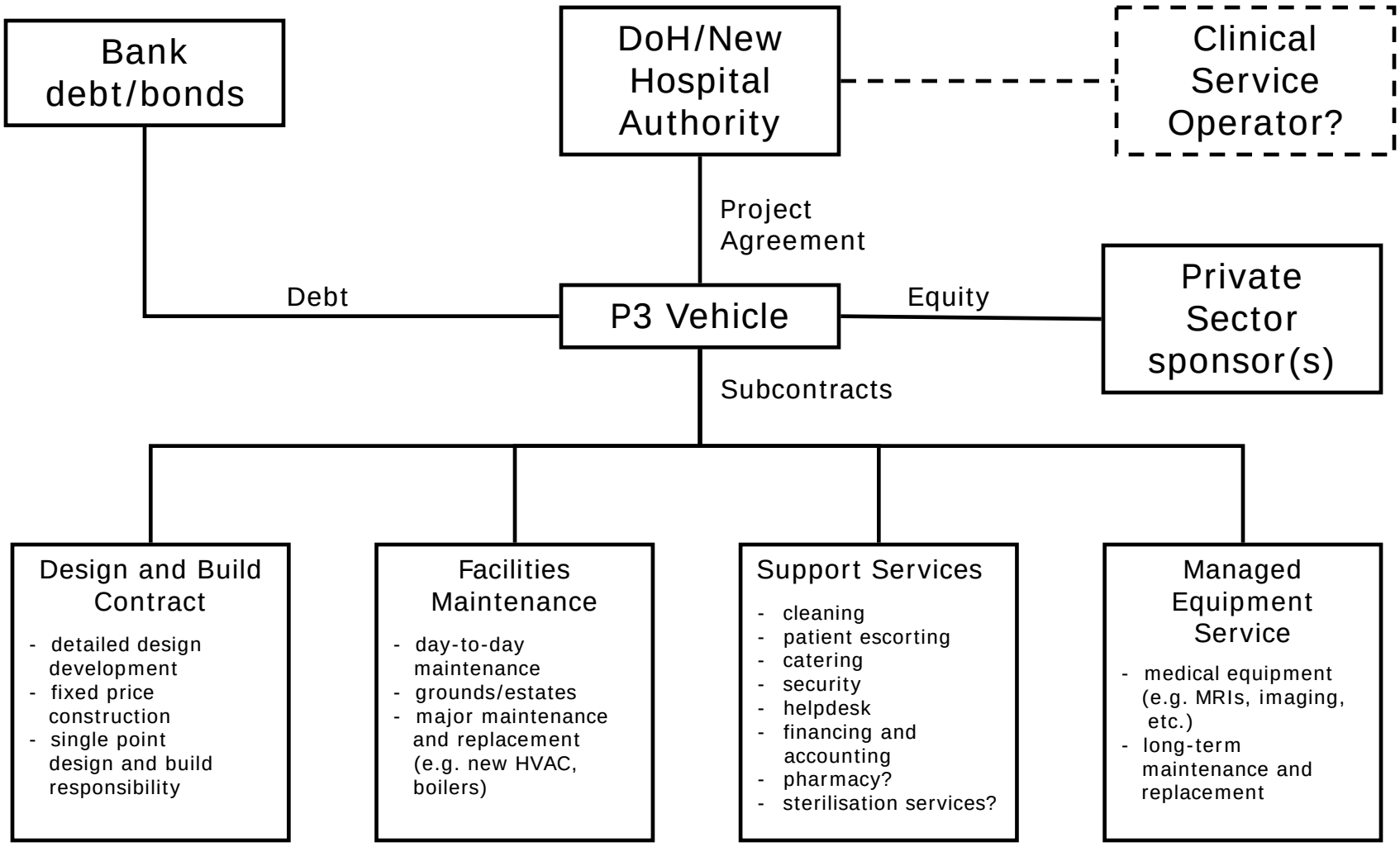
Potential New York Health P3 program structure



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Improving Capital Access

for Health Care Providers in New York State

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