Improving Capital Access for Health Care Providers in New York State
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New York State Department of Health
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Senior Vice President, Health Finance & Reimbursement
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Healthcare Association of New York State
Dan Heim
Executive Vice President
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
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
For Further Information:

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Richard Herrick
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
BAR  RIERS TO  
CAPITAL FORMATION

• Timeliness of Regulatory Approvals

• NY “Risks” seem higher...are they?

• Capital Investment faces Road Blocks

• “Perception / Reality”
• 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.)
• Large Amounts of Capital are waiting to go to work in New York

• Cost of Capital - historically low
TO FURTHER THE DISCUSSION:

NYS Health Facilities Association
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President & CEO
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President and Chief Executive Officer
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

www.chcanys.org
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 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

Contact Information:

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eswain@chcanys.org
Portia Lee
Managing Director
Division of Public Finance & Portfolio Monitoring
Dormitory Authority of New York State
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
Peter Millock
Partner
Nixon Peabody, LLP
David Burik
Managing Director
Navigant Healthcare
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
dburik@navigant.com
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
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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

**Evolution of Health System Governance Models**

- **~1990**
  - Subsidiary Boards maintained substantial autonomy
  - Representative governance models

- **~1990s**
  - Governance structures streamlined, reducing number, size and levels
  - Parent Boards began to have sufficient authority over to achieve synergies

- **~Early 2000s**
  - Move away from representative models
  - Focus on value: sub. Boards only maintained with non-duplicative functions

- **~2005**
  - Move from “Social Enterprise” model toward “Corporate Enterprise Model”
  - Fiduciary and strategic responsibilities shifting from subsidiaries to parents

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 nation’s 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

<table>
<thead>
<tr>
<th></th>
<th>NY</th>
<th>U.S.</th>
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<tbody>
<tr>
<td>Hospitals in Systems</td>
<td>46%</td>
<td>59%</td>
</tr>
<tr>
<td>Number of Health Systems (per State)</td>
<td>20</td>
<td>6.5&gt;</td>
</tr>
<tr>
<td>Average System Size</td>
<td>4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Source: American Hospital Association (2012) NCI analysis.
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

1) CON REGULATIONS ARE ALIVE & WELL IN NY

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

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

- 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

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

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?

### Public Hospital Systems in Major U.S. Metro Areas

<table>
<thead>
<tr>
<th>City</th>
<th>Admissions/1,000 Pop</th>
<th>Beds per 1,000 Pop</th>
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<tbody>
<tr>
<td>New York City</td>
<td>17</td>
<td>0.45</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>6</td>
<td>0.15</td>
</tr>
<tr>
<td>Chicago</td>
<td>2</td>
<td>0.05</td>
</tr>
<tr>
<td>Houston</td>
<td>3</td>
<td>0.03</td>
</tr>
<tr>
<td>Boston</td>
<td>4</td>
<td>0.02</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>1</td>
<td>0.01</td>
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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 – it's 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
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

Increase in Metropolitan Statistical Areas with 1 or 2 Healthcare Organizations

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**
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
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

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

Source: Queries of hospital websites, NCI interviews and NCI analysis
<table>
<thead>
<tr>
<th>Topic</th>
<th>Focus</th>
<th>Time</th>
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<tbody>
<tr>
<td>Reconfiguration of U.S. Healthcare Underway</td>
<td>» Translate environmental changes in hospital actions</td>
<td>5 mins</td>
</tr>
<tr>
<td>NY’s Unique Pattern of Reconfiguration</td>
<td>» Identify unique facets of NY’s healthcare delivery system</td>
<td>10 mins</td>
</tr>
<tr>
<td></td>
<td>» Discuss potential drivers of NY’s uniqueness</td>
<td></td>
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<tr>
<td>Recapitalization Strategies in NY v. the U.S.</td>
<td>» Discuss current approaches to recapitalization underway nationally</td>
<td>10 mins</td>
</tr>
<tr>
<td>Challenges Created by NY’s Unique Trajectory</td>
<td>» Identify implications of the current NY landscape</td>
<td>5 mins</td>
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## NY HOSPITALS HAVE LIMITED OPTIONS TO RECAPITALIZE

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<tr>
<td>B. Convert to taxable</td>
<td>» Effectively prevented by Character and Competence</td>
</tr>
<tr>
<td>C. Form super regional system</td>
<td>» One example, at best, in NY state</td>
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<tr>
<td>D. Change sponsors (if Catholic)</td>
<td>» State’s Catholics remain fragmented, locally focused</td>
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<td>» National Catholics are either not present or have not organized across referral regions</td>
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<td>» Some models (e.g., hybrid) face regulatory challenges</td>
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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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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

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

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

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

Strategic Alternatives

- Status Quo
- Strategic Affiliation
- JOC
- Joint Venture
- Sell / Acquire
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)

<table>
<thead>
<tr>
<th></th>
<th>‘AA’ Average</th>
<th>‘A’ Average</th>
<th>‘BBB’ Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum</td>
<td>6.87%</td>
<td>7.58%</td>
<td>9.19%</td>
</tr>
<tr>
<td>Average</td>
<td>5.01%</td>
<td>5.42%</td>
<td>6.32%</td>
</tr>
<tr>
<td>Minimum</td>
<td>4.27%</td>
<td>4.35%</td>
<td>4.44%</td>
</tr>
<tr>
<td>Current</td>
<td>4.46%</td>
<td>4.75%</td>
<td>5.10%</td>
</tr>
</tbody>
</table>
Health Care Issuance has Fallen Dramatically

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Fixed</th>
<th>Total Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$60.5bn</td>
<td>-24.2%</td>
</tr>
<tr>
<td>2009</td>
<td>$45.8bn</td>
<td>-32.0%</td>
</tr>
<tr>
<td>2010</td>
<td>$31.2bn</td>
<td>-23.7%</td>
</tr>
<tr>
<td>2011</td>
<td>$23.8bn</td>
<td>20.4%</td>
</tr>
<tr>
<td>2012YTD</td>
<td>$20.8bn</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

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
### North Shore LIJ

**$135mm**  
**Pricing Date:** 9/8/2012  
**Ratings:** 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  
**Ratings:** A3 / A- / A-  
- General corporate purposes  
- 30-year bullet maturity / spread: +187.5 bps to 30yr UST (4.43% yield)  
- Gross receipts pledge  
- Corporate – 3a4

### Memorial Sloan-Kettering Cancer Center

**$150mm**  
**Pricing Date:** 1/6/2012  
**Ratings:** Aa2 / AA- / AA  
- Finance capital projects to expand clinical service network  
- 30-year bullet maturity / spread: +188 bps to 30yr UST (4.90%) on 01/06/12  
- General unsecured obligation  
- Corporate – 3a4

**$250mm**  
**Pricing Date:** 12/1/2011  
**Ratings:** Aa2 / AA- / AA  
- 30-year bullet maturity / spread: +188 bps to 30yr UST (5.00%) on 12/01/11  
- Corporate – 3a4
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
It’s Not “All or Nothing”
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- We will not vary the price or other terms of any product or service offered by Citibank or its subsidiaries on the condition that you purchase another product or service from Citibank or any Citi affiliate, unless we are authorized to do so under an exception to the Anti-tying Rules.
- 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
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NEW MARKETS TAX CREDITS
Improving Capital Access for Health Care Providers in New York State

Neil S. Faden
Manatt, Phelps & Phillips, LLP
(212) 830-7181 | www.manatt.com

October 2, 2012

The information contained in this presentation is not intended to and does not constitute legal advice or create an attorney-client relationship.
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?

- 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?

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?

NMTC Investor

Investor Member 99.99%

$10M QEI (Equity)

$3.9M NMTC (claimed over 7 years: $500K/yr in first 3 years, $600,000/yr in next 4 years)

Allocatee

Managing Member 0.01%

$10M QLICI (Debt or Equity)

CDE

QALICB
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**
WHAT IS A CDE?

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
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)

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)

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
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)
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
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?

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?

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
HOW IS A TRANSACTION STRUCTURED?

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.
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

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

![Diagram of NMTC investor investing $2.7M in the Investment Fund]
HOW IS A TRANSACTION STRUCTURED? Leverage Model

♦ A lender provides a loan to the Investment Fund

Leverage Model

A lender provides a loan to the Investment Fund

- NMTC Investor
- Investment Fund
- Lender

Investment Fund

$2.7M Equity

$7.3M Debt
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 cannot have a collateral interest in the QALICB or its assets.
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
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

- 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

- 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?

Questions?
Leo Brideau
President and CEO
Ascension Health Care Network
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
Participating Entities appoint the 12 members of Ascension Health Ministries, the Public Juridic Person which sponsors Ascension Health Alliance.

Founding Participating Entities:
- Sisters of St. Joseph of Carondelet
- Daughters of Charity Province of St. Louise
- Congregation of St. Joseph
- Alexian Brothers

Participating Entities:
- Congregation of St. Joseph
- Daughters of Charity
- Province of St. Louise

PJP Approved by Rome June 30, 2011

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.
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**

- **Sg2 Forecast**: +32%
- **Population-Based Forecast**: +15%

**The Market Will See New Entrants**

- Walgreens
- Walmart
- Nike

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.

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.
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.

Net promoter score distribution (FY 12 through May 2012): Number of Hospitals

NY State Average is 48
No Ascension Hospitals are at or below the National Average of 59

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>46-50</td>
<td>0</td>
</tr>
<tr>
<td>51-55</td>
<td>0</td>
</tr>
<tr>
<td>56-60</td>
<td>0</td>
</tr>
<tr>
<td>61-65</td>
<td>3</td>
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<tr>
<td>66-70</td>
<td>8</td>
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<tr>
<td>71-75</td>
<td>24</td>
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<td>76-80</td>
<td>19</td>
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<tr>
<td>81-85</td>
<td>13</td>
</tr>
<tr>
<td>86-90</td>
<td>4</td>
</tr>
<tr>
<td>90+</td>
<td>2</td>
</tr>
</tbody>
</table>

USAA = 83
Amazon = 76
Ascension = 75.8
Trader Joe’s = 73
Apple = 71
Costco = 71

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

Detroit Medical Center

October 2, 2012
Overview of Company

- Fortune 500 company publicly 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

- Phoenix
  - 6 hospitals
  - 1,032 licensed beds
  - Phoenix Health Plan
  - Abrazo Advantage Health Plan

- San Antonio
  - 5 hospitals
  - 1,753 licensed beds

- Chicago
  - 4 hospitals
  - 1,121 licensed beds
  - Chicago Health System

- Detroit
  - 8 hospitals
  - 1,734 licensed beds

- Massachusetts
  - 3 hospitals
  - 640 licensed beds

- Harlingen/Brownsville
  - Valley Baptist Health System
  - 2 hospitals, health plan, and related services
  - 866 licensed beds

- Texas
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
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

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

USA: 49%
OECD Countries: 43%
BRIC Countries: 8%

Health Spend 2020
$12.8 Trillion

USA: 52%
OECD Countries: 37%
BRIC Countries: 11%
Linking health spending to improved outcomes

The Cost of a Long Life

Average Life Expectancy

Per Capita Spending (International Dollars)

Life Expectancy

Per Capita Spending

United States
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

Mature Health P3 Market
- Mexico
- Chile
- Ecuador
- Peru
- US
- Canada
- Brazil
- Australia
- Colombia
- Sweden
- UK
- Spain
- Italy
- France
- Germany
- Turkey
- South Africa
- Ghana
- Nigeria
- Poland
- Kuwait & UAE

Emerging health P3 markets
- Some experience of health P3s
- India
- Nigeria
- Sweden
- Ghana
- UK
- Spain
- Portugal
- France
- Italy
- Germany
- Poland
- Kuwait & UAE
- India
- Nigeria
- South Africa
- Ghana
- Nigeria
- Sweden
- Ghana
- UK
- Spain
- Portugal
- France
- Italy
- Germany
- Poland
- Kuwait & UAE

Emerging health P3 markets
- South Africa
- Ghana
- Nigeria
- Sweden
- Ghana
- UK
- Spain
- Portugal
- France
- Italy
- Germany
- Poland
- Kuwait & UAE

India
- Nigeria
- Sweden
- Ghana
- UK
- Spain
- Portugal
- France
- Italy
- Germany
- Poland
- Kuwait & UAE

Australia
- South Africa
- Ghana
- Nigeria
- Sweden
- Ghana
- UK
- Spain
- Portugal
- France
- Italy
- Germany
- Poland
- Kuwait & UAE
Examples of health PPP projects

- Majadahonda Hospital - ISTC
- William Osler
- Turks & Caicos
- Proton Beam Therapy Centre
- New Karolinska Solna
- Zumpango, Mexico
- Belo Horizonte Primary Care
- Inkosi Albert Luthuli
- Yao City
- Berwick Community Hospital
Potential New York Health P3 program structure

Bank debt/bonds

DoH/New Hospital Authority

Clinical Service Operator?

Private Sector sponsor(s)

P3 Vehicle

- Design and Build Contract
  - detailed design development
  - fixed price construction
  - single point design and build responsibility

- Facilities Maintenance
  - day-to-day maintenance
  - grounds/estates
  - major maintenance and replacement (e.g. new HVAC, boilers)

- Support Services
  - cleaning
  - patient escorting
  - catering
  - security
  - helpdesk
  - financing and accounting
  - pharmacy?
  - sterilisation services?

- Managed Equipment Service
  - medical equipment (e.g. MRIs, imaging, etc.)
  - long-term maintenance and replacement

- Debt
- Equity
- Subcontracts
- Project Agreement
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Improving Capital Access for Health Care Providers in New York State

Please visit http://www.health.ny.gov/capforum for slides, agenda, presenter bio and other information