Minding the Gap: Financial Planning to Guide the Volume-to-Value Transition

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Factors Driving the Change
The Current State of Healthcare Is “Unsustainable”

- The size of the federal budget deficit is unsustainable
- The annual increase in the Medicare budget is unsustainable
- The percentage of healthcare spending to GDP is unsustainable
- State Medicaid programs are unsustainable
- The continued transfer of costs to employers and consumers is unsustainable
Everyone Is Feeling the Squeeze

• **Individuals are paying more**
  – Employers have shifted more out-of-pocket responsibility to individuals and families through higher employee contributions, co-pays, and deductibles

• **Businesses are paying more**
  – On average, small businesses pay up to 18 percent more than large firms for the same health insurance policies
  – Large companies that are self-insured are directly bearing the brunt of increased costs, utilization, and administrative expenses
  – Insurance companies continue to pass administrative and other costs to their customers to maintain their margins

• **Medicare spending is growing despite cost-control efforts**
  – Represents almost half of all healthcare spending and has steadily risen since 1965, significantly outpacing inflation and CPI
  – Healthcare spending has risen from 7% of GDP in 1970 to 17.9% in 2011 and continues to rise

Healthcare Spending per Capita
2008 Adjusted for differences in cost of living

* 2007.
Source: OECD Health Data 2010 (Oct. 2010)
Cost by Age Categories

Healthcare Costs by Age

U.S. is spending much more for older ages

National and International Employers Are Taking the Initiative Based on Value

Walmart essentially constructed a national “narrow network” to deliver transplant, heart, and spine services at a set price.
Understand and Accept the Macro Environment
The Environment in Which You Must Compete

1. Provider revenues will be under severe pressure as payment mechanisms migrate toward value-based approaches – need to do less with less

2. Continuing to compete on volumes and rate will be a riskier strategy than shifting to value-based reimbursement – being a rate taker in a shrinking market is not a viable strategy

3. A new set of core competencies will be required for provider success

4. Inpatient and outpatient use rates will decline
The Environment in Which You Must Compete (continued)

5. Providers will consolidate at an accelerated pace – horizontally and vertically

6. The competitive landscape will be reshaped by existing competitors and by new competitors

7. Regardless of what happens at any regulatory level, improving quality and efficiency is the right thing to do

8. Providers will need to determine how they will participate in the future healthcare delivery system; then they need to prepare for that transformation
New Core Competencies Will Be Required for Success

- Financial Strength & Capital Capacity
- Payer Relationship Management
- Risk Absorption and Management
- Market Essentiality
- Physician Integration
- Care Coordination/Management Infrastructure
- Information Technology Sophistication
- Service Delivery System Rationalization
- Cost Effectiveness
Over Time, Provider’s Are Likely to Become One of Five Organization Types

**Population Manager:** Large, regional provider organization that will be able to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to manage full plan-to-plan risk and/or direct contracting.

**Population Co-Manager:** Regional provider organizations, clinically integrated with other provider organizations that jointly (and/or equally) capitalize formation of value-based delivery systems (e.g., narrow networks); well positioned to participate in population and risk management, in delegated/direct fashion.

**Multi-Product Participant:** Provider organization that works within a network(s) managed by a Population Manager to provide a defined set of services in an efficient manner to serve a broad population base comprised of both government and private pay patients; critical role in future delivery system.

**Single Product Participant:** Provider organization working within a network managed by a Population Manager providing specified and targeted services and/or population; these organizations will be critical components of narrow networks.

**Contractor:** Smaller, less essential and/or niche providers, some of which may serve rural communities, provide population access points; not critical to future delivery systems and face significant risk of commoditization.
Downward Pressure on Utilization Is Building

2006-2010 Change in Inpatient Use Rates for States in National Sample

- 46% of sample states experienced use rate declines greater than 5%
- Only 11% of sample states experienced an increase in use rates
- 43% of sample states experienced use rate declines between 0 and 5%

The Transition in Payment Rates and Structures to Pursue Value-Based Care Will Have Direct and Indirect Impacts on Health System Performance

- Reimbursement will likely decline in the near term, eroding margins
- Transitioning to value-based payment streams will decrease margins in the short term
- Significant investment in infrastructure and physicians will be needed in the short term. These investments will not qualify for traditional financing and will be based on short lived assets from a depreciation point of view
- If reimbursement for physicians continues to fall, margins will be negatively impacted by the losses on employed physicians; independent physicians will flock to the employment model
- All pieces of an integrated delivery system will be impacted
Current Trends Will Re-shape Healthcare; We Are Entering the Front End of What Will Most Likely Be a 10-Year Cycle:

- Excess capacity will be eliminated in the form of beds, ancillary/ambulatory service providers and, in certain cases, physicians.
- Until excess capacity is eliminated, reimbursement will decrease as entities compete for volume based on rates.
- Economic alignment of participants across the spectrum will occur as value-based initiatives get traction and value establishes itself as the currency for the industry.
- Capital availability for the industry will shrink as margins and underlying asset values decline.
- At some point, excess capacity will be eliminated, value-based care will become common, and stability will be attained.
Creating The Financial Planning Foundation

The corridor of control is the balancing point between two opposing goals:

1. Compete as effectively as you can, which requires aggressive investment of capital and commitment of operating dollars, **BUT**

2. Respect the fiduciary role of management and the board to maintain the long-term financial integrity of a community asset.
The Integration of Strategy with a Corporate Finance-Based Discipline on an Annual Basis Creates the Required Decision Making Framework

Financial Planning
- Balance financial abilities to strategy over five years
- Build cash and debt capacity
- Maintain credit profile

Capital Structure
- Support strategic implementation within credit profile
- Optimize flexibility and cost

Mission-Based Market Strategies

Feedback and control

Annual Budget
Completely integrated with strategic plan, financial plan, and capital budget

Capital Allocation
- Corporate-based approach
- Quantitative rigor, NPV
- Monitoring of results


Can the strategies be implemented within an acceptable credit context?

How much can/should we be spending? Where are the capital dollars best deployed?

Accountability, credibility, and results are key.
Historic Credit Profile – Creating a Fact Base
Credit Ratings Are Largely a Function Of...

- **Financial trends and expectations**
  - ✓ Ratio analysis: consistent operating performance and stable liquidity are key

- **Market position**
  - ✓ Location, market share, competition, and population demographics

- **Governance/management**
  - ✓ Effective and accountable leadership

- **Strategic and financial planning**
  - ✓ Effective market strategy, quality planning process, organizational culture of achieving targeted results (show five years of budget vs. actual)

- **Payer mix**
  - ✓ Reimbursement: price maker vs. price taker in the market

- **Physician relations**
  - ✓ Loyalty, average age, growth and specialties represented

- **Debt position**
  - ✓ High debt levels increase risk and lead to lower ratings

- **Size**
  - ✓ Critical mass

- **Industry trends and external perception of risk**
## RHS – Historical Credit Analysis ($ millions)

<table>
<thead>
<tr>
<th>Ratio / Statistic</th>
<th>Moody’s “A3”</th>
<th>S&amp;P (A) “BBB+”</th>
<th>Fitch (A) “BBB+”</th>
<th>Fiscal Year Ended December 31,</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2008</td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$428.7</td>
<td>$892.7</td>
<td>---</td>
<td>$1,504.5</td>
</tr>
<tr>
<td>Operating Income</td>
<td>$9.4</td>
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<td>---</td>
<td>$44.3</td>
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<tr>
<td>Operating EBIDA</td>
<td>$42.2</td>
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<td>---</td>
<td>$135.6</td>
</tr>
<tr>
<td>Net Income (B)</td>
<td>$21.5</td>
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<td>$63.5</td>
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<td>Cash Flow (Net Inc + Depr) (C)</td>
<td>$46.6</td>
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<td>---</td>
<td>$128.0</td>
</tr>
<tr>
<td>Unrestricted Cash</td>
<td>$179.2</td>
<td>$343.1</td>
<td>---</td>
<td>$470.4</td>
</tr>
<tr>
<td>Total Debt</td>
<td>$161.2</td>
<td>---</td>
<td>---</td>
<td>$492.5</td>
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<tr>
<td>Capital Expenditures</td>
<td>$30.8</td>
<td>---</td>
<td>---</td>
<td>$109.0</td>
</tr>
</tbody>
</table>

### Profitability

- **Operating Margin**: 2.4% (2008), 1.4% (2009), 2.0% (2010), 2.7% (2011), 2.8% (2012)
- **Operating EBIDA Margin**: 9.2% (2008), 8.4% (2009), 8.5% (2010), 8.2% (2011), 7.9% (2012)
- **Excess Margin**: 4.7% (2008), 3.3% (2009), 3.4% (2010), 3.2% (2011), 3.6% (2012)

### Debt Position

- **Debt to Capitalization**: 40.5% (2008), 61.7% (2009), 48.8% (2010), 48.7% (2011), 42.9% (2012), 38.1% (2013), 38.9% (2014), 37.4% (2015)

### Liquidity

- **Cash to Total Debt**: 104.0% (2008), 76.7% (2009), 87.4% (2010), 95.5% (2011), 129.9% (2012), 145.8% (2013), 128.9% (2014), 131.2% (2015)

### Other

- **Capital Spending Ratio**: 120.0% (2008), 103.0% (2009), 138.9% (2010), 168.8% (2011), 110.8% (2012), 124.4% (2013), 161.4% (2014), 230.9% (2015)
- **Compensation Ratio**: --- (2008), 48.3% (2009), 52.5% (2010), 67.5% (2011), 66.4% (2012), 67.0% (2013), 67.4% (2014), 66.7% (2015)

**Note (A)**: Based on Moody’s and Fitch August 2010 and S&P July 2010 Not-for-Profit Hospital medians.

**Note (B)**: Normalized investment return at 4%.

**Note (C)**: Excludes unrealized gain/loss on investments and change in fair value of interest rate swap.

**Note (D)**: 2006-2009 does not include St. Josephs.
Credit-Related Observations

RHS is currently rated A3 (Positive Outlook), BBB+ (Stable), BBB+ (Positive), by Moody’s, S&P and Fitch, respectively.

**Strengths**

- Size and critical mass as a multi-hospital system
- Good demographics and solid payer mix with low Medicaid exposure as compared to national averages
- A solid number two inpatient market share at 22 to 23%, approximately 10% behind the market leader but 10% ahead of several providers
- Steady year-over-year growth within net patient revenue
- Sustained improvement operating margins that are in excess of rating category medians
- Improved liquidity with cash to debt in excess of 100% and approximately 130 days cash on hand

**Key Concerns**

- Operating EBIDA margin and days cash on hand are both below credit median peers
- Expectation of sizeable capital expenditures over the next five years
- The system heavily relies on one hospital for operating cash flow margins
- High compensation ratio
RHS Capital Position Analysis
Balancing Capital Sources and Uses

How much cash? #3 - Cash

#2 - Debt

How much debt?

#1 - Capital

Operations

How much capital?

Philanthropy and Other Sources?

How much profitability?

How should these tradeoffs be optimized within an appropriate credit and risk context?
Variable #1: Capital Requirements ($ millions)

Variable #2 – Debt Capacity

- Access to incremental new debt capital is a function of creditworthiness (factual) and the willingness of the capital markets to support an organization’s perceived strategy (evaluative)

- Three standard industry approaches are used to determine debt capacity

  1. **Cash Flow Approach**
     - Widely viewed as the most important indication of debt capacity
     - Dependent on the relationship between current profitability and maximum annual debt service
     - Earnings volatility is a concern (multiplier effect)

  2. **Leverage Approach**
     - Dependent on the relationship of debt to total capitalization
     - Primarily a function of debt and historical earnings (fund balance)
     - Least volatile approach (cumulative earnings – lagged effect)

  3. **Liquidity Approach**
     - Dependent on the relationship of liquidity to debt
Based on 2012 results, RHS could support $100 million of incremental debt. While the balance sheet indicates more incremental debt capacity, the cash flow approach limits practical debt capacity. Improving upon current cash flows would significantly improve debt capacity.

Note (A): Cash flow debt capacity calculated using 30-year amortization at 5.5% interest rate and normalized investment return at 4.0%.
Variable #3 – Calculation of Minimum Cash Position

<table>
<thead>
<tr>
<th>($ in millions)</th>
<th>Current Rating Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Projected Cash Operating Expenses (^{(A)})</td>
<td>$2,324.8</td>
</tr>
<tr>
<td>Expenses Per Day (2017)</td>
<td>$6.37</td>
</tr>
<tr>
<td>Target Days Cash on Hand</td>
<td>140.0</td>
</tr>
<tr>
<td>Cash Required to Target</td>
<td>$891.7</td>
</tr>
<tr>
<td>Less: FY 2012 Unrestricted Cash</td>
<td>$699.3</td>
</tr>
<tr>
<td>Five - Year Funding Requirement (Excess)</td>
<td>$192.4</td>
</tr>
</tbody>
</table>

Given future challenges to reimbursement, competitive threats and demand for capital, RHS should maintain a minimum of 140 days cash on hand. This will require an additional $192.4 million of liquidity funding over the next five years.

Note (A): Cash operating expenses defined as total operating expenses less depreciation and amortization.
## RHS Capital Position Analysis ($ millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Investment</td>
<td>$751.0</td>
<td>Unrestricted Cash (Beg. Balance)</td>
<td>$699.3</td>
</tr>
<tr>
<td>Funding of Minimum Cash Position (End Balance)</td>
<td>891.7</td>
<td>Monetization, Philanthropy, Other</td>
<td></td>
</tr>
<tr>
<td>Principal Payments on Existing Debt</td>
<td>149.1</td>
<td>New Debt (Net Proceeds)</td>
<td>0.0</td>
</tr>
<tr>
<td>Working Capital</td>
<td>12.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital Uses</strong></td>
<td><strong>$1,811.4</strong></td>
<td><strong>Total Capital Sources</strong></td>
<td><strong>$699.3</strong></td>
</tr>
</tbody>
</table>

### Cumulative 5-Year Operating Cash Flow Requirement:
- **$1,112.1**
- **Annual** **$185.3**

### Historical Operating Cash Flow: *(A)*
- **2012 Actual**: $128.2
- **2011 Actual**: $135.1
- **2010 Actual**: $190.2

In order to maintain its current rating, while pursuing the capital investment plan as well as projects under consideration, RHS will need to generate approximately $1.2 billion in cash flow over the next 5 years – approximately $186 million annually, which is approximately 50% above fiscal year 2012 levels.

Note (A): Operating cash flow defined as net income plus depreciation
Baseline Financial Projections
RHS Assumptions – “Risk Profile”

<table>
<thead>
<tr>
<th>Category</th>
<th>Conservative</th>
<th>Moderate</th>
<th>Aggressive</th>
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</thead>
<tbody>
<tr>
<td><strong>Volumes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IP volume declines FY14-15: 2.3%, FY16-17: 1.6%</td>
<td>![star]</td>
<td>![star]</td>
<td>![star]</td>
</tr>
<tr>
<td>• OP weighted average annual growth of .8%</td>
<td>![star]</td>
<td>![star]</td>
<td>![star]</td>
</tr>
<tr>
<td><strong>Reimbursement – Medicare</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual inflation averages 1.1%</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reimbursement – Medicaid</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual inflation averages -2%</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reimbursement - Commercial Payers</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• +3-+5% annual growth</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Salary Expense</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Grown at +3.0% annually</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Salary Expenses</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Grown at an average of ~+3.0% annually</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capital Spending</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $751M over 5-years</td>
<td>![star]</td>
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</tr>
<tr>
<td><strong>Investment Income</strong></td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• +4.0% annual return</td>
<td>![star]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Baseline Financial Projections – Summary Credit Profile ($ millions)

<table>
<thead>
<tr>
<th>Ratio / Statistic</th>
<th>Moody's (A) &quot;A3&quot;</th>
<th>S&amp;P (A) &quot;A-&quot;</th>
<th>Fitch (A) &quot;A-&quot;</th>
<th>Fiscal Year Ended December 31,</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>$428.7</td>
<td>$892.7</td>
<td>---</td>
<td>$1,987.8</td>
</tr>
<tr>
<td>Operating Income</td>
<td>$9.4</td>
<td>---</td>
<td>---</td>
<td>$115.5</td>
</tr>
<tr>
<td>Operating EBIDA</td>
<td>$42.2</td>
<td>---</td>
<td>---</td>
<td>$247.5</td>
</tr>
<tr>
<td>Cash Flow (Net Inc + Depr)</td>
<td>$46.6</td>
<td>---</td>
<td>---</td>
<td>$248.0</td>
</tr>
<tr>
<td>Unrestricted Cash</td>
<td>$179.2</td>
<td>$343.1</td>
<td>---</td>
<td>$727.7</td>
</tr>
<tr>
<td>Total Debt</td>
<td>$161.2</td>
<td>---</td>
<td>---</td>
<td>$498.4</td>
</tr>
<tr>
<td>Capital Expenditures</td>
<td>$30.8</td>
<td>---</td>
<td>---</td>
<td>$237.0</td>
</tr>
</tbody>
</table>

**Profitability**
- Operating Margin: 2.4% (Moody's), 1.4% (S&P), 2.0% (Fitch)
- Operating EBIDA Margin: 9.2% (Moody's), 8.4% (S&P), 8.5% (Fitch)

**Debt Position**
- MADS Coverage (x): 4.3 (Moody's), --- (S&P), --- (Fitch)
- Debt to Capitalization: 40.5% (Moody's), 61.7% (S&P), 48.8% (Fitch)

**Liquidity**
- Cash to Total Debt: 104.0% (Moody's), 76.7% (S&P), 87.4% (Fitch)
- Days Cash on Hand (days): 168.5 (Moody's), 171.8 (S&P), 152.1 (Fitch)

**Other**
- Average Age of Plant: 10.6 (Moody's), 10.8 (S&P), 10.9 (Fitch)
- Capital Spending Ratio: 120.0% (Moody's), 103.0% (S&P), 138.9% (Fitch)

The baseline financial projections depict significant deterioration in profitability as well as liquidity.

Note (A): Based on Moody’s, S&P and Fitch August 2012 Not-for-Profit Health System Medians.
Major Initiative #1: Significant Expense Reductions
Sustainable Cost Transformation Requires Changing the Way Business Is Done and Strengthened Execution

The cost reduction pathways pursued will vary depending on financial need, priorities, timing, ongoing performance improvement initiatives, and organizational strengths and weaknesses.
RHS determined that it needed to significantly realign its cost structure in order to be a low-cost provider in the market.
Major Initiative #2: Physician Alignment
Significant physician alignment efforts are aimed at increasing the primary care base as well as specialists across multiple service lines.
Major Initiative #3: Restructure Reimbursement Models
“Value-based” Payment Systems Imply that Providers Have Increased Accountability for the Total Cost of Care, in Addition to the Quality of Care

Today

Payment Reform

1. Increased provider accountability for “Total Cost of Care”
2. Provider (re)alignment, improved care coordination, and integrated information systems
3. Reimbursement based on “Clinical Value” (clinical outcomes and utilization)
4. Increased prevalence of bundled payments

More Accountability

Less

More Accountability

Less

1. Payers bear most accountability for cost of care
2. Fragmented care delivery and management
3. Reimbursement based on volume, rather than value
4. Separate payments for services

Source: Accenture
Convert From Fee-for-Service Contracts to Value-Based Contracts

“When 30 percent of your business is in a non-fee-for-service model, your structure starts to change.”

Stephen M. Shortell, Ph.D., M.P.H.

Major Initiative #4: Healthcare Exchange As Growth Vehicle
Healthcare Exchanges Are Coming

• National health reform law calls for state or regional exchanges to be established by January 2014

• “Exchange” is another term for marketplace for individuals and businesses to comparison shop and purchase coverage

• Public and private exchanges will co-exist in many areas

• Goal is to increase competition and/or consumer choice while providing benefit standardization

• Exchanges are expected to offer broader choice, increased transparency, and potentially lower costs

• Premiums will be community-rated and risk-adjusted based on only four factors (single/ family, geography, age, tobacco use)

• Small business tax credits and individual subsidies may make exchanges attractive

• Currently there is a funding/cost imbalance for the exchanges
Public Exchanges

• Become available in all 50 states in 10/2013 for 01/2014 effectiveness for
  ✓ Individual and Families
  ✓ Small Business Health Options (SHOP) – companies with fewer than 50 or 100 employees (state determined through 2017)

• Operated at state or federal levels (or shared)

• Must meet minimum (essential) benefit standards and be consistent across five levels (bronze, silver, gold, platinum, and catastrophic)

• Plans will compete based on price not benefit coverage within any given level (price variance on age, geography, smoking not gender/health)

• Certain public exchanges may have limited plan options based on amount of payer participation

• Individual and small group subsidies will be possible via tax credits (avg $4,650 pp in 2014)
Public Exchanges: Premiums and Subsidies

• Individual premium rates may increase between 15% and 35% due to increased taxes, benefit mandates, and underwriting reforms

• Older consumers cannot be charged more that 3X the rate younger consumers pay (3:1 rate band requirement) which may result in lower premium prices for older consumers and much higher premiums for younger consumers

• Small group premium rates may not be as significantly impacted due to less stringent underwriting reforms

• Premiums will have actuarial values between 60% and 90%

• Out-of-pocket limits capped at HSA limits ($6K/&12K) however lower income consumers would have much lower (⅓ to ⅔) OOP exposure

• Subsidies will be available for those individuals and families whose income is between 133% and 400% of the FPL

• Subsidies in the form of refundable and advanceable tax credits will range from 2% to 9.5% of income based on FPL
Strategic Financial Projections
### Strategic Financial Projections – Key Credit Ratios ($ millions)

<table>
<thead>
<tr>
<th>Ratio / Statistic</th>
<th>Moody’s (A)</th>
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<tr>
<td>Unrestricted Cash</td>
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<tr>
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<td>---</td>
<td>$249.8</td>
</tr>
<tr>
<td><strong>Profitability</strong></td>
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<td></td>
<td>6.8%</td>
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<tr>
<td>Operating Margin</td>
<td>2.4%</td>
<td>1.4%</td>
<td>2.0%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Operating EBIDA Margin</td>
<td>9.2%</td>
<td>8.4%</td>
<td>8.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Debt Position</strong></td>
<td></td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>MADS Coverage (x)</td>
<td>4.3</td>
<td>---</td>
<td>---</td>
<td>32.0%</td>
</tr>
<tr>
<td>Debt to Capitalization</td>
<td>40.5%</td>
<td>61.7%</td>
<td>48.8%</td>
<td></td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td></td>
<td></td>
<td></td>
<td>154.5%</td>
</tr>
<tr>
<td>Cash to Total Debt</td>
<td>104.0%</td>
<td>76.7%</td>
<td>87.4%</td>
<td>149.4</td>
</tr>
<tr>
<td>Days Cash on Hand (days)</td>
<td>168.5</td>
<td>171.8</td>
<td>152.1</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td>230.8%</td>
</tr>
<tr>
<td>Capital Spending Ratio</td>
<td>120.0%</td>
<td>103.0%</td>
<td>138.9%</td>
<td></td>
</tr>
</tbody>
</table>

The initiatives drive significant improvement in operations with operating EBIDA margins exceeding 10% and liquidity at or above median levels.

Note (A): Based on Moody’s, S&P and Fitch August 2012 Not-for-Profit Health System Medians.
Sensitivity Analysis
Key Risk Variable Sensitivity Analysis: Impact on Projected FY2017\(^{(A)}\) Results

FY2017 Days Cash on Hand: 179.5 177.6 164.5 144.5 137.6 214.0

Note\(^{(A)}\): All sensitivities are calculated independent of each other.
Strategic and Financial Implications
Objective Answers to Questions Related to Risk Will Also Drive Your Organization’s Future Positioning Strategy

- At what level of risk are we able to participate now and at what level do we want to participate in the future?
- To achieve the desired level:
  - Do we have the scale necessary to accept the desired level of risk alone or do we need a partner?
  - What should be our priorities – to what initiatives should we allocate resources?
## Transforming Your Organization – Where to Focus

<table>
<thead>
<tr>
<th>Transformational Pathways</th>
<th>Change Initiative</th>
<th>Contracted Provider</th>
<th>Major Participant</th>
<th>Population Health Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Evaluation and Planning</strong></td>
<td>Core competency assessments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Strategic options analysis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Business Transformation</strong></td>
<td>Transaction execution</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Pre- and post- merger integration</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Network development and maintenance</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Contracting efficiency and effectiveness</td>
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<td></td>
<td>Risk management/ predictive modeling</td>
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<td>Integrated strategic and financial planning decision support tools</td>
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<tr>
<td></td>
<td>Physician integration</td>
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<td>✓+</td>
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</tr>
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<td></td>
<td>Clinical variation reduction</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Care management infrastructure and analytics development</td>
<td>✓</td>
<td>✓+</td>
<td>✓+</td>
</tr>
<tr>
<td></td>
<td>Managed population interface and connectivity</td>
<td>✓</td>
<td>✓+</td>
<td>✓+</td>
</tr>
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</table>
## Transforming Your Organization – Where to Focus (continued)

<table>
<thead>
<tr>
<th>Transformational Pathways</th>
<th>Change Initiative</th>
<th>Contracted Provider</th>
<th>Major Participant</th>
<th>Population Health Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Transformation</td>
<td>Governance and organization restructuring</td>
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<td>Management organization and incentive restructuring</td>
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<tr>
<td>Business portfolio optimization</td>
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<td>Regional service delivery system planning</td>
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<td>Strategic cost management</td>
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<td>Physician services performance optimization</td>
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<td>Care Transformation</td>
<td>Physician integration</td>
<td>✓</td>
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<tr>
<td></td>
<td>Clinical variation reduction</td>
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</tr>
<tr>
<td></td>
<td>Care management infrastructure and analytics development</td>
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<tr>
<td></td>
<td>Managed population interface and connectivity</td>
<td>✓</td>
<td>✓+</td>
<td>✓+</td>
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</table>
Questions and Answers
Carlos A. Bohorquez, Vice President

Carlos Bohorquez is a Vice President in Kaufman Hall’s Los Angeles office. Mr. Bohorquez consults on a national basis with clients including regional healthcare systems, academic medical centers, and community medical centers. He specializes in financial and capital planning, financial advisory on tax-exempt debt transactions, and contract renegotiations and due diligence analysis related to managed care organizations/companies.

Prior to joining Kaufman Hall, Mr. Bohorquez was a Senior Consultant with Cap Gemini Ernst & Young’s Healthcare Practice, where he planned, implemented and directed organizational restructuring in the areas of finance, managed care contracting and revenue cycle. Mr. Bohorquez also previously held regional managed care contracting positions in both the health plan and provider settings.

Mr. Bohorquez is a regular speaker on healthcare finance topics at Healthcare Financial Management Association regional and local chapter educational programs. Additionally, Mr. Bohorquez has been a guest lecturer on healthcare finance topics to graduate students in the Masters of Health Administration program at USC. Mr. Bohorquez has a Masters in Health Administration with a specialization in Finance from the University of Southern California and a Bachelor of Science in Neuroscience from the University of California, Los Angeles.

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KHA Services at a Glance

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