Strategies for Independent Community Hospitals to Remain Viable

Can Your Community Hospital Remain Independent?
April 15, 2014

Today’s Speakers

- Fred Geilfuss, Partner, Foley & Lardner LLP
- Holly Sullivan, Senior Vice President and Partner, Hammes Company; Board Member, American Hospital Association’s Society of Healthcare Strategy and Market Development
- Michael Quinn, Managing Director, Ziegler
- Susan Green, Senior Vice President and CFO, Lowell General Hospital
C. Frederick Geilfuss II is a partner with Foley & Lardner LLP and is a member of the firm’s Health Care Industry Team. Foley & Lardner’s health care practice has been recognized by US News and World Report as the top health practice for the past two years. Mr. Geilfuss is co-chair of the Health Care Industry Team Business and Transactions Work Group. He counsels health systems, hospitals, medical clinics, rehabilitation agencies, nursing homes, and other health care providers on general operational concerns, regulatory and business matters. He has many years of experience in health care acquisitions, integrated delivery service issues, managed care contracting, and other health law issues. Mr. Geilfuss is listed in Best Lawyers in America and has been recognized as one of the nation’s outstanding health care transaction lawyers by Nightingale’s Health Care News. He also has received a Lilly Award for his service on behalf of the mentally ill.

Before joining the firm, Mr. Geilfuss served as a law clerk to the Hon. Harlington Wood, Jr., Circuit Judge, on the United States Court of Appeals, Seventh Circuit. Upon completing the clerkship, he became an attorney on the Civil Division Appellate Staff at the United States Department of Justice, representing the United States Department of Health and Human Services in matters involving Medicare and Medicaid, as well as other federal agencies.

Mr. Geilfuss’ professional memberships include the Health Law Section of the State Bar of Wisconsin and the Health Law Section of the American Bar Association. He also serves on the boards of directors of several civic, charitable and health organizations, including the University School of Milwaukee Endowment, Grand Avenue Club, Inc., Curative Foundation, Inc. (currently serving as president), Wisconsin Psychoanalytic Foundation, State of Wisconsin Historical Foundation, and the Gardner Foundation (currently serving as secretary).

Mr. Geilfuss graduated from the University of Wisconsin Law School (J.D., cum laude), where he was elected to the Order of the Coif and was an editor of the University of Wisconsin Law Review. He also is a graduate of the University of Wisconsin School of Economics (M.A.), and Williams College (B.A., cum laude).

Mr. Geilfuss is admitted to the Wisconsin Bar and also is admitted to practice before the United States Court of Appeals for the Seventh Circuit and the United States Supreme Court.

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Holly Sullivan

Holly Sullivan is a senior healthcare executive with more than twenty years of strategic and business planning, marketing, physician relations and business development experience. Currently, Ms. Sullivan is a Senior Vice President at Hammes Company with responsibility for leading and managing the firm’s work with large, multi-state healthcare systems as well as overseeing the Company’s marketing, communication and public relations activities. Ms. Sullivan manages the relationships and ongoing work with many renowned health systems across the country. Her prior experience includes marketing and business development for a major pharmaceutical company, developing educational programs for a wide variety of physicians. She also worked in banking, structuring and syndicating financing for large corporate clients.

Her education includes: Master of Business Administration, Marketing & Strategy - Kellogg School of Management Northwestern University, Evanston, Illinois; Bachelor of Business Administration, Accounting & Finance - University of Michigan, Ann Arbor, Michigan

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Michael Quinn

Mike Quinn joined Ziegler in 2010 as a Director focusing on the east coast region and providing capital markets and strategic advisory services to healthcare organizations, including health care systems and independent hospitals. Since joining Ziegler, Mike has led more than $1 billion of financing transactions for his healthcare clients and was promoted to Managing Director in January of 2014.

Mike started his career in the financial guaranty business at Radian where he spent five years in the municipal underwriting group focusing on credit analysis and underwriting in the healthcare sector. He spent two years at Financial Guaranty Insurance Company as a Vice President in Public Finance where his responsibilities included underwriting primary market public finance transactions and running their secondary market desk. Prior to joining Ziegler, Mike was a Vice President at Shattuck Hammond Partners.

Prior to joining Shattuck Hammond Partners, he managed Assured Guaranty Corporation’s healthcare and higher education underwriting group. At Assured, his group guaranteed more than $10 billion of tax-exempt bond issuance across over 100 obligors with no claims paid or reserves established against any insured risk. Mike is a member of the National Federation of Municipal Analysts, the Municipal Analyst Group of New York and the NJ Chapter of the Healthcare Finance Management Association.

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Susan Green

Susan Green serves as Treasurer and Senior Vice President and Chief Financial Officer of Lowell General Hospital. With more than two decades committed to healthcare finance, she leads the hospital's financial operations including revenue systems, cost-management and reimbursement.

Green previously served as chief financial officer and acting chief executive officer at Anna Jaques Hospital, and as director of finance at Winchester Hospital. She also spent eight years as a CPA focused on healthcare at Deloitte & Touche, LLP and Mullen & Company.

Green is a fellow in the Massachusetts Health Leadership College and is a member of the Healthcare Finance Management Association. She holds a graduate degree in taxation from Bentley College and an undergraduate degree in accounting from Salem State University. Green is also active in several community organizations including Treasurer of the Board of Directors of Lowell Community Health Center, Board Member of the Jeanne Darc Credit Union and the American Textile History Museum.

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Introduction

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Introduction

- First session of web series
- Focus has been on consolidations/affiliations/mergers since ACA adopted
- Merger activity increasing
- Comments frequently heard
  - Not if, but with whom and when
  - Community hospital is an “endangered species”
  - Foresee 80-100 hospitals
- Recent survey shows 87% of responding hospitals considering mergers

Introduction (cont.)

- Community hospitals do have choices
- Today focus on:
  - What hospital boards should consider as merger issues arise
  - Background data on merger activity
  - How to assess whether your hospital has the attributes to be successful as an independent
  - What tools can assist in decision making
  - A case study: Lowell General Hospital
Web Series

Web Series will explore:
» Can mission of hospital be met through transactions/relationships/activities while keeping independence?
» What strategies and alternatives are available and have they been tried?
» Are goals of a merger possible through pursuit of other strategies?
» How does a board critically assess suggestions brought forward by executive leadership?
» Case study focus on strategies that have been utilized.

The Environment

New environment:
» Market environment for hospitals has changed
  • Health care cost increases slowing
    o Health care as percent of GDP actually decreased
    o Businesses demanding cost reductions
    o Unsustainable costs
  • Old strategies not as easily successful
» Reimbursement changes
  • Medicare cuts
  • Different payment methods
  • Commercial payers stronger
The Environment (cont.)

- New models
  - Employers taking risk
  - Accountable care structures in public and private markets
  - Physician-led ACOs
  - New relationships

- Consumers more involved
  - High deductible plans
  - More transparency
  - More shopping
  - Mobile apps

The Environment (cont.)

- Capital demands increasing
  - IT
  - Equipment
  - Facilities

- Quality focus
- Compliance focus
- Capital access
- Physician costs
Mergers

- Mergers may be an easy answer
- Address environment
- Increase scale and achieve economies
- Size allows better care coordination/population health
- Share of resources
- Lock in referrals
- Better capital access with scale
- Increase market share
- Balance strength of managed care companies

Merger Not Only Answer

- Immediate or short-term issues addressed by a permanent solution
- Not all mergers deliver as expected
  - Acquiror’s capabilities may not match expectation
  - Further acquisition/changed ownership
  - Cultural fit
  - Surprises
  - Different perspective/mission
- Independence may be best way to ensure mission
Mergers Not Automatic

- New antitrust enforcement
  - Success of enforcement actions
  - Increasing skepticism of claims of pro-competitive input
  - Vertical arrangements challenged
  - Challenges after the fact

What Strategies/Alternatives are Available?

- Board role
  - Duty of loyalty
  - Duty of care
  - Be informed
- Market share important in any environment
- Develop centers of excellence
- Management service/leased departments
- New partnerships – with insurers, other independent hospitals, tertiary hospitals, device manufacturers
Clinical integration in organization and ACO participation

Private equity ventures

Contracting strategies – narrow, branded and value networks

Collaborative physician structures – co-management

Become the acquiror

Review operations for savings
  » Reduce readmissions; follow-up arrangements
  » Optimize quality
    • Better data
  » Logistics improvement
  » Improve purchasing
    • Phillips/Georgia Regions
    • Payor partnerships with drug companies

Enhance patient experience
  » Mobile apps
  » Improve facility design to enhance experience

Creative Capital Access
Current Challenges Magnified for Community Hospitals

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Unprecedented change
  » Reform and market trends

Emergence of new competitors
  » CVS, Walgreens, Target, other retail players, insurance providers

Market pressures are significant
  » Significant investment will be required in the near term

Consolidation continues at all levels
A Trend Toward Consolidation

- System-affiliated hospitals continue to outnumber those with independent status, and the trend continues
- 61% of all community hospitals are part of a greater system


Association Perspective

- American Hospital Association
  - Majority of AHA member hospitals are system affiliated
  - Trend toward more system affiliated hospitals and fewer freestanding/community hospitals
  - Strategies to align and bring value in new environment
Association Perspective

- Society of Healthcare Strategy and Market Development (“SHSMD”)
  - What does a healthcare strategist do in new world?
  - How can we deliver value as our membership profile changes?
  - How can we change what we offer to reflect this shift?

What Are Some of the Issues of Consolidation?

- Anti-trust scrutiny
- Bureaucracy
- Unwieldy
- Agility
- Control
- Culture

Remaining Independent

- Still a sustainable and even preferred model for some
- Serve as a strong pillar in the community
- Strong consumer loyalty and philanthropy


Mandate for Community Hospitals

- Create viable strategies for sustained relevance and long-term market growth
  - Care management expertise
  - Comprehensive network and geographic reach
  - Physician integration and collaboration
  - Low cost, quality care for the entire population
  - Independence possible, isolation is not (partnerships, affiliations, co-branding)
Do We Need to Merge or Find a Strategic Partner?

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CHANGING HEALTHCARE ENVIRONMENT is LEADING TO INCREASED Strategy Discussion

Do we need to merge or find a strategic partner?
Key Healthcare Sector Trends

- Macroeconomic
  - Systemic reform impact on reimbursement
  - Recovery from national, regional and local financial crises

- Demographics
  - Aging population: growing Medicare
  - Consumer-driven healthcare

- Technology
  - Advancement in medical technologies
  - Leveraging of information technologies

- Business Models
  - Care migration to the outpatient setting
  - Emergence of ACOs
  - Transition to value-based reimbursement

- Capital Markets
  - Perceived higher cost of capital
  - Less issuance

Growing pressure on bottom lines and care integration

Hospital M&A Deals Over the Past Decade

- 89 announced hospital M&A transactions in 2012
- 3rd most during ten-year period
  - Over $19 billion in reported dollars committed, the most since 2006 and the 2nd most during ten-year period
  - Headlined by two “mega deals”
    - 06/24/2013 - Tenet announced the acquisition of Vanguard valued at $4.3 billion
    - 7/30/2013 - CHS announced the acquisition of HMA valued at $7.6 billion

- 2014 transaction volume is off to a slower start with only 7 deals reported through February, a 36% decline compared to the same period last year
- A weak and uncertain operating environment and more aggressive state and federal regulatory challenges jeopardizes certainty of close and may be curtailing recent activity; further, early integration results of recently completed deals is mixed
Capital Costs: PERCEPTION MAY DIFFER FROM REALITY

- State of tax-exempt capital markets
  - Significant rate volatility
    - Overall market uncertainty and tapering concerns
    - Tax exempt supply/demand imbalances driving rates and credit spreads
      - Persistent weakness in taxable/tax-exempt rate relationship: primarily attributed to muni credit erosion (PR, Detroit, Stockton); hospitals are collateral damage
      - Decrease in tax-exempt bond issuance: healthcare down 30% YOY in 2013/likely down materially in 2014

- Hospital Specific
  - In general credit spreads have been trending lower since 2008 spike
  - For 2013, ratio of downgrades to upgrades across healthcare was 1.06

- Capital access remains good despite perception
  - Bonds attractive & other financing structures available at very attractive rates and terms for regional providers

ZIEGLER CREDIT WEIGHTING FACTORS

- NFP standalone hospitals and regional health systems are viable and can flourish in 2014 and beyond
- Short of a one-payor system, regional providers with strong management, dominant market share, and reasonable demographics will likely continue to outperform
  - These credits are currently undervalued by agencies and many investors placing heavy emphasis on scale/size, revenue diversity, risk dispersion
Undervalued Attributes of Regional Providers

- Nimble—can decide, implement and change faster
  - Competitive Strategy
  - Physician Integration
  - Capital Allocation
  - Managed Care Contracting
  - Financing Decision Decisiveness and Speed (critical in current volatile rate environment)

Undervalued Attributes of Regional Providers (cont.)

- Thorough understanding of market: Parent Board and Senior Management embedded in the market
  - Community needs
  - Physician preferences
  - Competitive forces
  - Demographics, payer mix and utilization trends

- Control own destiny
  - Capital allocation not impacted by performance of other regions/affiliates & system politics
  - Easier to measure efficiency and financial performance: not burdened by unnecessary or unfairly allocated overhead
Undervalued Attributes of Regional Providers (cont.)

- May maintain better negotiating leverage with insurers and physicians than large multi-state systems
  - Size relative to market more important than absolute size in contracting discussions
  - Whether fee for service or population based, negotiating leverage with insurers shaped by 1 fundamental question: is this provider a must have in the market in question for the insurer?

Can My Provider Maintain Independence?: Approach

- Management should continuously assess whether or not its mission and vision is best fulfilled by maintaining independence, entering into clinical affiliation or JV, forming a larger organization as an acquirer or affiliating with a larger partner
- Regional provider management should regularly assess competitive landscape with a focus on possible in-market affiliations that grant stronger leverage with payors and physicians
Underperforming providers with good market characteristics such as attractive demographics, good payer mix and market position with weak management teams may present hidden value and are attractive targets.

Acquisition of in-market underperformers may be an effective defensive strategy to keep a stronger competitor out of the market and could make sense despite dilution to financial position in the short run.

Management should regularly engage its key constituencies in strategic discussions:
- Regular dialogue with Board
- Engage physician leadership early and often

Routinely considering self-assessment questions can facilitate effective strategic dialogue and action plans.
Can My Provider Maintain Independence: 7 critical questions

Question #1: Does my organization have enough leverage with insurance payors to negotiate favorable contracts, whether fee-for-service or population-based, to offset governmental reimbursement pressure?
  » Am I “must have” for the insurers in the market?
  » Government reimbursement rate pressure exacerbated by growth of governmental reimbursement % in most markets
  » Depth and breadth of insurance market needs to be considered along with true market position which incorporates outpatient share (much harder to measure)
  » Having leverage and using it appropriately aren’t the same

Can My Provider Maintain Independence: 7 Critical Questions (cont.)

Question #2: Am I positioned to grow my delivery model?
  » Maintain share not sufficient with smaller pie; need to grow as utilization trending downward
  » Must generate enough cash flow for appropriate business reinvestment and balance sheet strength to insure access to capital
Can My Provider Maintain Independence: 7 Critical Questions (cont.)

- **Question #3: Physician Integration**—Does my hospital have enough projected operating cash flow, balance sheet liquidity and debt capacity to invest in the physician integration strategy that is most appropriate for my market while funding other routine and strategic capital requirements?
  - Young doctors overwhelmingly desire employment
  - Some regional providers are additionally challenged by lifestyle/quality of life issues for physician recruitment
  - Absolute revenue size can matter: may not be feasible to afford subsidy per employed doctor with a smaller consolidated revenue base
  - While benchmarking data is mixed and sparse: losses per doctor are growing for many regional providers

Can My Provider Maintain Independence: 7 Critical Questions (cont.)

- **Question #4: Information Technology**—Can my health system afford the requisite IT investment to promote a metric driven culture of accountability, demonstrate meaningful use, and measure quality and efficiency in real time?
  - Critical in digitized healthcare age with growing governmental reimbursement
    - Providers are price takers/need to IT to assist with efficiency
  - Absolute revenue size can be a factor for smaller providers
  - Different financing considerations versus bricks and mortar given shorter useful life and tax exempt use eligibility for IT
Can My Provider Maintain Independence: 7 Critical Questions (cont.)

Question #5: Looming Threats - Is there a looming competitive threat that will challenge the organization’s financial position over the next 5 to 10 years?
   » Stronger provider competition
   • Outcompeting a stand alone competitor may make competitor acquisition target of stronger system
   » Growing physician competition (especially if reliant on outpatient services for earnings)
   » Big adverse shift in payer mix, de-population or other market challenges

Can My Provider Maintain Independence: 7 Critical Questions (cont.)

Question #6: Access to the Full Continuum-Can I afford or at least have good access to the full care continuum over the next five to ten years?
   » Providing care in most appropriate setting growing in importance for profitability
   » More critical with growing governmental reimbursement, readmission penalties and pay for performance initiatives
   » While we are still predominantly fee for service which we believe persists for the next 5 to 7 years in most markets, population based reimbursement is undeniably growing
Can My Provider Maintain Independence: 7 Critical Questions (cont.)

Question #7: The Talent Pool – Do we have sufficient managerial talent and depth?
   » Many regional providers benefit from outstanding and deep talent that could succeed at any multi-state health system in the country

Can My Provider Maintain Independence: Conclusion

Community Based Regional Systems can and will be viable in 2014 and beyond:
   » Operating, competitive, managed care and capital strategies that are most appropriate for individual market is critical to success
   » While scale clearly matters more with reform, digitized healthcare age, new emerging payment models, growing physician employment, revenue diversity and risk diversion, two attributes of multi-state health systems, are overvalued and won’t drive profitability and quality
   » Can be more nimble than multi-state system/AMC and easier to have a comprehensive understanding of marketplace
   » Value to having decisions with regard to how healthcare is delivered made in-market
Regional providers should continually assess if mission and vision is best fulfilled as an independent and consider this question with key constituencies.

If we under-estimate the value of “system-ness,” a provider that builds its market position and essentiality to its community, will negotiate its affiliation with a larger system from a position of strength in the future.

Can My Provider Maintain Independence: Conclusion (cont.)
Agenda

- Introduction
- History, Mission, Vision
- Market Position
- Dahod Tower Expansion
- Saints Acquisition and Merger
- Making Circle Health’s Vision a Reality – Strategic Planning and Imperatives
The Lowell General Hospital Overview

- Regional, independent, not-for-profit community health care provider serving the greater Lowell area in Massachusetts
- Two Acute care campuses with 434 licensed beds
  - 301 adult medical/surgical
  - 29 intensive care
  - 40 pediatric
  - 26 obstetrical
  - 10 level IIB special care nursery bassinets
  - 28 well-newborn bassinets
- Approximately 3,300 employees and 700 physicians on staff

Primary Service Area Total Discharges
FY11 - FY12 Market Share by Hospital

Total PSA discharges and hospital market shares remained fairly stable between FY11 and FY12
Circle Health Discharge Distribution

LGH Inpatient Origin, FY12

SMC Inpatient Origin, FY12

<table>
<thead>
<tr>
<th>Source</th>
<th>PSA</th>
<th>% of Total</th>
<th>SMC</th>
<th>% of Total</th>
<th>Circle Health</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA</td>
<td>14,694</td>
<td>89%</td>
<td>5,639</td>
<td>91%</td>
<td>20,333</td>
<td>89%</td>
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<tr>
<td>SSA</td>
<td>1,054</td>
<td>8%</td>
<td>237</td>
<td>4%</td>
<td>1,291</td>
<td>6%</td>
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<tr>
<td>Outside</td>
<td>911</td>
<td>5%</td>
<td>301</td>
<td>5%</td>
<td>1,212</td>
<td>5%</td>
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<tr>
<td>Total</td>
<td>16,559</td>
<td>100%</td>
<td>6,177</td>
<td>100%</td>
<td>22,836</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: Includes Normal Newborns; Sources: LGH, SMC; Navigant Analysis, FY12 MA inpatient database

8th Largest Hospital in MA
2nd Largest Community Hospital in MA
Ranked by Total Discharges

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospital Name</th>
<th>FY12 Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Massachusetts General Hospital</td>
<td>51,798</td>
</tr>
<tr>
<td>2</td>
<td>Brigham and Women’s Hospital</td>
<td>50,515</td>
</tr>
<tr>
<td>3</td>
<td>UMass Memorial Medical Center</td>
<td>44,194</td>
</tr>
<tr>
<td>4</td>
<td>Baystate Medical Center</td>
<td>37,306</td>
</tr>
<tr>
<td>5</td>
<td>Beth Israel Deaconess Medical Center</td>
<td>36,846</td>
</tr>
<tr>
<td>6</td>
<td>Boston Medical Center-Menino Pavilion Campus</td>
<td>26,164</td>
</tr>
<tr>
<td>7</td>
<td>South Shore Hospital</td>
<td>25,367</td>
</tr>
<tr>
<td>8</td>
<td>LGH</td>
<td>16,559</td>
</tr>
<tr>
<td>9</td>
<td>SMC</td>
<td>6,177</td>
</tr>
<tr>
<td>10</td>
<td>Combined LGH/SMC</td>
<td>22,836</td>
</tr>
</tbody>
</table>

All Other Hospitals: 249,281

MA FY12 Discharges: 829,868

Actual FY12 Rankings
(out of 80 MA hospitals)

» LGH ranks #15 @ 16,559 discharges
» SMC ranks #44 @ 6,177 discharges
» Combined LGH/SMC ranks as the 8th largest hospital and 2nd largest community hospital in MA

Source: FY12 MA Inpatient Database
Circle Health Total Service Area

Service Area Population Summary

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Total Estimated Population 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA</td>
<td>292,000</td>
</tr>
<tr>
<td>SSA</td>
<td>367,000</td>
</tr>
<tr>
<td>Total</td>
<td>659,000</td>
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Facilities and Services Offered

- Existing facilities consist of multiple buildings situated on approximately 80 acres located in Lowell & Chelmsford, Massachusetts including:
  - Hospital (Main campus and Saints campus)
  - Cancer Center
  - Heart & Vascular Center
  - Regional Center for Maternal and Child Health
  - Endoscopy Center
  - Neuroscience Center
  - Level III Trauma Center
  - Center for Weight Management and Bariatric Surgery
  - Center for Health & Wellness
  - Maintains high level of care extensive breadth and depth of inpatient and outpatient services
  - Value-Based emphasis on quality and low cost of service makes Lowell more attractive to payors and consumers while distinguishing it from competitors

- In Fiscal Year 2013 approximately:
  - 23,000 inpatient discharges
  - 14,000 surgeries
  - 2,300 births
  - 100,000 emergency room visits
Legacy Project

Floor Levels and Occupancy Dates

05 Labor & Delivery
   Open Date: October 23, 2012

04 Intermediate Medical Care (28 Beds)
   Open Date: October 15, 2012

03 Medical Surgical Unit (38 Beds)
   Open Date: October 1, 2012

01 Emergency Department
   Open Date: December 6, 2012

06 Lobby/PSC/Outpatient Services
   Open Date: August 13, 2012

09 OR/ICU/PCU
   Open Date: September 17, 2012
Physician Hospital Organizational Structure
- 300 MD’s in the PHO
- Large Atrius group in Chelmsford, MA
- Merrimack Valley IPA – NEQCA Pod

All commercial contracts under risk based arrangements

Early adopters of the BCBSMA “Alternative Quality Contract”
- Renewed AQC for a second 5 Year deal

Medicare ACO “Circle Health Alliance” participates in Medicare Shared Savings upside only track – achieved over 6% savings in year 1

Introduction
- History, Mission, Vision
- Market Position
- Dahod Tower Expansion
- Saints Acquisition and Merger
- Making Circle Health’s Vision a Reality
Governance Structure

- Circle Health & Lowell General’s Boards of Trustees currently comprised of same 13 members:
  - 6 members from Lowell General, 6 members Saints and CEO
- Broad representation, specific experience include:
  - Physicians
  - Health Care Executives
  - Bankers
  - Accountants
  - Attorneys
  - Local Business Leaders
- Written conflict of interest policy where Board members must disclose conflicts & abstain from voting

Governance Structure

- Responsible for establishing Hospital policy
- Full authority to act on behalf of Hospital in matters pertaining to operations and management
- Meet four times per year & annual meeting in May
- Board of Directors approvals consist of:
  - Annual business plans and budgets
  - Capital expenditures, borrowing and disposition of assets
  - Board appointments
  - Medical Staff appointments
Agenda

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What is Circle Health?

- Preventive, Primary and Specialty Care
- Norm and Hospice Care
- Emergency and Inpatient Care
- Community-Based Health and Wellness

Our Community of Physicians

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Healthcare Today

Our Strategic Pillars
Circle Health Strategic Imperatives

I. **Continuum of Care**: Develop coordinated, comprehensive, and integrated programs of patient-centered care in partnership with physicians and other providers to provide patients with convenient access to the entire continuum of care.

II. **Value**: Deliver high value, affordable healthcare services through the provision of exceptional patient experiences, superb quality, safety, and efficiency.

III. **Population Health**: Improve the health status of the populations we serve through community outreach and education, disease management, wellness programs and the engagement and empowerment of all Circle Health patients.

Circle Health Strategic Imperatives (cont.)

IV. **Physician Alignment**: Align, engage, and integrate with all Circle Health physicians and allied health professionals to provide our patients with complete, connected care.

V. **Scale**: Expand existing relationships and develop new partnerships to attain optimal size and geographic footprint and enable Circle Health to excel in the management of the health care needs of the populations we serve.
2013 Key Accomplishments

- Consolidated key service lines across system campuses to provide more efficient and integrated programs of patient-centered care:
  - Cancer Services
  - Orthopedics
  - Cardiac Rehab
  - Cardiac Catheterization
  - Pain Center
  - Endoscopy
  - Medical Day Care

- Brought hospital system campuses live with Cerner’s Millennium product in June of 2013 to provide essential linkages across the full continuum of care

- Completed comprehensive study of Circle Health’s current service line offerings to identify gaps in the continuum of care as well as opportunities to further develop Centers of Excellence in areas that support our strategic imperatives.

- Provided comprehensive training and support services for Circle Health personnel to assure complete, connected care is consistently delivered across the full continuum of care

Continuum of Care Imperative

Develop coordinated, comprehensive, and integrated programs of patient-centered care in partnership with physicians and other providers to provide patients with convenient access to the entire continuum of care

Value Imperative

Deliver high value, affordable healthcare services through the provision of exceptional patient experiences, superb quality, safety, and efficiency

2013 Key Accomplishments

- Continuous Improvement projects undertaken including hosting the MHA Lean Program with PHO and Hospital participation

- Successful AQC contract renewal with BCBS to reward quality outcomes and value-based performance

- Top performer in BCBS AQC Outpatient Quality Measure set with highest performance in the state for the majority of the measures

- Quality Reporting to CMS executed as part of our ACO’s Medicare Shared Savings Program (MSSP) reporting. Performed above the 90th percentile on over 20% of the measures. Achieved 6% savings in first 12 mths of MSSP

- Complete, connected care trainings provided to all hospital employees and Circle Health personnel from employed practices
2013 Key Accomplishments

- Successful bond refinancing with favorable ratings from S&P and Fitch
- Lowell General Hospital: Realized gains in Perfect Care scores across both campuses reaching the mid to high 90’s on many of these quality measure sets
- VNA of Greater Lowell: receives two BCBS Innovation Awards to serve the chronically ill
- LCHC: recognized as Level 3 Patient Centered Medical Home – the highest level
- LCHC: began participation in the Medicaid Primary Care Payment Reform program for reimbursement through bundled payment

Population Health Imperative

*Improve the health status of the populations we serve through community outreach and education, disease management, wellness programs and the engagement and empowerment of all Circle Health patients*

2013 Key Accomplishments

- Completed a comprehensive Community Health Needs Assessment to identify health needs and health status disparities within the Greater Lowell area. Action planning underway based on key findings
- Lowell Community Health Center opens 100,000 sq. ft. state-of-the-art health center with primary medical care, OB-Gyn, pharmacy, behavioral health, teen programs, community outreach and education, some specialty care and expansion of Metta Health Center
- LCHC: opens Access Center to facilitate continuity of care between hospitals and health center
- VNA of Greater Lowell: develops and implements a Behavioral and Mental Health Program in response to community need
- Creation of the Circle Health Network under a self-insured platform with BCBS of MA including a Wellness Portal for LGH employees
2013 Key Accomplishments

- Appointment of new Chief Medical Officer for Circle Health
- Collaborative discussions held between the PHO and IPA to identify opportunities to work together to improve performance and service to patients
- Significant progress achieved in bringing our 400 medical staff members onto an integrated technology platform through implementation of a single electronic medical record (EMR) system at the hospital level and began extension to the physician office level
- Community physicians included in the Circle Health Advance 2013 forum to identify actionable priorities that engage the physicians in the advancement of Circle Health’s strategic priorities

Scale Imperative

Expand existing relationships and develop new partnerships to attain optimal size and geographic footprint and enable Circle Health to excel in the management of the health care needs of the populations we serve

2013 Key Accomplishments

- Expanded services and new primary care base at Lowell General North Andover site
- Developed plans for new Circle Health facility to open in Westford in 2014
- Successfully launched a brand awareness campaign for Circle Health including, print, radio, TV as well as outdoor advertising and a full PR/media campaign
- Completed comprehensive studies for each geographic area within our primary and secondary service areas to identify growth opportunities for Circle Health to expand our geographic footprint. Currently developing specific business plans to grow our network based on key findings from the studies
- Significant progress achieved in development of IT infrastructure to support network integration and connectivity across all Circle Health members
System Development and No-Regret Strategies

- Best be done with the hospital and physicians together
- Allow for significant local autonomy
- Achieve economies of scale (infrastructure support, buying power)
- Provide breadth and depth of clinical services across the care continuum
- Coordinate care locally
- Improve quality and efficiencies (provide high quality care at lower cost)
- Pursue risk-based global budget contracts which reward quality outcomes and value-based performance
### Pros and Cons of Circle Health System Strategy

#### Form a Network - Join a Network – Remain Independent

It is generally believed that the independent strategy may not be sustainable over the long term but that Circle Health is in a strong position to maintain independence in the short run.

<table>
<thead>
<tr>
<th></th>
<th>&quot;Former&quot;</th>
<th>&quot;Joiner&quot;</th>
<th>&quot;Independent&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local control/governance</td>
<td>moderate/strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Cost containment control</td>
<td>moderate/strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Quality and transparency control</td>
<td>moderate/strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Agility: flexibility to quickly make course correction</td>
<td>moderate/strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Freedom to affiliate with multiple tertiary providers</td>
<td>moderate/strong</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain strength of current Circle Health culture</td>
<td>moderate/weak</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Maintain strength of current hospital/medical staff relations</td>
<td>moderate/weak</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Maintain metric-driven culture of accountability</td>
<td>moderate/weak</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Maintain community-centric focus</td>
<td>moderate/weak</td>
<td>weak</td>
<td>strong</td>
</tr>
<tr>
<td>Financial/Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale to succeed under population health</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
<tr>
<td>Financial leverage with payers</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
<tr>
<td>Access to capital</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
<tr>
<td>Economies of scale/Shared overhead/Purchasing power</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
<tr>
<td>Comprehensive continuum of care offerings/Expansion of services</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
<tr>
<td>Maintain value proposition</td>
<td>moderate/strong</td>
<td>strong</td>
<td>weak</td>
</tr>
</tbody>
</table>

#### Board Advance No Regret Strategies

<table>
<thead>
<tr>
<th>Category</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuum of Care</strong></td>
<td>Provide breadth and depth of clinical services across care continuum</td>
</tr>
<tr>
<td></td>
<td>Coordinate care locally</td>
</tr>
<tr>
<td></td>
<td>Develop Centers of Excellence for key service lines</td>
</tr>
<tr>
<td><strong>Value</strong></td>
<td>Achieve economies of scale</td>
</tr>
<tr>
<td></td>
<td>Improve quality and efficiencies</td>
</tr>
<tr>
<td></td>
<td>Utilize evidence based medicine</td>
</tr>
<tr>
<td></td>
<td>Pursue risk-based global contracts</td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td>Increased covered lives</td>
</tr>
<tr>
<td></td>
<td>Expand community health &amp; wellness network</td>
</tr>
<tr>
<td></td>
<td>Improve access to primary care and specialists</td>
</tr>
<tr>
<td></td>
<td>Invest in pop health infrastructure</td>
</tr>
<tr>
<td><strong>Physician Alignment</strong></td>
<td>Improve ability to recruit and retain talent</td>
</tr>
<tr>
<td></td>
<td>Expand physician network</td>
</tr>
<tr>
<td></td>
<td>Develop and engage physician leadership</td>
</tr>
<tr>
<td></td>
<td>Clinical Integration (EMR and care management protocols)</td>
</tr>
<tr>
<td><strong>Growth</strong></td>
<td>Expand geographic footprint</td>
</tr>
<tr>
<td></td>
<td>Acquire or affiliate with new providers</td>
</tr>
<tr>
<td></td>
<td>Access to capital</td>
</tr>
<tr>
<td></td>
<td>Improve contracting power</td>
</tr>
<tr>
<td></td>
<td>Improve marketing and branding</td>
</tr>
<tr>
<td></td>
<td>Develop IT infrastructure</td>
</tr>
</tbody>
</table>
No Regrets Strategy

■ Continuum of Care
  » Provide breadth and depth of clinical services across care continuum
  » Coordinate care locally
  » Develop Centers of Excellence for key service lines

■ Value
  » Achieve economies of scale (infrastructure support, buying power)
  » Improve quality and efficiencies (provide high quality care at lower cost)
  » Utilize evidence based medicine
  » Pursue risk-based global budget contracts which reward quality outcomes and value-based performance

No Regrets Strategy (cont.)

■ Population Health
  » Increase covered lives
  » Expand the community health and wellness network
  » Improve access to primary care and specialists
  » Invest in infrastructure to support population health management (e.g., medical home development, new models of care delivery, and data-sharing analytic tools)

■ Physician Alignment
  » Improve ability to recruit and retain talent
  » Expand physician network
  » Develop and engage physician leadership
  » Achieve clinical integration through EMR platform and development of care-management protocols
Stable Volumes

Inpatient Admissions

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>11,486</td>
<td>14,163</td>
<td>15,877</td>
<td>20,916</td>
<td>5,121</td>
</tr>
</tbody>
</table>

Patient Days

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>53,537</td>
<td>54,549</td>
<td>62,381</td>
<td>86,145</td>
<td>21,238</td>
</tr>
</tbody>
</table>

Observation Stays

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>1,206</td>
<td>1,257</td>
<td>1,856</td>
<td>2,358</td>
<td>886</td>
</tr>
</tbody>
</table>

Stable Outpatient Statistics

Outpatient Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>226,382</td>
<td>235,875</td>
<td>325,825</td>
<td>472,770</td>
<td>108,500</td>
</tr>
</tbody>
</table>

Outpatient Surgeries

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>108,500</td>
<td>101,800</td>
<td>120,803</td>
<td>24,800</td>
<td>3,400</td>
</tr>
</tbody>
</table>

Emergency Room Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>48,931</td>
<td>51,973</td>
<td>66,131</td>
<td>100,803</td>
<td>24,166</td>
</tr>
</tbody>
</table>

Total Surgeries

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>11,108</td>
<td>11,108</td>
<td>11,108</td>
<td>14,349</td>
<td>2,358</td>
</tr>
</tbody>
</table>

Source: Hospital Records, 2010 & 2011 based on LGH, 2012 includes ½ year of Saints data.
**Payor Mix Trends**

2012 Payor Mix
- Medicare 36.1%
- Medicaid 18.8%
- Blue Cross 0.9%
- Commercial 1.5%
- Self Pay & Other 2.4%

2013 Payor Mix
- Medicare 40.3%
- Medicaid 20.8%
- Blue Cross 40.8%
- Commercial 2.4%
- Self Pay & Other 4.0%

Note: Based on gross patient; Blue Cross & Commercial percentages are for non-managed.
Source: Hospital Records

**Operating Performance**

2012 vs. 2013 vs. Dec-13

- **Net Patient Revenue**
  - 2012: $190,481
  - 2013: $293,992
  - Dec-13: $391,921

- **Operating Margin**
  - 2012: 0.0%
  - 2013: 4.2%
  - Dec-13: 0.2%

- **Operating Cash Flow Margin**
  - 2012: 9.0%
  - 2013: 7.4%
  - Dec-13: 7.7%

- **Cash from Operations**
  - 2012: $27,320
  - 2013: $25,605
  - Dec-13: $7,876

Note: 2012 includes results from Saints operations from July 1, 2012 only.
Source: Lowell General Hospital September 30, 2013, Audited Financial Statements and December 31, 2013 Interim Unaudited Reports
Liquidity Position

Unrestricted Cash & Investments

<table>
<thead>
<tr>
<th>Year</th>
<th>Unrestricted Cash &amp; Investments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$114,114</td>
</tr>
<tr>
<td>2013</td>
<td>$121,632</td>
</tr>
<tr>
<td>Dec-13</td>
<td>$129,342</td>
</tr>
</tbody>
</table>

Days Cash on Hand

<table>
<thead>
<tr>
<th>Year</th>
<th>Days Cash on Hand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>150</td>
</tr>
<tr>
<td>2013</td>
<td>117</td>
</tr>
<tr>
<td>Dec-13</td>
<td>113</td>
</tr>
</tbody>
</table>

Cash to Debt

<table>
<thead>
<tr>
<th>Year</th>
<th>Cash to Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>76.4%</td>
</tr>
<tr>
<td>2013</td>
<td>72.5%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>73.2%</td>
</tr>
</tbody>
</table>

Note: 2012 includes results from Saints operations from July 1, 2012 only
Source: The Lowell General Hospital September 30, 2013, Audited Financial Statements and December 31, 2013 Interim Unaudited Reports

Conclusion

- Presenters will answer questions as time permits
- This presentation will be available on www.foley.com in 2-3 business days
- Thank you for attending today’s web conference
  » Save the date for the next session in our series: Thursday, May 8.