

University Medical Center – Proposed Business Plan Validation

*Presented to: University Medical Center Management
Corporation Board of Trustees*

University Medical Center

New Orleans, Louisiana / June 2, 2011

KaufmanHall

Financial Strategies for Healthcare
5202 Old Orchard Road
Suite N700
Skokie, IL 60077
847.441.8780 phone
847.965.3511 fax
kaufmanhall.com

Contents

- Engagement Overview
- Context Setting: State of the Healthcare Industry
- Proposed University Medical Center (“UMC”) Business Planning Materials Review
 - Strategic assumptions and projection scenarios
 - Financial assumptions and projection scenarios
- Considerations: Critical Success Factors, Risks
- Appendix

Engagement Overview

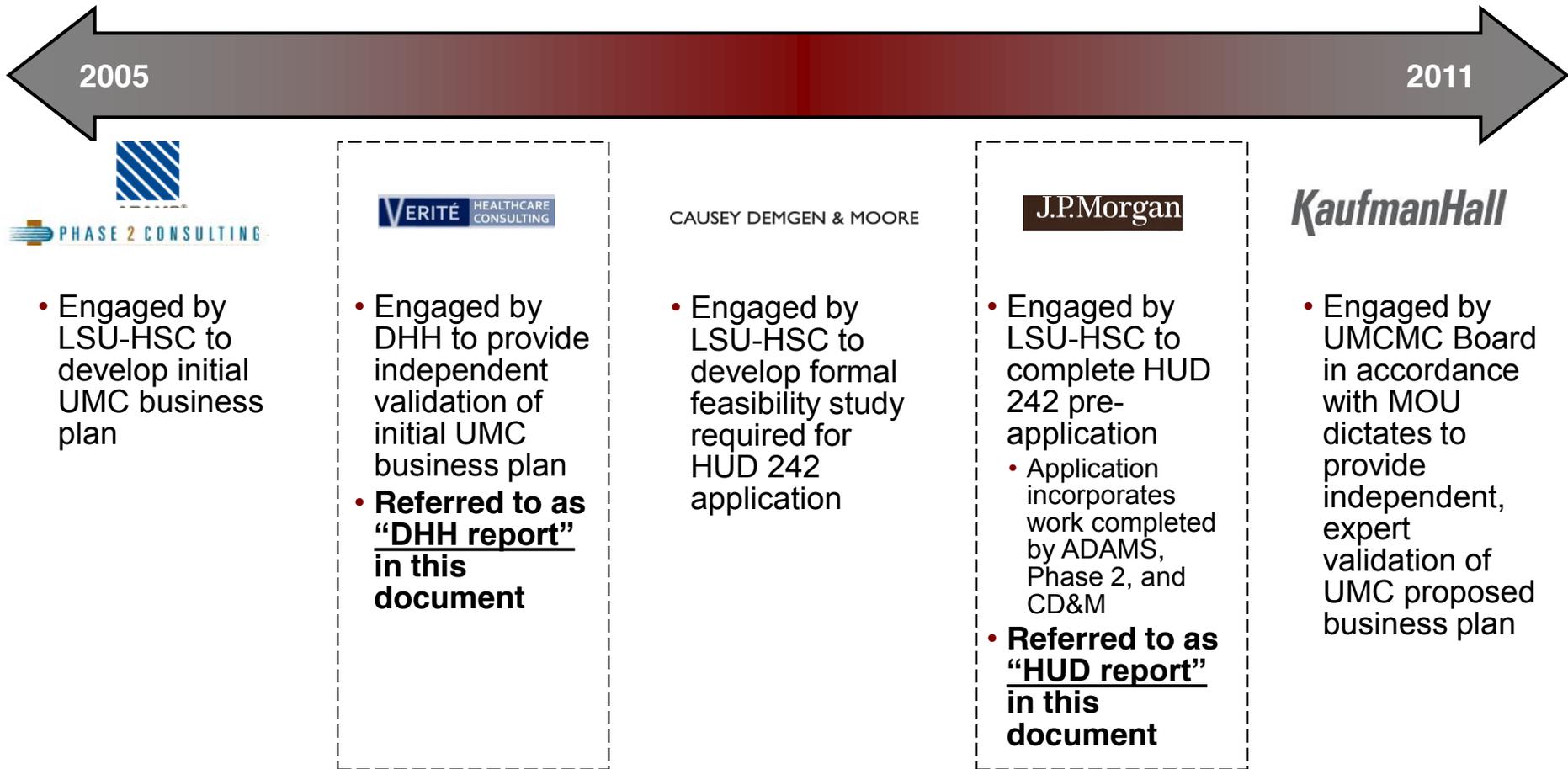
Kaufman Hall's Charge

The Memorandum of Understanding (“MOU”) dated August 29, 2009 articulates Kaufman Hall’s (“KHA”) charge:

Independent verification of the financial plan for financing purposes will be obtained and must be provided to the Corporation Board for its review and approval before any binding final action on financing. A firm with expertise in health care bond financing will be utilized. The scope and cost of the project may be adjusted accordingly based on the input of the financial analysis to ensure the project can be financed successfully.

The MOU language is consistent with what was described in the request for proposals dated October 29, 2010, as well as with communications from the University Medical Center Management Corporation (“UMCMC”) Board to KHA throughout the course of our engagement.

UMC Planning Timeline – Kaufman Hall’s Understanding



Note: Kaufman Hall took a “bottom up” approach to the development of all assumptions and projections illustrated herein, as we did not want to introduce bias into our work. Upon developing our independent assumptions and projections, we based our validation against the DHH and HUD reports (referenced above), as they represent the most recent and comprehensive sets of planning assumptions and methodologies.

Defining “Validation”

- A critique of key assumptions and findings associated with previously developed UMC business planning materials – **not** the development of a full and comprehensive UMC business plan or “optimal solution” – based on:
 - Previous consultants’ reports, as well as information made available by stakeholders through May 20, 2011 and/or gleaned from other public sources related to the proposed University Medical Center (*complete list of source materials in Appendix*)
 - Interviews with relevant stakeholders, including UMC participating organizations, UMCMC Board members, city and state officials and regional (competing) hospital executives (*interviewee list in Appendix*)
 - Kaufman Hall’s experience and expertise as a national strategic and financial advisory practice with over 25 years of service to the U.S. provider industry
- Reflective of the strategic, financial and market implications associated with the proposed UMC; assumes optimal business operations and required support infrastructures are in place to support the enterprise
- As complete and accurate as information made available (and complemented through secondary research) will allow
- *Reflective only of the proposed UMC clinical enterprise; not a commentary/critique of its educational and/or research functions*

Engagement Objectives – As Developed and Agreed to by Kaufman Hall and the UMCMC Board Steering Panel

1. Evaluate, provide commentary on and suggest changes (as necessary) to previously developed strategic and financial assumptions
2. Determine likely range of UMC operating performance given strategic and financial assumptions
3. Quantify the level of start-up and ongoing external support required to support UMC operations and to create long-term capital capacity
4. Test resiliency of proposed business planning materials to unforeseen future changes that could impact UMC

Engagement Timeline

	January				February				March				April				May				June			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
A. Project Initiation																								
B. Baseline and Strategic Materials Review and Validation																								
C. Baseline and Strategic Materials Preliminary Review Teleconferences																								
D. Baseline and Strategic Materials Review Working Session																								
E. Baseline and Strategic Materials Revision and Finalization																								
F. Sensitivity Analysis/ Scenario Development																								
G. Sensitivity Analysis/ Scenario Review Session																								
H. Final Report Preparation and Delivery																								
Teleconferences/ Onsite Sessions	Days 1-30				Days 30-60				Days 60-90				Days 90-120				Days 120-150				Days 150-180			
Teleconference																								
Onsite Review/ Work Session																								
Prep Sessions																								
Final Report Delivery/ Presentation																								

UMCMC Board Steering Panel

In addition to stakeholder interviews, Kaufman Hall met with a Board Steering Panel – a subset of the UMCMC Board and other community representatives – on a regular basis to review work completed to date and discuss the implications of the results. Steering Panel members included:

Name	Title, Organization	Project Role
Bobby Yarborough	CEO, Manda Fine Meats	UMCMC Board Chairman
Elaine Abell	Attorney at Law	UMCMC Board Member
Darryl Berger	Principal, The Berger Co.	UMCMC Board Member
Byron Harrell	President, Baptist Community Ministries	UMCMC Board Member
Lee Kantrow	Attorney, Kantrow, Spaht, Weaver & Blitzer	UMCMC Board Counsel
Robert Boh	President, Boh Brothers Construction Co.	UMCMC Board Advisor
Lee Griffin	Interim CEO, LSU Foundation	UMCMC Board Advisor
Steve Hemperley	Greater New Orleans Market President, Capital One Bank	UMCMC Board Advisor
John Spain	Executive Vice President, The Baton Rouge Area Foundation	UMCMC Board Advisor
Bobby Stuart, Jr.	President, Louisiana - Capital One Bank	UMCMC Board Advisor

Context Setting: State of the Healthcare Industry

Since 2008, a Persistent Set of Strategic Challenges Plague Providers in Many Markets

Strategic Challenge	Implications for Academic Health Systems
Declining Volume (inpatient, outpatient and physician)	<ul style="list-style-type: none"> • Challenges maintaining top line revenue projections • Inability to balance the portfolio of services • Ability to compete for physicians who are increasingly seeking relative safety of employment/ acquisition
Deteriorating Payor Mix	<ul style="list-style-type: none"> • Self-pay/ charity care stubbornly high, with lessening ability to shift cost to commercial/ managed care payors; top-line stress • Ability to compete for physicians who are increasingly seeking relative safety of employment/ acquisition
Rise of “Super Insurers” with >50% Market Share	<ul style="list-style-type: none"> • Potentially decreased ability to leverage specialization/high acuity to “make” price; systems without dominant share become price takers • The historic tripartite mission is challenged
Unsettled Physician Communities	<ul style="list-style-type: none"> • Ability to compete for physicians who are increasingly seeking relative safety of employment/ acquisition • Increasing competition for physician services (often leading to “bidding wars” among health systems)

Since 2008, a Persistent Set of Strategic Challenges Plague Providers in Many Markets (continued)

Strategic Challenge	Implications for Academic Health Systems
<p>“Rising” Competitive Bar (emerging “supergroups” and “super regional” health systems)</p>	<ul style="list-style-type: none"> • Increasing redundancy in/ competition for high-acuity, high-cost services (e.g., specialized surgery, trauma, transplant) • Increasing competition for physician services (often leading to “bidding wars” among health systems) • Lack of incentive for hospitals and physicians to collaborate to drive value to patients
<p>Continued Financial Stress</p>	<ul style="list-style-type: none"> • Challenges associated with securing State appropriations • Quest for scale/ essentiality intensifies; often muddying organizational vision and strategic direction
<p>Continued Reform-related Uncertainty</p>	<ul style="list-style-type: none"> • Inability to effectively plan for medium- to long-term future • Dampening of innovation as providers “wait out” additional clarity

Kaufman Hall Provider Industry Observations – June 2, 2011

Growing recognition among providers that the world has changed and frenetic efforts to reposition for success in the new era of value-based reimbursement

- Rapidly increasing levels of physician-physician, physician-hospital and hospital-hospital integration
- Aggressive efforts to reduce costs (e.g., Lean)
- Massive investment in information systems/ other infrastructure to drive care, cost and quality management
- Experimentation with new delivery (e.g., medical home) and contracting (e.g., bundled payment, modified FFS, P4P) models that require greater integration among providers

Kaufman Hall Provider Industry Observations – June 2, 2011 (continued)

- Early movers focusing on brand, service delivery system rationalization, and portfolio management
- Adapting to a new competitive environment
 - Horizontal and vertical integration
 - Non-traditional market entrants (e.g., AT&T and WellDoc[®], Google health)
- Partnership discussions abound – across and within verticals

Providers Are Evolving Into a New Business Model

1. New value proposition: highest quality at lowest cost
2. New relationships between doctors and hospitals
3. An emphasis on longitudinal coordination of care
4. Steady and increasing pressure on price – the direction of average payment rates
5. Uncertain future utilization
6. Improved IT connectivity between hospitals/ doctors/ patients
7. Fee-for-service replaced by some kind of “managed care”
8. Scale/ market essentiality increasingly an advantage

Proposed UMC Business Planning Materials Review

Strategic Assumptions and Projections

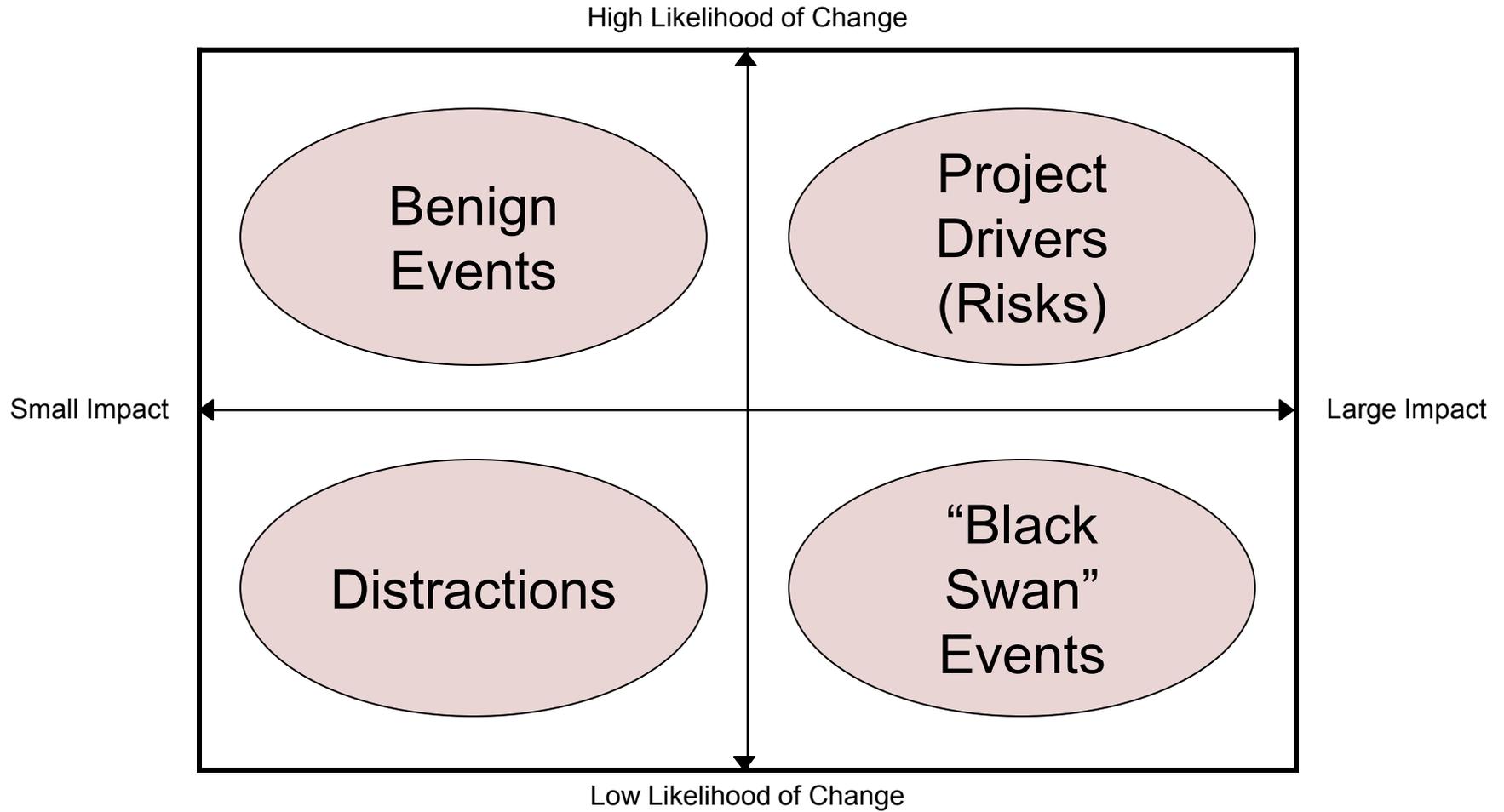
Kaufman Hall Evaluated a Comprehensive Set of Qualitative and Quantitative Criteria Related to UMC

	Strategic	Financial	Other
Qualitative	<ul style="list-style-type: none"> • Vision • Strategic differentiation • Competitive response(s) • Governance • Administrative leadership • Physician support 	<ul style="list-style-type: none"> • Ongoing state appropriations “tolerance” 	<ul style="list-style-type: none"> • Culture
Quantitative	<ul style="list-style-type: none"> • Market capacity • Market utilization • Population/ demographics • UMC volume/ market share <ul style="list-style-type: none"> – Payor mix – Patient mix • Immigration 	<ul style="list-style-type: none"> • Operating revenue • Operating expenses • Disproportionate share (“DSH”) funding • Graduate Medical Education (“GME”) reimbursement trajectory • Capital investments/ requirements • Project funding sources/ amounts 	<ul style="list-style-type: none"> • Project timing/ ramp-up

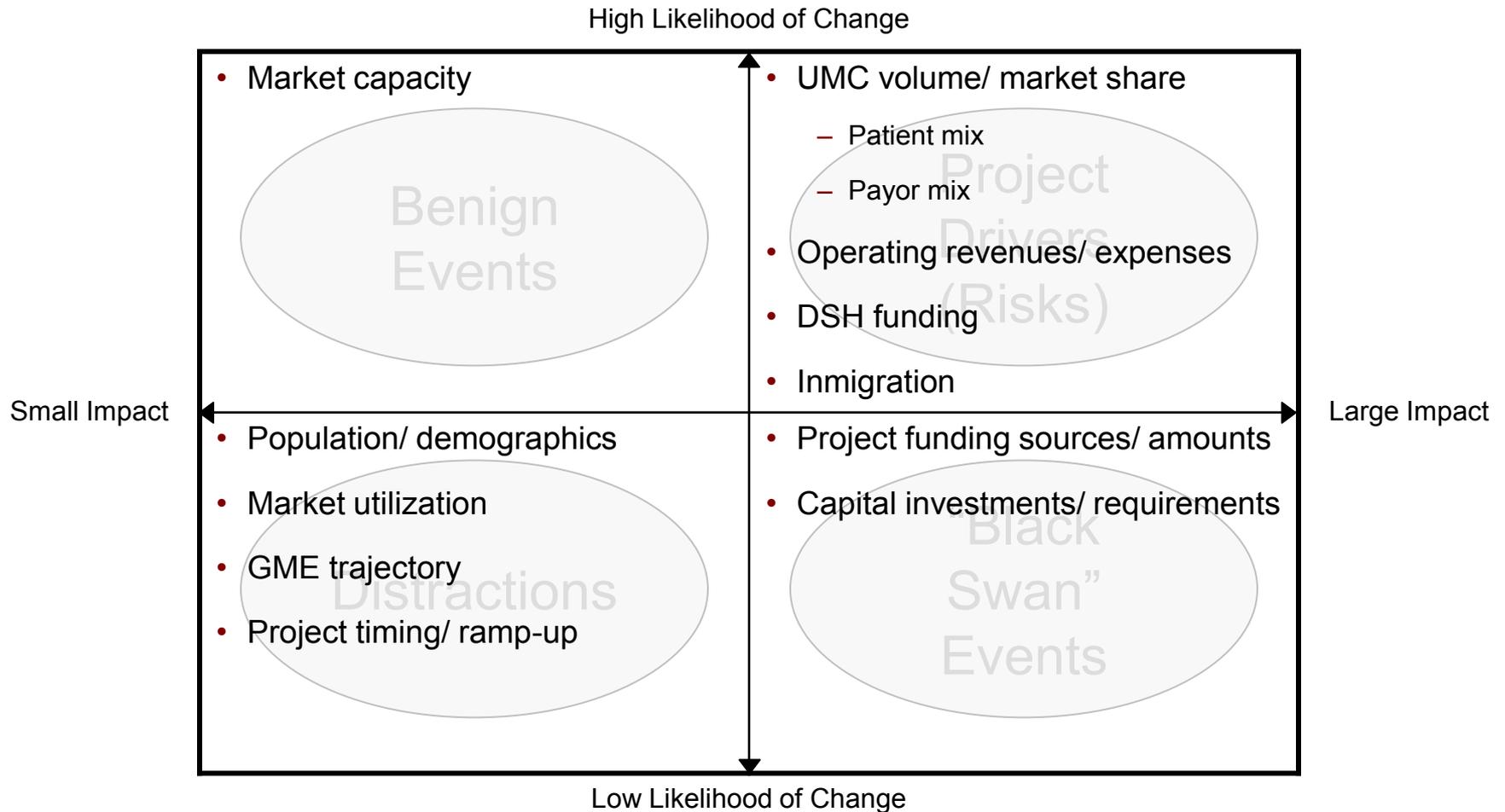
Prioritizing Quantitative Assumptions – Evaluation Frames

1. Degree to which recent information impacts previously developed assumptions
2. Likelihood that a given assumption may change during the projection period
3. Magnitude of impact on strategic/ financial projections associated with changes in a given assumption
4. Degree of difference between Kaufman Hall's perspective and previously developed planning materials

Prioritization Framework



Classifying and Understanding Quantitative UMC Assumptions



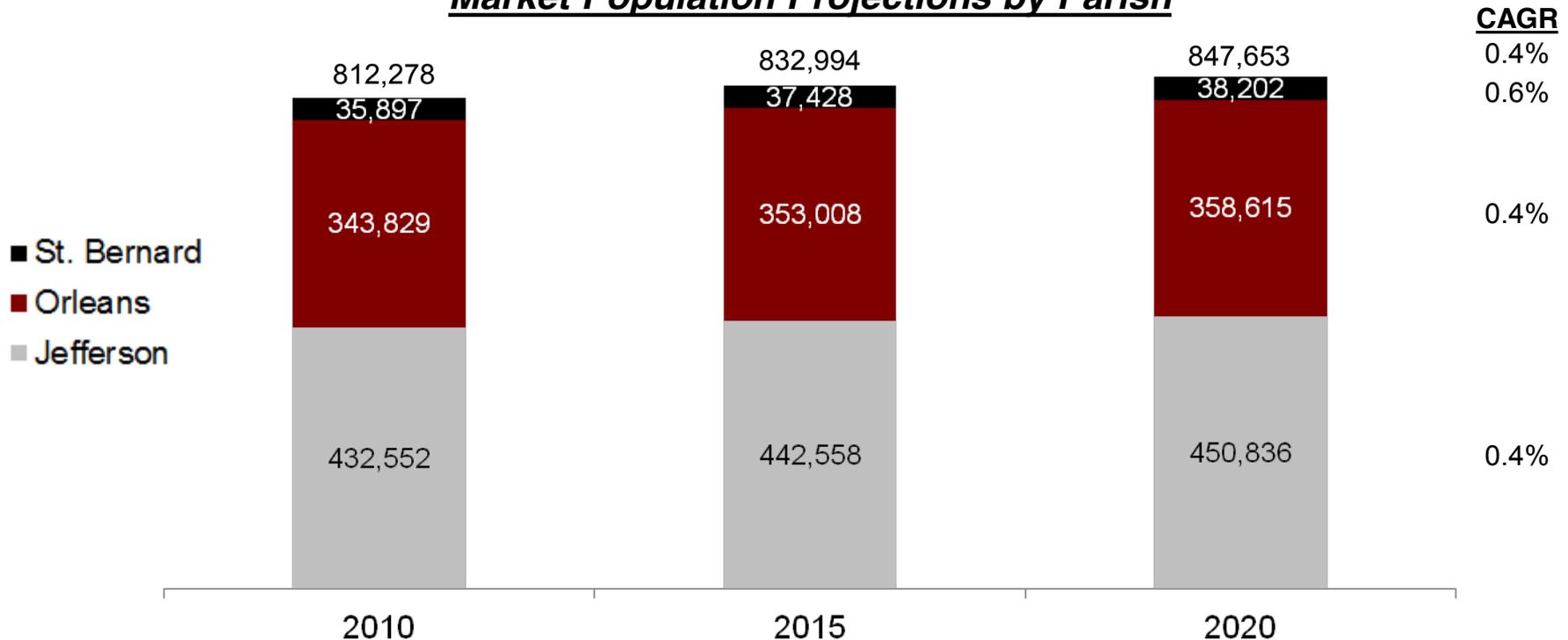
A more detailed discussion on qualitative assumptions is included in the “Considerations” section of this discussion document.

Volume Assumptions: Service Area Population and Projected Growth Rates

Kaufman Hall utilized data from the recently released 2010 census to quantify the base population for the three parish service area (Orleans, Jefferson, and St. Bernard parishes).

Using the 2010 census as the base, Kaufman Hall applied the most recent, generally-accepted service area population growth rates by Parish and age cohort, as provided by the State of Louisiana in its *Louisiana Parish Population Projections Series, 2010-2030* (developed by LSU for the State of Louisiana).

Market Population Projections by Parish



Sources: U.S. Census Bureau; State of Louisiana, *Louisiana Population Projections Series, 2010-2030*.

Note: CAGR = compound annual growth rate.

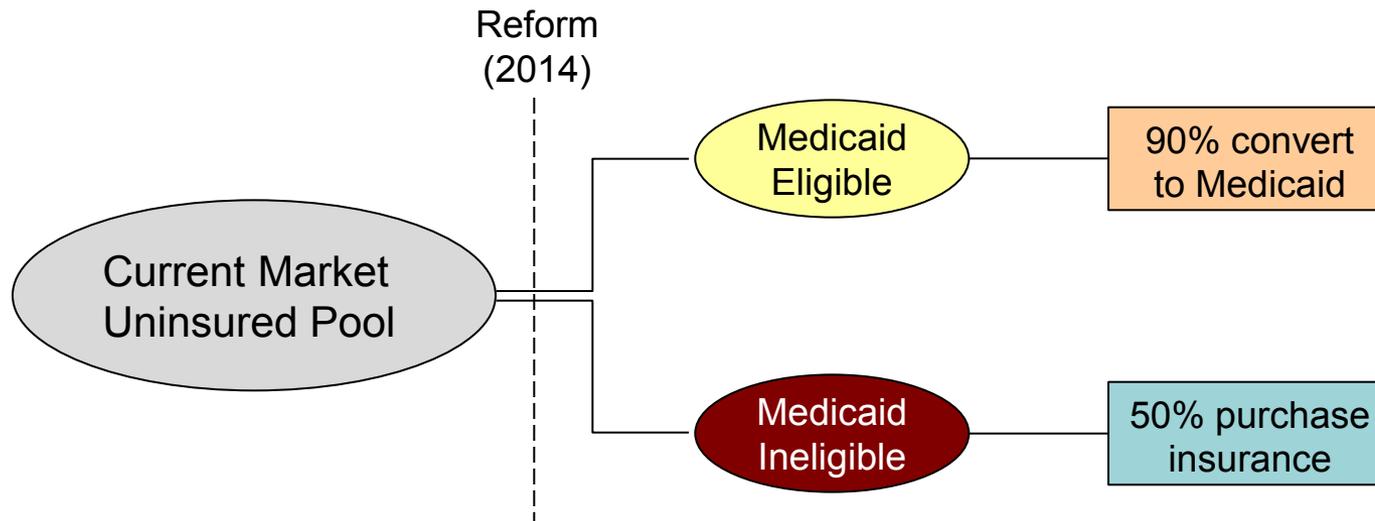
Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Volume Assumptions: Population Payor Mix

Given the need to understand the service area population's relative payor mix (required in order to model healthcare reform), KHA segmented UMC's service area population into major payor categories using a variety of publicly-available sources:

- 1) Uninsured and Medicare percentages: *2009 Louisiana Health Insurance Survey*
- 2) Medicaid percentage: DHH's Louisiana Medicaid Enrollment Numbers reports
- 3) Commercial percentage: assumed to represent the remainder of the population

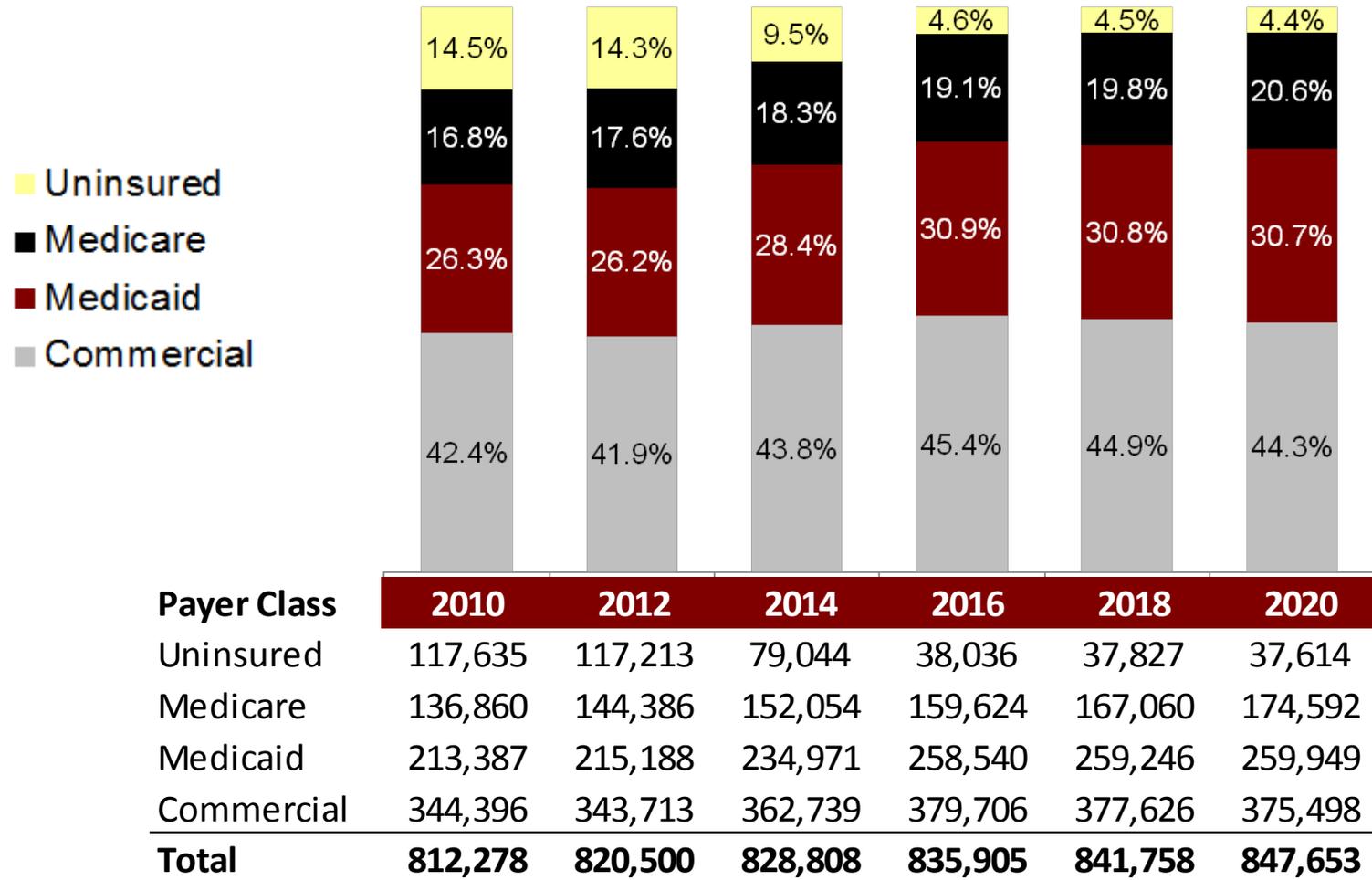
To model healthcare reform, KHA made the following assumptions regarding the conversion of the market's Uninsured population to Medicaid-like coverage:



Note: Medicaid eligibility based on income relative to Federal Poverty Level (FPL).

Volume Assumptions: Population Payor Mix (continued)

Market Population Projections by Payor



Sources: U.S. Census Bureau; State of Louisiana, *Louisiana Population Projections Series, 2010-2030*; Louisiana DHH, *2009 Louisiana Health Insurance Survey*; Louisiana DHH, *Medicaid Enrollees by Parish, December 2010*.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Volume Assumptions: Inpatient Utilization Rates (Payor-class Level)

Kaufman Hall calculated payor-specific inpatient utilization rates by combining the market's most recent 12 months of discharge data by payor with the aforementioned population by payor.

Inpatient utilization rates were assumed to decline 0.2% annually for Commercial and Medicare patients to reflect healthcare reform and the shift in care from the inpatient to outpatient setting. Medicaid and Uninsured utilization rates were held constant at 2010 calculated levels to reflect the historically greater challenges in managing patient populations within those payor classes, as well as the uncertainty associated with unintended consequences of health reform.

2010 Use Rate Calculation

Payer	Population	Discharges	Use Rate
Uninsured	117,635	8,362	71.1
Medicare	136,860	31,809	232.4
Medicaid	213,387	26,415	123.8
Commercial	344,396	26,477	76.9
Total	812,278	93,063	114.6

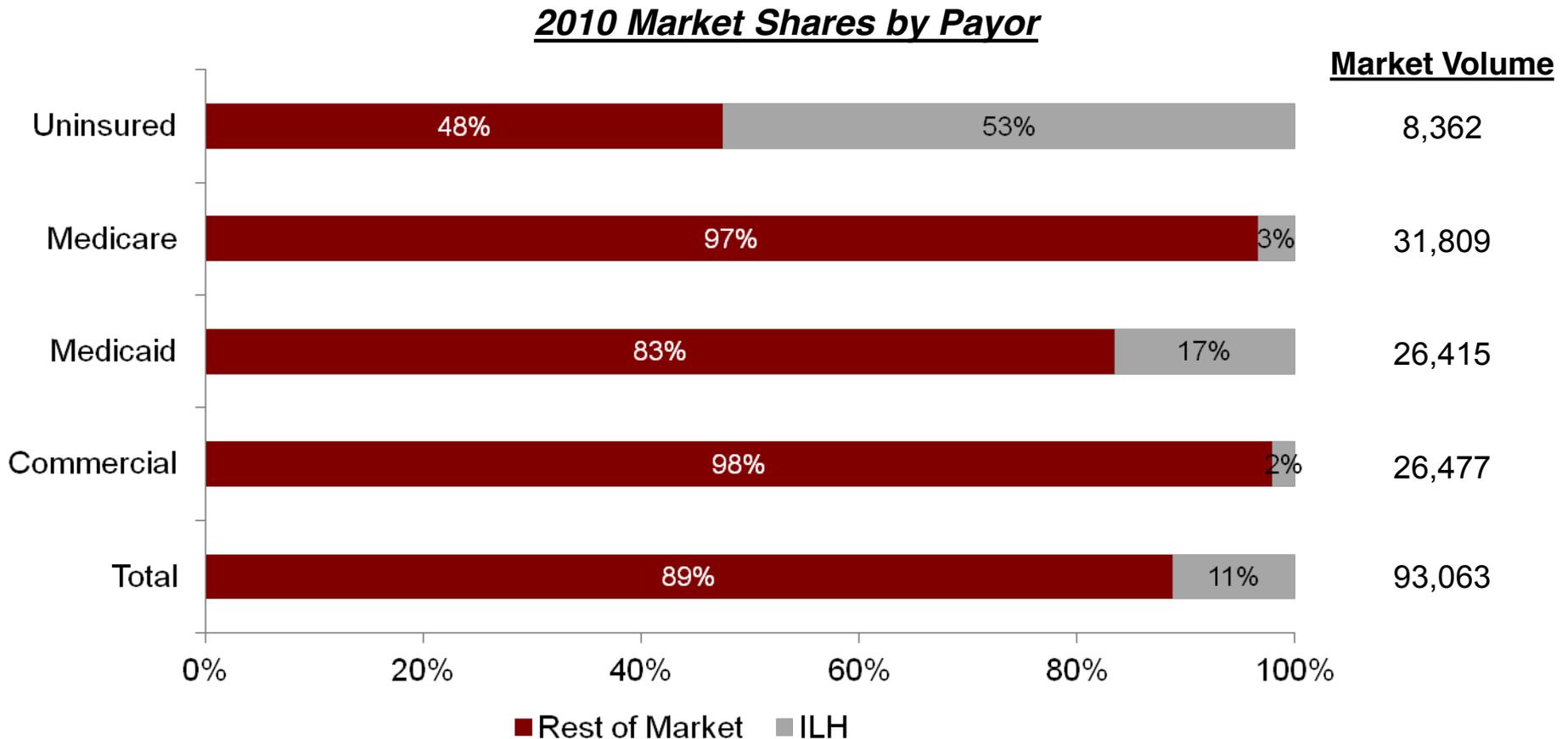
Changes in Inpatient Utilization Rates, 2010-2020

Use Rate	2010	2012	2014	2016	2018	2020
Uninsured	71.1	71.1	71.1	71.1	71.1	71.1
Medicare	232.4	231.5	230.6	229.6	228.7	227.8
Medicaid	123.8	123.8	123.8	123.8	123.8	123.8
Commercial	76.9	76.6	76.3	76.0	75.7	75.4
Overall	114.6	115.4	117.6	119.9	120.7	121.4

Sources: Louisiana Health Information Network, State Inpatient Database, 1st Quarter 2007 – 2nd Quarter 2010; U.S. Census Bureau; State of Louisiana, *Louisiana Population Projections Series, 2010-2030*; Louisiana DHH, *2009 Louisiana Health Insurance Survey*; Louisiana DHH, *Medicaid Enrollees by Parish, December 2010*.

Volume Assumptions: UMC Market Share Projections by Payor

Market discharge data and actual 2010 ILH discharge information were used to calculate base UMC market share estimates. These shares were held constant through 2013 to project ILH's inpatient volume pre-reform.



Source: Louisiana Health Information Network, State Inpatient Database, 1st Quarter 2007 – 2nd Quarter 2010.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

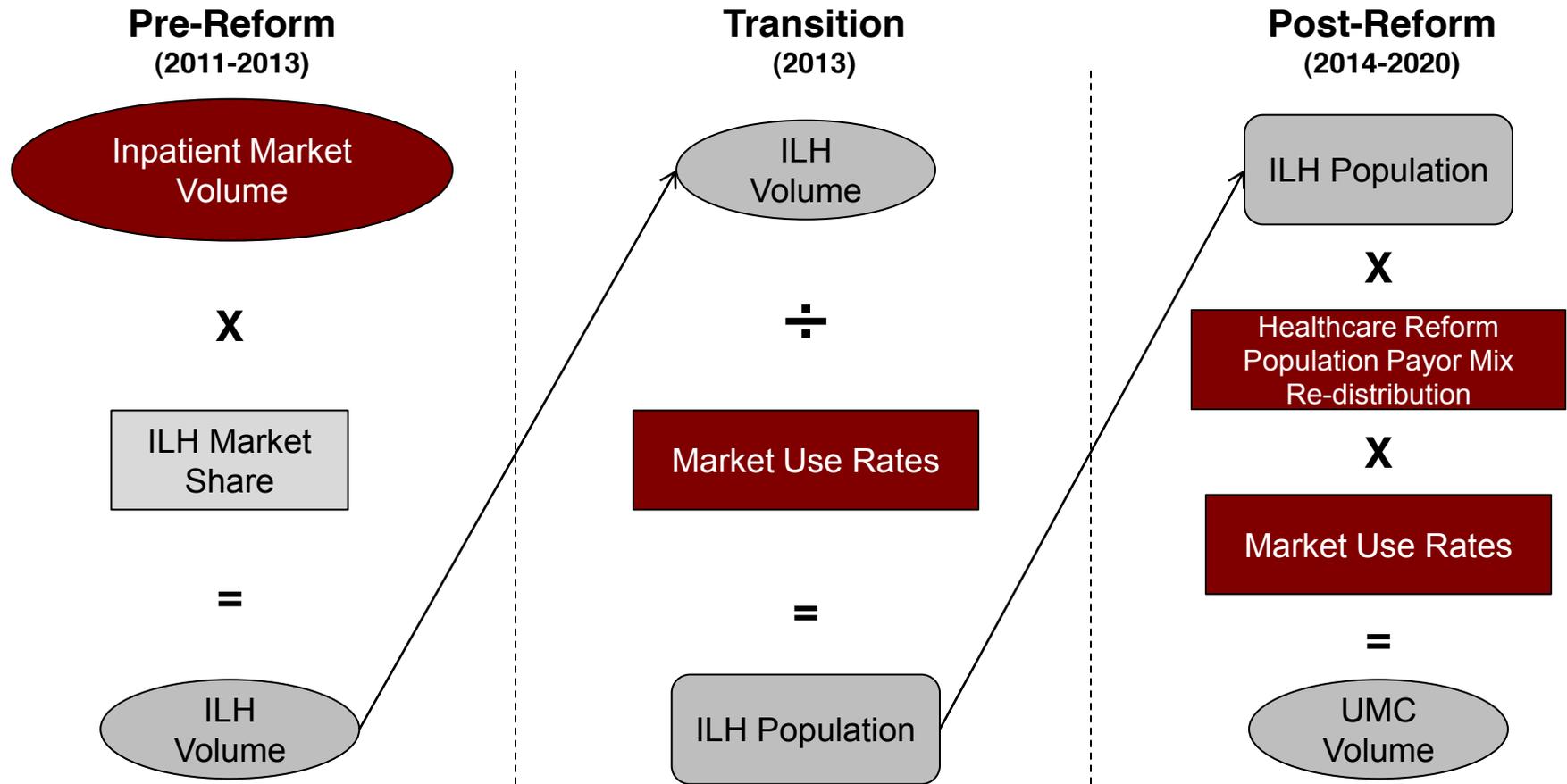
Volume Assumptions: Sources of UMC Volume Growth

Volume projections for the new UMC facility are built upon three distinct components:

- 1) Existing ILH volume: This volume represents the pre-reform population base that ILH cares for and the healthcare services this population will likely demand at ILH and/or UMC pre- and post-reform
- 2) Patient repatriation: This volume represents Commercial and Medicare cases that are currently seen by LSU faculty at competing facilities, but are expected to come back to the new Medical Center
- 3) Inmigration: Patients that travel from outside the service area for care; historically, inmigration to ILH represented 24.4% of inpatient volume (2010); this percentage is expected to remain constant in the future

UMC Volume: Underlying “ILH” Volume

To project UMC’s service area base volume, pre- and post-reform, Kaufman Hall utilized the following methodology:



Given competition and increased patient choice post-reform, Kaufman Hall assumed that UMC will “capture” between 45% and 95% of formerly uninsured/ newly Medicaid-covered patients.

UMC Volume: Patient Repatriation

Using information provided by LSU through its consultants, Kaufman Hall analyzed faculty volume by payor and facility. Repatriatable volume are defined as Commercial/ Medicare patients that could be reasonably expected to return to UMC upon physician direction. Kaufman Hall based its assessment of reasonability on: a) acuity level and b) patient willingness to travel for care.

Kaufman Hall segmented the non-ILH Commercial and Medicare volume by acuity (~15%¹ equates to high acuity), and then estimated the “moveability” of cases back to UMC by acuity (10-40% of low acuity and 65-90% of high acuity volume).

2008 LSU Faculty Volume by Payor and Site (provided by Phase II Consulting)

Note: 2005 volume analysis by Phase II Consulting can be viewed in the 2007 MCLNO Business Plan Update report at www.newhospital.org

2008	East			Med Ctr of	Ochsner	Ochsner	Ochsner	Ochsner	West		Grand Total	
	Children's Hospital	Jefferson Gen Hosp	LA/New Orleans	Baptist Med Ctr	MC - West Bank	Med Ctr - Kenner	Med Ctr - NO	Touro Infirmary	Jefferson Med Ctr	All Other		
Blue Cross/Blue Shield	119	53	72				119	35	84	35	2	520
Champus							16	8	10	6	-	41
Commercial Insurance	156	10	261				29		222	4	4	687
HMO/Managed Care	220	68			2		195	45	210	134	2	876
Medicaid	1,971	103	2,995	4	2		599	45	597	91	12	6,418
Medically Indigent/Free			202								-	202
Medicare		78	697	10			1,343	91	319	177	27	2,742
Other, Unknown		2	3,164						12	10	6	3,195
Self Insured							14	8		4	-	27
Self Pay	16						267	8	23	21	8	344
Workers'/State Comp	-	-	4	-	-		10	-	-	-	-	14
Grand Total	2,483	315	7,395	14	4		2,594	241	1,477	481	62	15,067

¹High acuity defined as CMI > 2.0. 15% estimation based on 2006 HCUP Survey of teaching hospitals.

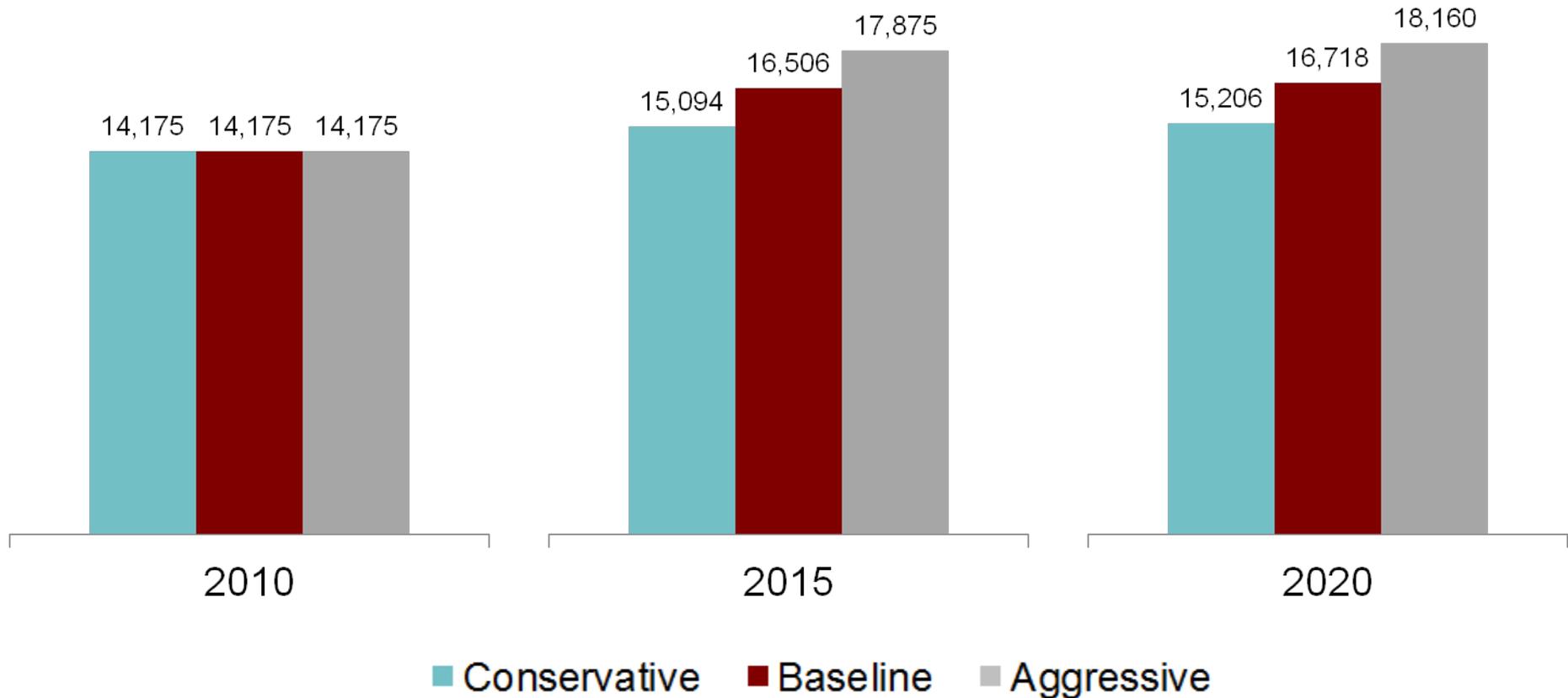
Volume Scenarios Overview

Kaufman Hall developed three planning scenarios to illustrate the range of volume and financial implications on UMC. The three scenarios are as follows:

- 1) Conservative scenario: Assumes 45% capture of the formerly Uninsured ILH population, repatriation of 700 cases by 2020 (65% of high acuity/ 10% of low acuity LSU faculty volume) and inmigration of 24.4%
- 2) Baseline scenario: Assumes 75% capture of the formerly Uninsured ILH population, repatriation of 1,119 cases by 2020 (80% of high acuity/ 20% of low acuity LSU faculty volume) and inmigration of 24.4%
- 3) Aggressive scenario: Assumes 90% capture of the formerly Uninsured ILH population, repatriation of 1,850 cases by 2020 (90% of high acuity/40% of low acuity LSU faculty volume) and inmigration of 24.4%

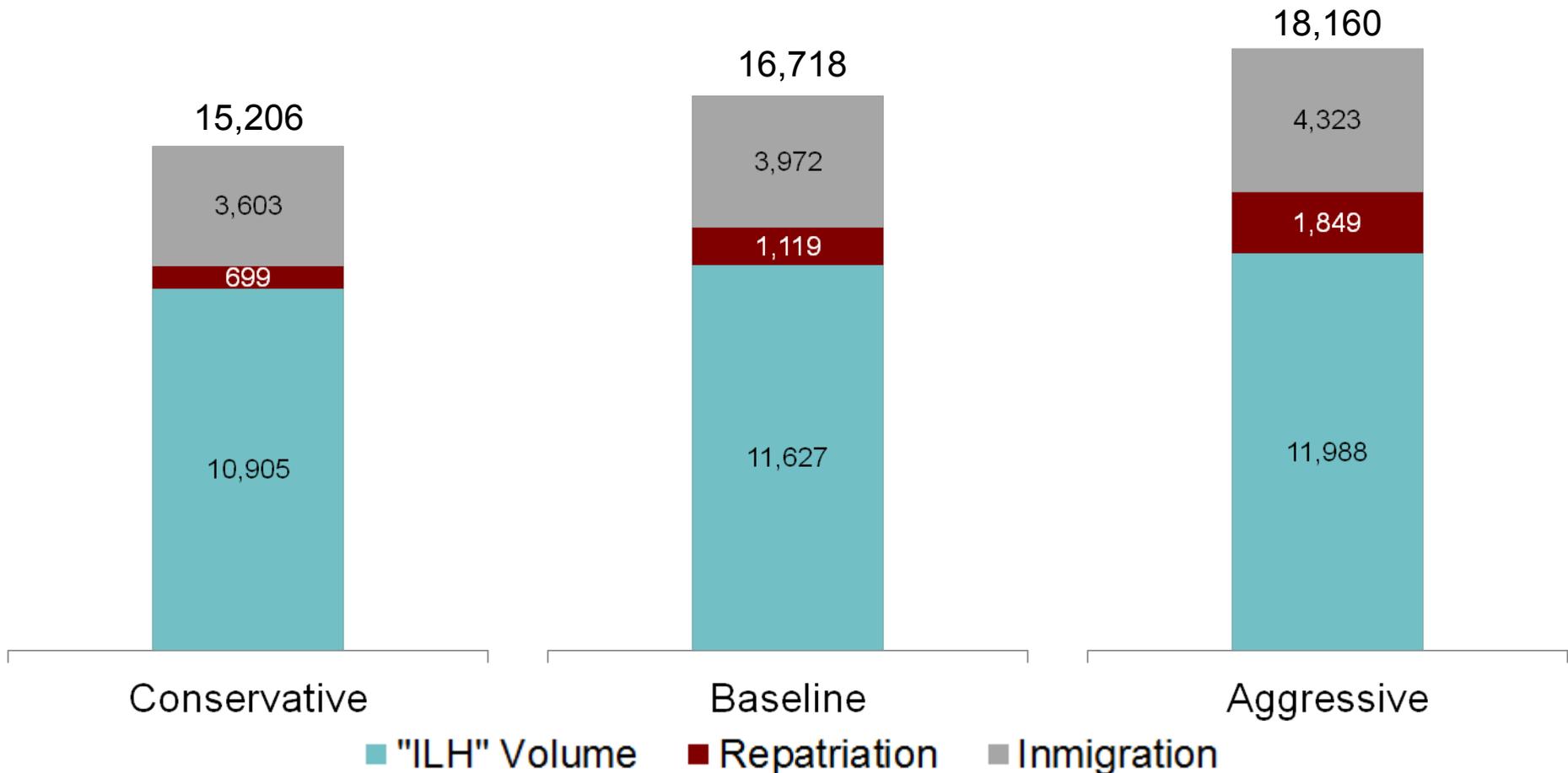
Volume Comparison by Scenario

Under the three scenarios, total UMC inpatient volume ranges between 15,000 and 18,000 cases by 2020.



2020 Volume Composition by Scenario

The 2,954 discharge variance between the conservative and aggressive scenario is comprised of the following: 1,083 cases from "ILH" volume, 1,150 cases from repatriation, and 720 cases from immigration.

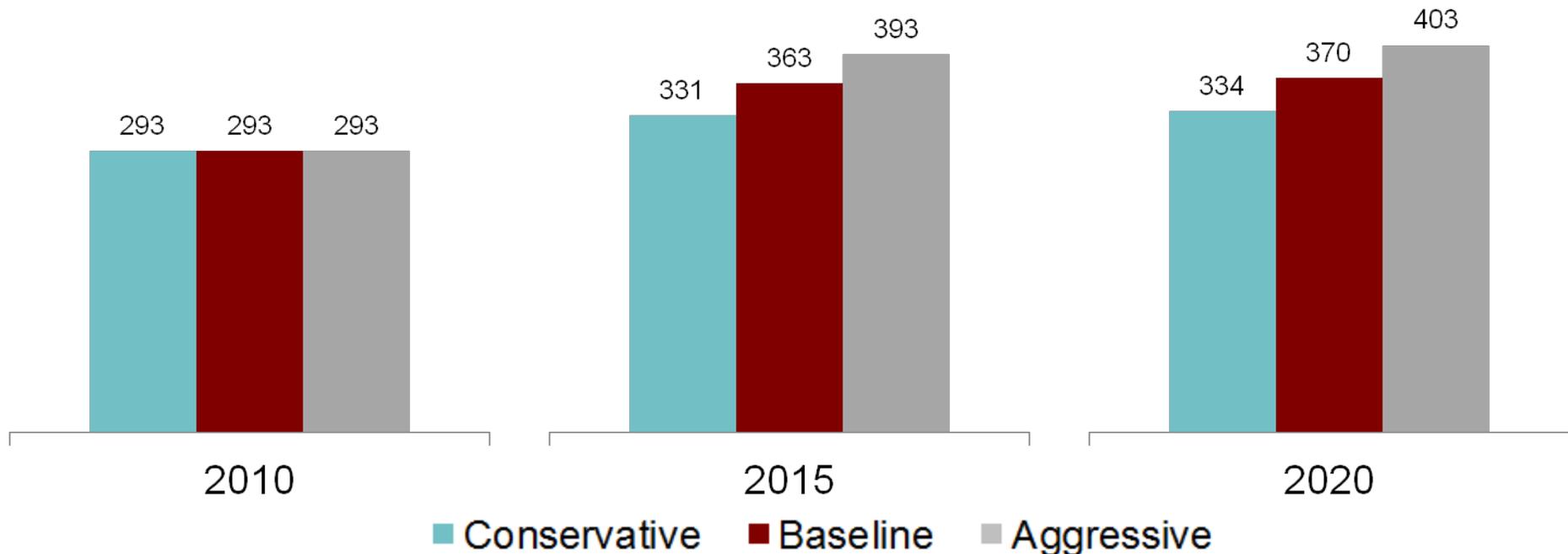


Bed Need Comparison by Scenario at 75% Occupancy

Using ILH's 2010 average length of stay by payor as a starting point, Kaufman Hall assumed a 0.1 day reduction annually between 2011 and 2013 for each payor group, and then held rates constant through 2020.

Average lengths of stay by payor were applied to projected discharges by payor to compute total days and derive bed need by scenario shown below.

Under the three scenarios, bed need ranges from 334 beds to 403 beds in 2020



Financial Assumptions and Projections

UMC Financial Projections – General

- Kaufman Hall created a financial model to identify the key drivers of UMC's future financial performance and estimate the range of State General Funds (SGF) that will be necessary to support the organization
- Four areas emerged as critical assumptions:
 - Volumes
 - DSH Replacement Funds
 - DSH Funds
 - Medicaid Reimbursement
- The following slides will demonstrate the sensitivity of SGF needs to assumptions in these and other areas
- For detail on these assumptions, as well as the various other assumptions in the model, please refer to the appendix

UMC Financial Projections – Baseline Scenario

- A primary goal of the financial model was to demonstrate for the UMC Board the key levers that will have the greatest impact on UMC's future SGF needs
- The baseline projections should not be interpreted as a specific point estimate around which there is little uncertainty
 - As the analysis on the following slides will demonstrate, the uncertain value of many key inputs creates a relatively wide range of potential SGF needs
- Therefore, the following baseline results should only be viewed as one estimate within a range of potential values

Calculating State General Fund Needs

- Kaufman Hall calculated State General Fund (SGF) needs by estimating the funds necessary to maintain approximately 100 days of cash on hand
- Given competitive pressures and reimbursement uncertainties, we would consider these levels of cash to be a minimum
 - 121 days cash on hand is the median for hospitals with the lowest investment grade credit rating (BBB)
- SGF is calculated annually to fund
 - Cash operating losses⁽¹⁾
 - Changes in working capital
 - Capital spending
 - Principal payments
 - Funding up to 100 days cash on hand minimum

Note (1): Operating revenues less operating expenses plus depreciation.
Source: Standard & Poor's 2009 Not-For-Profit Hospital Medians.

Baseline Projections – *SGF Needed to Maintain Cash Reserves*

Ratio/Statistic	S&P ⁽¹⁾ "BBB"	Actual	Projected Interim Hospital					Projected University Medical Center					
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	
Net Patient Service Revenue	\$180.2	\$447.2	\$375.2	\$402.6	\$404.1	\$391.2	\$432.5	\$454.2	\$468.1	\$484.6	\$488.1	\$517.1	
Operating Income	---	6.7	(32.5)	(33.2)	(31.1)	(20.3)	(15.9)	(25.5)	(23.1)	(19.7)	(18.9)	(12.6)	
Operating EBIDA	---	20.5	(18.1)	(19.1)	(17.3)	(15.5)	34.7	46.2	49.3	53.7	55.9	64.0	
Net Income	---	102.9	(32.4)	(32.7)	(30.9)	(20.3)	(13.2)	(21.3)	(18.8)	(15.4)	(14.5)	(8.1)	
Cash Flow (Net Inc. + Depr.)	---	116.3	(18.1)	(18.6)	(17.1)	(15.5)	8.0	21.3	24.8	29.8	32.6	41.3	
Unrestricted Cash	---	32.5	29.7	16.2	7.9	0.0	146.1	150.3	154.5	158.9	163.3	167.8	
Total Debt	---	5.2	0.0	406.2	406.2	406.2	401.0	395.4	389.3	382.9	375.9	368.5	
Capital Expenditures	---	32.0	105.2	179.2	574.1	325.3	31.8	8.5	12.7	17.0	21.2	25.4	
Profitability													
Operating Margin	1.6%	1.4%	(7.2%)	(7.3%)	(6.8%)	(4.5%)	(3.0%)	(4.6%)	(4.0%)	(3.3%)	(3.1%)	(2.0%)	
Operating EBIDA Margin	8.6%	4.2%	(4.0%)	(4.2%)	(3.8%)	(3.5%)	6.6%	8.3%	8.6%	9.1%	9.1%	10.0%	
Excess Margin	1.8%	17.5%	(7.2%)	(7.2%)	(6.7%)	(4.5%)	(2.5%)	(3.8%)	(3.3%)	(2.6%)	(2.3%)	(1.3%)	
Debt Position													
Annual Debt Service Coverage (x)	2.5	15.1	(3.4)	(1.8)	(0.9)	0.0	1.1	1.5	1.5	1.7	1.7	2.0	
Total Debt to Capitalization	42.1%	2.9%	0.0%	54.9%	36.4%	32.1%	27.6%	27.9%	28.0%	28.1%	28.1%	28.0%	
Liquidity													
Days Cash On Hand (days)	121.2	25.1	23.0	12.4	6.1	0.0	101.9	102.2	102.6	102.3	101.9	101.6	
Other													
Capital Spending Ratio	109%	238%	733%	1268%	4169%	6783%	150%	20%	29%	38%	45%	51%	
State General Funds		26.1	56.1	32.5	33.2	33.8	73.1	76.1	78.1	82.9	99.1	96.3	

Assuming additional State General Funds, financial projections depict operating profitability sufficient to cover working capital increases, debt service, and capital spending. The liquidity position stabilizes during the projection period, though days cash on hand remains below BBB medians.

Note: Dollar values in millions. Reclassifications include SGF (classified as operating revenue), bad debt (operating expense), and physician revenue (net patient service revenue, per request of LSU finance team). 2010 net income includes \$93.3M nonoperating revenues.

Note(1): Standard & Poor's 2009 Not-For-Profit Hospital Medians.

Source: FY10 MCLNO Audited Financial Statements.

UMC Financial Projections – Sensitivity Analyses

- Assumptions in four areas emerged as key drivers of UMC's financial profile:
 - Volumes
 - DSH Replacement Funds
 - DSH Funds
 - Medicaid Reimbursement
- The sensitivities in the subsequent pages demonstrate the potentially wide-ranging outcomes when these assumptions are altered
- Sensitivities were also performed for other core operational variables

Sensitivity Analysis – Volumes

2020 State General Funds Required to Maintain Stable Cash Reserves

Scenario	FY20 Discharges	FY20 SGF ⁽¹⁾
Conservative Volumes	15,206	\$99.1
Baseline Volumes	16,718	\$96.3
Aggressive Volumes	18,160	\$92.1

FY20 SGF needs range from \$92M to \$99M

- As discussed previously, Kaufman Hall developed multiple volume growth scenarios to evaluate the impact of volumes on financial performance
- The need for State General Funds decreases in the aggressive volumes scenario because profit from additional repatriated commercial cases outweighs losses from incremental Medicaid and Medicare patients.
- The reverse occurs in the conservative volumes scenario; as volumes decline, more profit is lost from lower commercial volumes than is gained from avoided losses on Medicare and Medicaid cases

Note(1): State General Funds required to maintain stable cash reserves.
Note: Dollar values in millions.

Sensitivity Analysis – DSH Replacement

2020 State General Funds Required to Maintain Stable Cash Reserves

Scenario	FY20 Non-SGF DSH Replacement ⁽¹⁾	FY20 SGF ⁽²⁾
Conservative DSH Replacement	\$0.0	\$105.6
Baseline DSH Replacement	\$9.3	\$96.3
Optimistic DSH Replacement	\$27.4	\$78.2

FY20 SGF needs range from \$78M to \$106M

- The FY12 Executive Budget allocates \$38.5M to the Interim Hospital to replace DSH funding lost due to the Audit Rule; of these funds, \$11.1M are State General Funds, and \$27.4M comes from new UPL programs
- In the baseline scenario, \$9.3M non-SGF DSH Replacement monies are maintained through FY20 due to significant uncertainties surrounding the UPL programs
- In an optimistic scenario, full DSH Replacement funding would be maintained through FY20. If this were to occur, SGF needs would be reduced by \$18.1M
- In a conservative scenario, no non-SGF DSH Replacement funds are assumed, increasing FY20 SGF needs to \$105.6M

Note(1): Funds from new UPL programs; excludes the \$11.1M SGF portion of DSH Replacement funds, which does not impact total SGF funding needs.

Note(2): State General Funds required to maintain stable cash reserves.

Note: Dollar values in millions.

Source: Discussions with LSU management and finance staff.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Key: Baseline Scenario

Sensitivity Analysis – LA DSH Cap Reduction and Medicaid Payment 2020 State General Funds Required to Maintain Stable Cash Reserves

		Medicaid Reimbursement 2015 - 2020		
		(1) 0% per year	(2) IP 60 % of Cost	(3) IP 100 % of Cost
LA DSH Cap Reduction	(A) Baseline Decline	\$128.5	\$96.3	\$96.3
	(B) Baseline + 10%	\$137.3	\$101.0	\$96.3
	(C) Baseline + 20%	\$147.2	\$110.8	\$96.3

FY20 SGF needs range from \$96M to \$147M

- Under baseline Medicaid reimbursement (inpatient cases reimbursed at 60% of cost, consistent with FY12 projections), additional SGF would be required if the Louisiana DSH Cap were reduced beyond baseline assumptions
- Reimbursement at 100% of inpatient cost would insulate UMC from downside DSH cut risk (unless cuts were to exceed baseline + 20%)

Notes: Dollar values in millions. Please refer to the appendix for a description of the Medicaid reimbursement scenarios.

Key: Baseline Scenario

Sensitivity Analysis

LA DSH Cap Reduction and Share of State DSH Spending

2020 State General Funds Required to Maintain Stable Cash Reserves

		% of State DSH Spending Allocated to UMC		
		(1) 15%	(2) 19%	(3) 23%
LA DSH Cap Reduction	(A) Baseline Decline	\$121.2	\$96.3	\$96.3
	(B) Baseline + 10%	\$128.2	\$101.0	\$96.3
	(C) Baseline + 20%	\$135.9	\$110.8	\$96.3

FY20 SGF needs range from \$96M to \$136M

- Under baseline state DSH allocations (19% of state spending, consistent with projected 2012 spending), UMC would face downside risk if DSH cuts worsen beyond baseline assumptions
- If UMC were to increase its share of state DSH to 23%, the downside risk of DSH cuts would be insulated (up to 20% beyond baseline assumptions)

Note: Dollar values in millions.
 Source: Discussions with DHH.
 Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Sensitivity Analysis – Other Variables

2020 State General Funds Required to Maintain Stable Cash Reserves

	UMC FY20 SGF	Variance from FY20 Results
<u>Baseline Scenario</u>	\$96.3	----
<u>Upside Scenarios</u>		
I. FTE/AOB Falls to 5.0	\$77.8	(\$18.5)
II. 1% Higher Annual Commercial Revenue Inflation	\$89.0	(\$7.3)
III. 1% Lower Annual Salaries Increase	\$88.1	(\$8.2)
<u>Downside Scenarios</u>		
I. FTE/AOB Falls No Further Than 6.5	\$106.5	\$10.2
II. 1% Higher Annual Salaries Increase	\$105.8	\$9.5
III. 1% Higher Annual Supplies Inflation	\$101.3	\$4.9

- DSH payments – which are based in part on cost – reduce sensitivity to operating cost changes
- State General Fund needs are particularly sensitive to labor productivity and commercial reimbursement increases

Note: Dollar values in millions.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Key: Baseline Scenario

Considerations: Critical Success Factors and Risks

Critical Success Factors and Risks

- Governance (functionality, empowerment, ability to act autonomously in UMC's best interest while operating within LSU Health, etc.)
- Management (transition timing, leadership traits, fundamental/functional capabilities, empowerment, ability to act autonomously and make tough decisions in UMC's best interest while operating within LSU Health, etc.)
- Community perception (timing of and ability to transcend legacy "Charity Hospital" perception (including location) and draw commercial and inmigrating patients)
- LSU Health shared services (cost allocation to UMC, functionality/value of services provided to UMC, transition execution, etc.)
- Ongoing state appropriations (amount, timing, certainty, etc.)
- Reimbursement (Medicaid funding (DSH, UPL, shift to managed care), Federal Healthcare Reform impact on Medicare, unknown impact of exchanges on commercial payor viability/ rates)

Critical Success Factors and Risks (continued)

- Competitive responses (competition over physicians, patients, brand perception, staff, etc.)
- Inmigration (materialization at historic rates given local/ regional competition)
- Cultural transformation (shift from a governmental structure, operation, and culture to an independent, competitive, customer service-focused provider)
- Physician strategy (compelling clinical delivery system model and significant funding support of alignment strategies to attract/ retain physicians in a very competitive environment)
- Capital funding (timing and reliability of FEMA and State pledged funds, timing/ cost/ ability to access additional capital to complete the project, future ability to meet bond/ lender's covenants, ability to fund future capital needs, etc.)
- Construction risk (ability to meet budget, unforeseen complications leading to timing delays or cost overruns, disruption of services, etc.)
- External event risk (global/ national/ state/ regional recession, healthcare reform uncertainties, future recurrence of natural/ man-made disasters, etc.)

Closing Observations

- Based on our analyses:
 - Estimated inpatient volume ranges from 15,000 to 18,000 discharges in 2020
 - Corresponding bed need in 2020 ranges from 330 to 400 beds
 - UMC is currently planning for 424 beds, allowing for growth beyond our projections
 - State General Fund support is expected to be approximately \$100 million annually by 2020, with a potential range of \pm \$25 million depending on key sensitivities affecting volume, reimbursement, and other sources of revenue. Other circumstances may widen the range in either direction.
- Achieving expected results will be highly dependent upon:
 - Controllable internal risks: governance, management, cost control, LSU Health shared services, and cultural transformation
 - External risks: community perception, state appropriations, reimbursement, competitive response, immigration, physician strategy, capital funding, construction and event risks

Appendix

Appendix

Kaufman Hall's Capabilities and Experience

Kaufman Hall At a Glance

DEBT-RELATED FINANCIAL ADVISORY

Since 1985, Kaufman Hall has acted as financial advisor to more than 900 healthcare debt transactions. Total debt and swaps issued on behalf of our clients exceeds \$90 billion and \$43 billion, respectively.

ENUFF SOFTWARE SUITE®

Over 1,300 software licenses are in place nationwide. The ENUFF Software Suite uses corporate finance principles to directly support the financial management cycle.

MERGERS, ACQUISITIONS, AND DIVESTITURES

Kaufman Hall has advised clients on hundreds of M&A-related engagements including analyzing, structuring, negotiating and executing mergers, acquisitions, divestitures, joint ventures, strategic partnerships and affiliations.

FINANCIAL AND CAPITAL PLANNING

Introduced concept of strategic financial planning to healthcare field in 1983. Kaufman Hall has prepared financial and capital plans for over 800 hospitals and healthcare systems.

STRATEGIC SERVICES

Kaufman Hall provides a broad range of strategy-related services to support organizational management and decision making. Kaufman Hall pioneered the development of the integrated strategic financial plan.

CAPITAL ALLOCATION

Kaufman Hall helps organizations design and implement capital allocation processes which provide consistent and rigorous methodologies to guide the capital decision-making process.

Select Kaufman Hall Academic Medical Center and Public Hospital Clients

UCSF Medical Center

San Francisco, CA

UCLA Health System

Los Angeles, CA

UWHealth

Madison, WI

LSU Health Sciences Center
HEALTH CARE SERVICES DIVISION
Multiple Locations, LA

KU MEDICAL CENTER
The University of Kansas
Kansas City, KS

EMORY HEALTHCARE

Atlanta, GA

UAMS

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

Little Rock, AR

University of Colorado Hospital
ANSCHUTZ MEDICAL CAMPUS
Aurora, CO

USC
UNIVERSITY
HOSPITAL

Los Angeles, CA

THE OHIO STATE UNIVERSITY Medical Center

Columbus, OH

STANFORD MEDICINE

Palo Alto, CA

utmb Health

Galveston, TX

University of Missouri Health Care

Columbia, MO

Harris County Hospital District

Houston, TX

HALIFAX HEALTH

Daytona Beach, FL

Yale Medical Group

THE PHYSICIANS OF YALE UNIVERSITY

New Haven, CT



M Northwestern Memorial Hospital

Chicago, IL

Tufts Medical Center

Boston, MA

DMC
DETROIT MEDICAL CENTER

Detroit, MI

Appendix

Key Volume Assumptions

Volume Assumptions: Service Area Population and Projected Growth Rates

Kaufman Hall utilized data from the recently released 2010 census to quantify the base population for the three parish service area (Orleans, Jefferson, and St. Bernard parishes).

Using the 2010 census as the base, Kaufman Hall applied the most recent, generally-accepted service area population growth rates by Parish and age cohort, as provided by the State of Louisiana in its *Louisiana Parish Population Projections Series, 2010-2030* (developed by LSU for the State of Louisiana).

Comparison to Prior Reports

Kaufman Hall Assumptions

Parish	2010	2015	2020	Annual Growth Rate
Jefferson	432,552	442,558	450,836	0.4%
Orleans	343,829	353,008	358,615	0.4%
St. Bernard	35,897	37,428	38,202	0.6%
Total	812,278	832,994	847,653	0.4%

DHH Report Assumptions

Parish	2010	2015	2020	Annual Growth Rate
Jefferson	436,430	450,195	N/A	0.6%
Orleans	343,818	350,623	N/A	0.4%
St. Bernard	43,188	45,024	N/A	0.8%
Total	823,436	845,842	N/A	0.5%

HUD Report Assumptions

Parish	2010	2015	2020	Annual Growth Rate
Jefferson	N/A	N/A	N/A	N/A
Orleans	N/A	N/A	N/A	N/A
St. Bernard	N/A	N/A	N/A	N/A
Total	824,320	912,814	N/A	2.1%

Volume Assumptions: Population Payor Mix

Given the need to understand the service area population's relative payor mix (required in order to model healthcare reform), Kaufman Hall segmented UMC's service area population into major payor categories using a variety of publicly-available sources:

- 1) Uninsured and Medicare percentages: Kaufman Hall applied parish-specific population rates published in the *2009 Louisiana Health Insurance Survey*, developed by the LSU Public Policy Research Lab for the Louisiana Department of Health and Hospitals ("DHH"), to the 2010 parish populations
- 2) Medicaid percentage: Actual parish-level enrollment figures from DHH's *Louisiana Medicaid Enrollment Numbers December 2010* report were used to quantify the Medicaid-covered population for 2010. These figures were then compared to total population to calculate the percentage that is covered by Medicaid for each parish.
- 3) Commercial percentage: Given the reasonably-derived estimates of the uninsured, Medicare and Medicaid populations, the Commercially-insured percentage was assumed to represent the remainder of each parish's population

The calculated rates were held constant and projected forward to set the base population payor mix. To quantify implications of health reform on coverage, Kaufman Hall developed and applied assumptions related to the shift of the uninsured population to Medicaid and Commercial coverage under reform, starting in 2014. Kaufman Hall assumed that 90% of the uninsured population that becomes Medicaid-eligible (based on Federal Poverty Levels) will shift to Medicaid over three years (growing from 40% to 90% from 2014-2016). Of the remaining uninsured population, it was assumed 50% will access Commercial insurance through public exchanges.

Volume Assumptions: Population Payor Mix (continued)

Comparison to Prior Reports

Kaufman Hall Assumptions

Payer Class	2010	2014	2015	2016
Commercial	42.4%	43.8%	46.0%	45.4%
Medicaid	26.3%	28.4%	30.5%	30.9%
Medicare	16.8%	18.3%	18.7%	19.1%
Uninsured	14.5%	9.5%	4.8%	4.6%
Total Population	812,278	828,808	832,994	835,905

DHH Report Assumptions

Payer Class	2010	2014	2015	2016
Commercial	52.6%	55.0%	57.7%	57.4%
Medicaid	16.3%	18.7%	21.1%	21.7%
Medicare	15.3%	15.6%	15.7%	15.7%
Uninsured	15.8%	10.7%	5.5%	5.2%
Total Population	823,436	841,310	845,842	850,400

HUD Report Assumptions

Payer Class	2010	2014	2015	2016
Commercial	N/A	N/A	N/A	N/A
Medicaid	N/A	N/A	N/A	N/A
Medicare	N/A	N/A	N/A	N/A
Uninsured	N/A	N/A	N/A	N/A
Total Population	824,320	N/A	912,814	N/A

Volume Assumptions: Inpatient Utilization Rates (Payor-class Level)

Kaufman Hall determined to utilize actual population and market utilization information to develop inpatient utilization rates. Patient-level discharge data from 2007 through Q2 2010 were obtained from the Louisiana Health Information Network, a statewide all payor data sharing program that provides the most current, comprehensive patient data available to Louisiana member hospitals.

The most recent 12 months of discharge data (Q3 2009 – Q2 2010) was segmented by payor class and compared to the corresponding population group to derive 2010 payor-specific utilization rates. Commercial and Medicare utilization was then assumed to decline 0.2% annually between 2010 and 2020 to reflect health reform and the shift of care from the inpatient to the outpatient setting. Medicaid and Uninsured inpatient utilization was held constant at 2010 calculated levels throughout the projection period, to reflect the greater challenges in managing utilization within those payor classes, as well as the uncertainty associated with any unintended consequences of health reform on them.

Use Rate Comparison Between KHA and DHH Report

Kaufman Hall	2010	2012	2014	2016	2018	2020
Commercial	76.9	76.6	76.3	76.0	75.7	75.4
Medicaid	123.8	123.8	123.8	123.8	123.8	123.8
Medicare	232.4	231.5	230.6	229.6	228.7	227.8
Uninsured	71.1	71.1	71.1	71.1	71.1	71.1
Total	114.6	115.4	117.6	119.9	120.7	121.4
Commercial/Medicare	121.1					

DHH Report	2010	2012	2014	2016	2018	2020
Commercial/Medicare	127.1	127.1	127.1	127.1	N/A	N/A
Medicaid	184.3	184.3	184.3	184.3	N/A	N/A
Uninsured	75.6	75.6	75.6	75.6	N/A	N/A
Total	128.3	128.3	132.3	136.9	N/A	N/A

Volume Assumptions: UMC Market Share Projections by Payer

Market discharge data were used to calculate base UMC market share estimates. These shares were held constant through 2013 to project ILH's inpatient volume pre-reform.

KHA 2010 Market Share Calculations by Payer

Payer	Market	ILH	ILH Share
Commercial	26,477	553	2.1%
Medicaid	26,415	4,387	16.6%
Medicare	31,809	1,070	3.4%
Uninsured	8,362	4,389	52.5%
Total	93,063	10,399	11.2%
Commercial/Medicare	58,286	1,623	2.8%

DHH Report 2010 Market Shares by Payer

Payer	Market	ILH	ILH Share
Commercial/Medicare	71,003	1,995	2.8%
Medicaid	24,757	4,271	17.3%
Uninsured	9,869	5,428	55.0%
Total	105,630	11,694	11.1%

UMC Volume Source: Underlying “ILH” Volume

To project UMC’s service area “base” volume, pre- and post-reform, Kaufman Hall utilized a hybrid methodology:

- 1) Pre-reform volumes (2011-2013): 2010 ILH market shares by payor were held constant to project ILH’s service area volume
- 2) Post-reform volumes: The population that ILH cares for in 2013 was first derived by payor using projected discharges and the aforementioned utilization rates by payor. Kaufman Hall then assumed that ILH’s patient population by payor would grow at corresponding market rates by payor.

Kaufman Hall then assumed healthcare reform, beginning in 2014, would have the same impact on ILH’s patient population as on the market population (90% of eligible Uninsured receive Medicaid coverage, 50% of remaining uninsured purchase insurance through exchanges). With ILH’s/ UMC’s post-reform patient population derived by payor, Kaufman Hall then applied utilization rates to project discharges.

Given increased patient choice under reform, Kaufman Hall assumed that ILH/ UMC would be able to “capture” between 45% and 95% of its formerly uninsured/ newly Medicaid-covered patients.

UMC Volume Source – Patient Repatriation

Assumptions:

- If ~15% of the non-LSU facility volume is high acuity (defined as CMI>2.0)¹, then LSU faculty volume in non-LSU facilities is comprised as follows:
 - High acuity: 538 cases
 - Low acuity: 3,257 cases
 - Total: 3,795 cases
- High acuity volume is more “moveable” than low acuity volume, resulting in the following repatriation volumes:
 - High acuity: 80% “moveable”, resulting in 430 cases
 - Low acuity: 20% “moveable”, resulting in 651 cases
 - Total: 1,082 cases will be repatriated back to LSU in 2015 (growing to 1,119 cases by 2020)

Note: Kaufman Hall considers the second assumption regarding “moveability” of low acuity volume to be very optimistic, given unwillingness to travel for care, justifiability that care must be provided in an academic setting, etc.)

¹Estimated based on 2006 HCUP Survey (teaching hospitals)

Appendix

Key Financial Assumptions

Baseline Operations Assumptions

- Volume and payor mix assumed as previously discussed
- Annual Reimbursement Inflation
 - Medicare – Inpatient (-1.1% to 1.45%), Outpatient (1.45% to 2.35%)
 - Medicaid⁽¹⁾ – 40% IP decline (FY12), 0.0% (FY13-14), 2012 % of allowable cost (FY15-20)
 - Commercial – 3.0%
 - Other revenues – 3.0%
- Expenses
 - Labor
 - ✓ FTE/ AOB falling from 6.8 in FY11 to 6.0 by FY17
 - ✓ Annual Salary per FTE Inflation: 0.0% FY11-12, 4.0% FY13-20
 - ✓ Benefits: Falling from 38.0% of salaries in FY11 to 33.0% by FY15
 - Professional Fees – Flexes with resident/intern count
 - Annual Supplies Inflation: 4.0% (70% variable)
 - Annual Repairs & Maintenance, Utilities Inflation – 3.0% (flexes with beds)

Note (1): One-time inpatient reimbursement reduction of 40% (to 60% of allowable cost) in FY12 a result of the new State Hospital UPL Program.

Source: State Hospital UPL State Plan Amendment.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Baseline Operations Assumptions (continued)

- Medicare DSH Reimbursement
 - Consistent with Medicare DSH calculation methodology
 - Health Reform Adjustments
 - ✓ FY14: 37.5% reduction
 - ✓ FY15 to FY16: 75% reduction
- Medicaid DSH Reimbursement
 - See appendix titled *Medicaid Disproportionate Share*
- Medicare GME Reimbursement
 - Reimbursement flexes based on Medicare formulas
 - Intern/ Resident FTEs
 - ✓ FY11 to FY14: 284 (FY10 levels)
 - ✓ FY15: 342 (UMC opens)
 - ✓ FY16 to FY20: 450
- Medicaid GME Reimbursement
 - Reimbursement flexes with GME costs and Medicaid days as % of total
 - Share of DSH attributable to GME estimated

Baseline Balance Sheet Assumptions

1) Fresh UMC Balance Sheet in 2015

- Assets and liabilities of ILH assumed to not carry over to UMC
- OPEB Liability assumed to not carry over to UMC
 - ✓ Costs related to retiree medical coverage and life insurance
 - ✓ \$43M unfunded liability in FY10
 - ✓ Could reach close to \$100M by the end of FY14 if current trends persist

2) \$175.8M cash and working capital assumed funded in 2015 through various sources

- Cash Reserves (\$143.4M)
 - ✓ 100 days of cash expenses (days cash on hand)
 - ✓ Conservative - less than BBB benchmark (121 days)
- Working Capital (\$32.4M)
 - ✓ Non-cash reserve working capital (e.g., inventory)

3) Capital Expenditures

- Increasing from 20% to 51% of depreciation (\$8.5M to \$25.4M) from 2016 to 2020

Project Financing Plan

- Total project cost: \$1.2B
 - Estimated \$915M for sitework, hospital (inpatient and diagnostics and testing) and garage
 - Ambulatory care building (\$81M), utility building, and second parking garage constitute the remainder of the major budget items
- Funding
 - Equity - Approximately \$893M of total funds, including \$301M State contribution, \$435M from FEMA and \$157M in “potential” additional FEMA funds
 - Debt – Kaufman Hall was instructed by LSU management to assume that the \$307M of remaining funds will be financed through bonds issued by UMCMC without HUD insurance with the following terms:
 - ✓ 7.25% interest rate with final maturity in 2041
 - ✓ Debt service reserve fund
 - ✓ 1.5% financing fees
 - ✓ Assumed borrowing of \$406M exceeds \$307 million capital needs due to debt service reserve fund, capitalized interest, and financing fees

Appendix

Medicaid Disproportionate Share

Medicaid Disproportionate Share Hospital (DSH) Payment Overview

- The Federal Government created the DSH program to offset losses by hospitals serving large numbers of Medicaid and uninsured patients
- There are two types of DSH payments: Medicare DSH (immaterial to UMC) and Medicaid DSH (the focus of this document)
 - Unless otherwise specified, the term Disproportionate Share Hospital (DSH) in this document refers only to Medicaid DSH
- Medicaid DSH payments are funded from state funds and matching federal dollars
 - The size of the federal match is determined by the Federal Match Rate (or “FMAP”), which is updated annually
 - The federal government will pay matching funds up to the Louisiana DSH allotment, which is the share of the national Medicaid DSH allotment that has been allocated to Louisiana

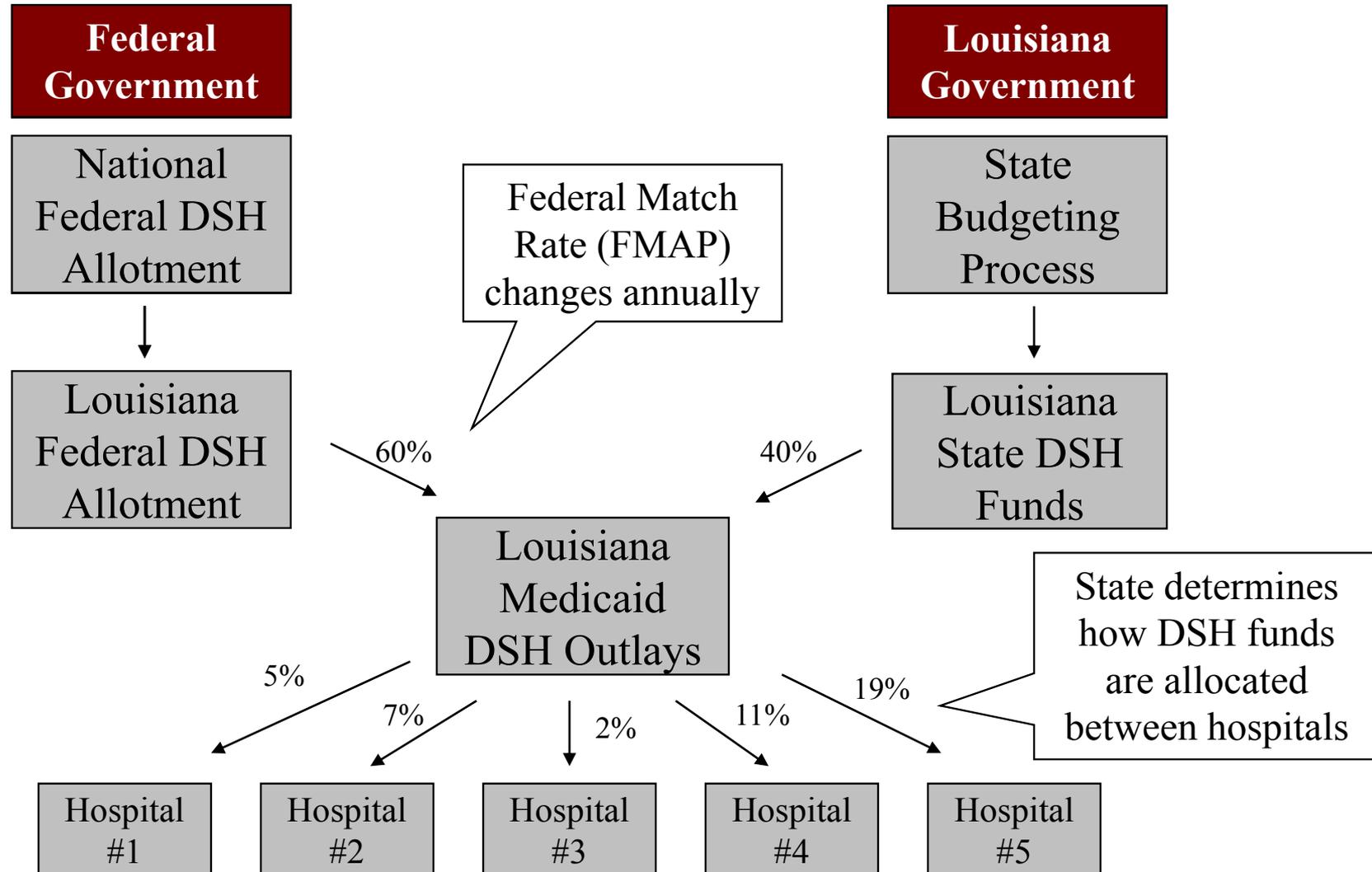
Source: Discussions with LSU reimbursement staff.

Medicaid Disproportionate Share Hospital (DSH) Payment Overview

(continued)

- A hospital may receive Medicaid DSH payments up to its UCC (uncompensated care cost)
 - The “Audit Rule” changed the UCC calculation in FY11
 - UCC is now equal to:
 - ✓ Allowable costs related to treatment of Medicaid and uninsured patients
 - ✓ Less: payment from Medicaid and uninsured patients
 - The Audit Rule resulted in reduced DSH payments to ILH in FY11, which were partially offset by “DSH Replacement Funds”
- A hospital does not necessarily receive the full UCC as DSH
 - The state has the discretion to allocate DSH payments less than a hospital’s UCC
 - Currently, ILH receives DSH payments equivalent to 100% of UCC
 - Whether UMC will receive DSH payments equivalent to 100% of UCC will depend on the severity of DSH reductions and the percentage of statewide DSH spending allocated to UMC, among other variables

Medicaid DSH Funding Mechanism Overview



Note: Match rate equivalent to projected FY13 values as reported in March 2011 FFIS analysis.

Historical DSH Payments to ILH/ MCLNO

	ILH / MCLNO Fiscal Year Ended June 30,										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total DSH Payments	262.3	255.3	250.4	277.5	236.6	201.0	110.2	112.2	167.2	172.0	153.1
<i>State Match Rate</i>	29.7%	29.5%	29.7%	25.8%	25.4%	29.0%	30.2%	30.3%	27.5%	24.0%	20.0%
Federal DSH Payments	184.5	180.0	176.0	206.0	176.5	142.8	76.9	78.2	121.2	130.7	122.5
State DSH Payments	77.9	75.2	74.4	71.5	60.2	58.2	33.3	34.0	46.0	41.3	30.6

- Louisiana's DSH match rate ranged from 20% to 30% from FY00 to FY10
- Federal stimulus legislation temporarily reduced the state match rate in FY09 and FY10
- When stimulus expired in 2011, match rates reset to levels higher than those experienced historically due to the impact of Hurricane Katrina recovery funds on per capita income
- Kaufman Hall forecast assumes state match rate of 38.3% in 2012, consistent with LSU expectations
- Match rate assumed at 40.0% beyond 2012, consistent with the FY13 FFIS forecast provided by DHH⁽¹⁾

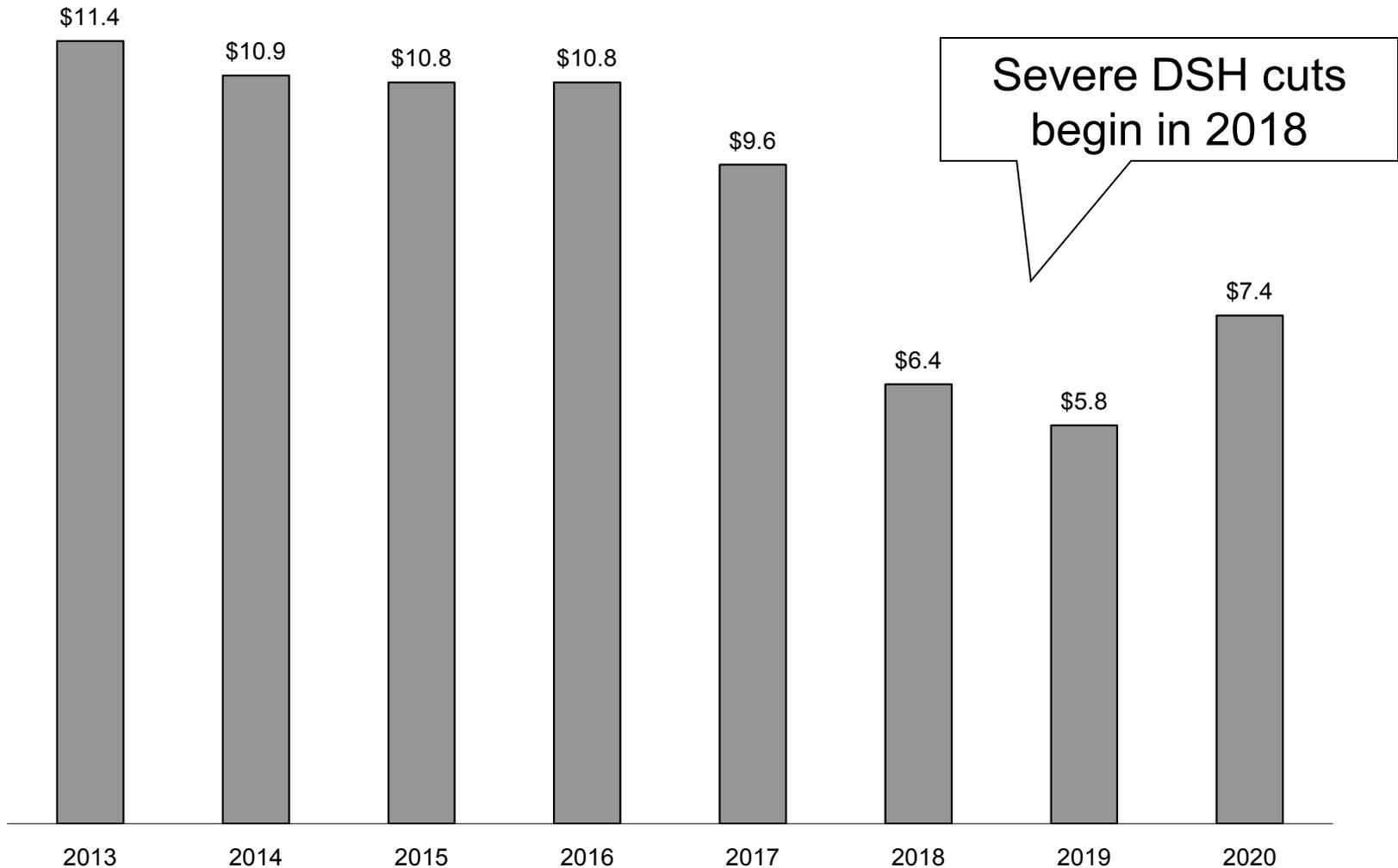
Note (1): Kaufman Hall requested DHH's long-term FMAP forecast; however, only the FY13 FFIS FMAP forecast was provided due to inconsistencies between the FFIS projection and the long-term DHH forecasts that were available.

Sources: FY08/09/10 MCLNO audited financial statements; Verite UMC Business Plan Analysis, April 2010; Louisiana Department of Health & Hospitals, FMAP Informational Briefing; ISU HCSD FY12 Budget Request; Federal Funds Information for States, Issue Brief 11-11, FY 2013 FMAP Projections – A Moving Target; Mar 25, 2011.

DSH Reductions Related to Health Reform

- Federal health reform legislation passed in 2010 (the Affordable Care Act) stipulates national Medicaid DSH cuts beginning in 2014
- However, the Affordable Care Act does not specify state-specific Medicaid DSH Allotment cuts
- Instead, it instructs the HHS Secretary to carry out the cuts using a “DSH Health Reform Methodology” that meets the following requirements:
 - Smaller % reduction for low DSH states
 - Largest % reductions imposed on states that
 - ✓ Have lowest % of uninsured individuals
 - ✓ Do not target their DSH payments on
 - ↳ High volumes of Medicaid inpatients
 - ↳ Hospitals with high levels of uncompensated care

National Federal DSH Allotment Reductions Stipulated by the Affordable Care Act (\$ billions)



Source: Affordable Care Act legislation.

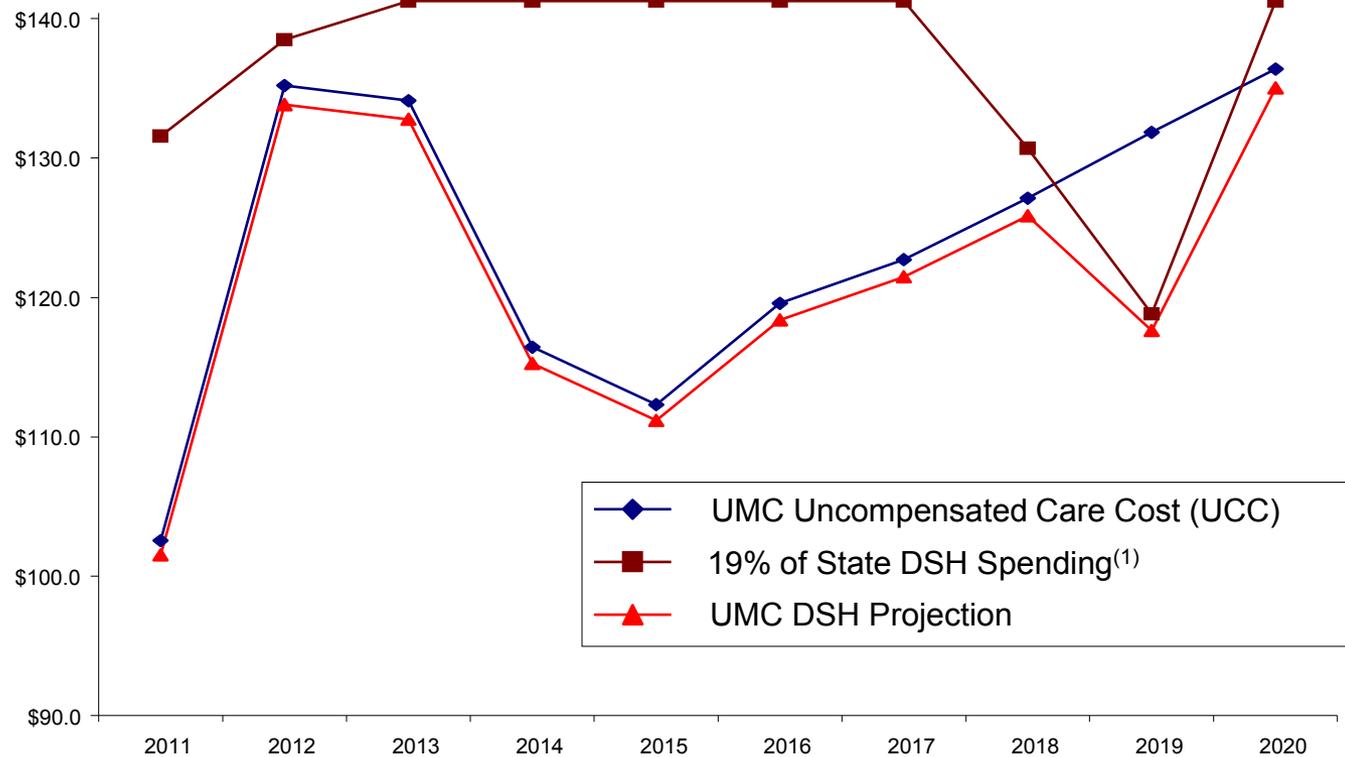
Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Baseline Louisiana Medicaid DSH Projections (\$ millions)

Year	National Federal Allotment		LA Federal Allotment		LA DSH Cap		LA DSH Spending	
	National DSH Allotment	% Reduction vs. 2011	(A) LA Federal Allotment	% Reduction vs. 2011	(B) State Match	(A+B) Total DSH CAP	Estimated LA DSH Spending	Room Under DSH Cap
2011	11,400	0%	750	0%	359	1,110	692	417
2012	11,400	0%	750	0%	465	1,216	729	487
2013	11,400	0%	750	0%	500	1,251	744	507
2014	10,900	-4.4%	705	-6.0%	470	1,176	744	432
2015	10,800	-5.3%	698	-7.0%	465	1,163	744	419
2016	10,800	-5.3%	698	-7.0%	465	1,163	744	419
2017	9,600	-15.8%	623	-17.0%	415	1,038	744	294
2018	6,400	-43.9%	413	-45.0%	275	688	688	0
2019	5,800	-49.1%	375	-50.0%	250	625	625	0
2020	7,400	-35.1%	450	-40.0%	300	750	744	7

- As a high DSH state, Louisiana's Federal DSH Allotment reductions are projected to modestly exceed the national average
- Significant current room under the DSH cap provides some buffer against cuts
- Cuts are expected to constrain Louisiana DSH spending during the final years of the decade

UMC Baseline DSH Projection (\$ millions)



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
UMC UCC	\$102.5	\$135.2	\$134.1	\$116.4	\$112.3	\$119.6	\$122.7	\$127.1	\$131.8	\$136.4
19% of State Spending	\$131.6	\$138.5	\$141.3	\$141.3	\$141.3	\$141.3	\$141.3	\$130.7	\$118.8	\$141.3
UMC DSH Projection	\$102.5	\$135.2	\$134.1	\$116.4	\$112.3	\$119.6	\$122.7	\$127.1	\$118.8	\$136.4

Note(1): The Interim Hospital accounts for approximately 19% of FY12 state-wide DSH spending in the FY12 executive budget recommendation. Therefore, in the baseline scenario it is assumed that the State will allocate no more than 19% of state-wide DSH spending to UMC. Please see the scenario analysis section of the document to see the impact of the State deciding to allocate a different share of state-wide DSH spending to UMC.

Notes: Assumes inpatient Medicaid reimbursement equivalent to 60% of allowable cost from FY15 to FY20. Excludes DSH Replacement. 2012 DSH projection increases significantly due to the State Hospital UPL Plan (which lowers inpatient reimbursement 40% and increases DSH as an offset).

Sources: LSU Audit Rule DSH Worksheet (FY11); Discussions with LSU management and reimbursement staff.

Disproportionate Share Hospital (DSH) Replacement Funds

2011

- ILH lost an estimated \$44.0M of DSH as a result of the Audit Rule
- State paid \$38.8M in “DSH Replacement” funds to ILH
 - State General Funds - \$32.8M
 - Medicaid Settlement - \$6.0M⁽¹⁾
- Projected FY11 net payments to ILH
 - DSH - \$102.5M
 - DSH Replacement - \$38.8M (not included in DSH payment)

2012

- FY12 Executive Budget earmarks approximately \$38.5M in DSH Replacement Funds to ILH via 3 sources
 - 1) State Hospital Upper Payment Limit (UPL) Program (\$18.5M)
 - 2) Private Hospital UPL Program (\$8.9M)
 - 3) State General Funds (\$11.1M)

Note (1): The Federal share of a Medicaid cost report settlement is used to fund \$6.0M of total FY11 DSH Replacement. LSU reimbursement staff notes that had the \$6.0M not been available, ILH would have received State General Funds instead.

Sources: LSU Audit Rule DSH Worksheet (FY11); Discussions with LSU management and reimbursement staff.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Three Funding Sources for 2012 DSH Replacement Funds

1) State Hospital (LSU) UPL Program

- E.A. Conway receives additional net funds via new UPL payment
- Funds are distributed from E.A. Conway to other LSU hospitals, including ILH

2) Private Hospital UPL Program

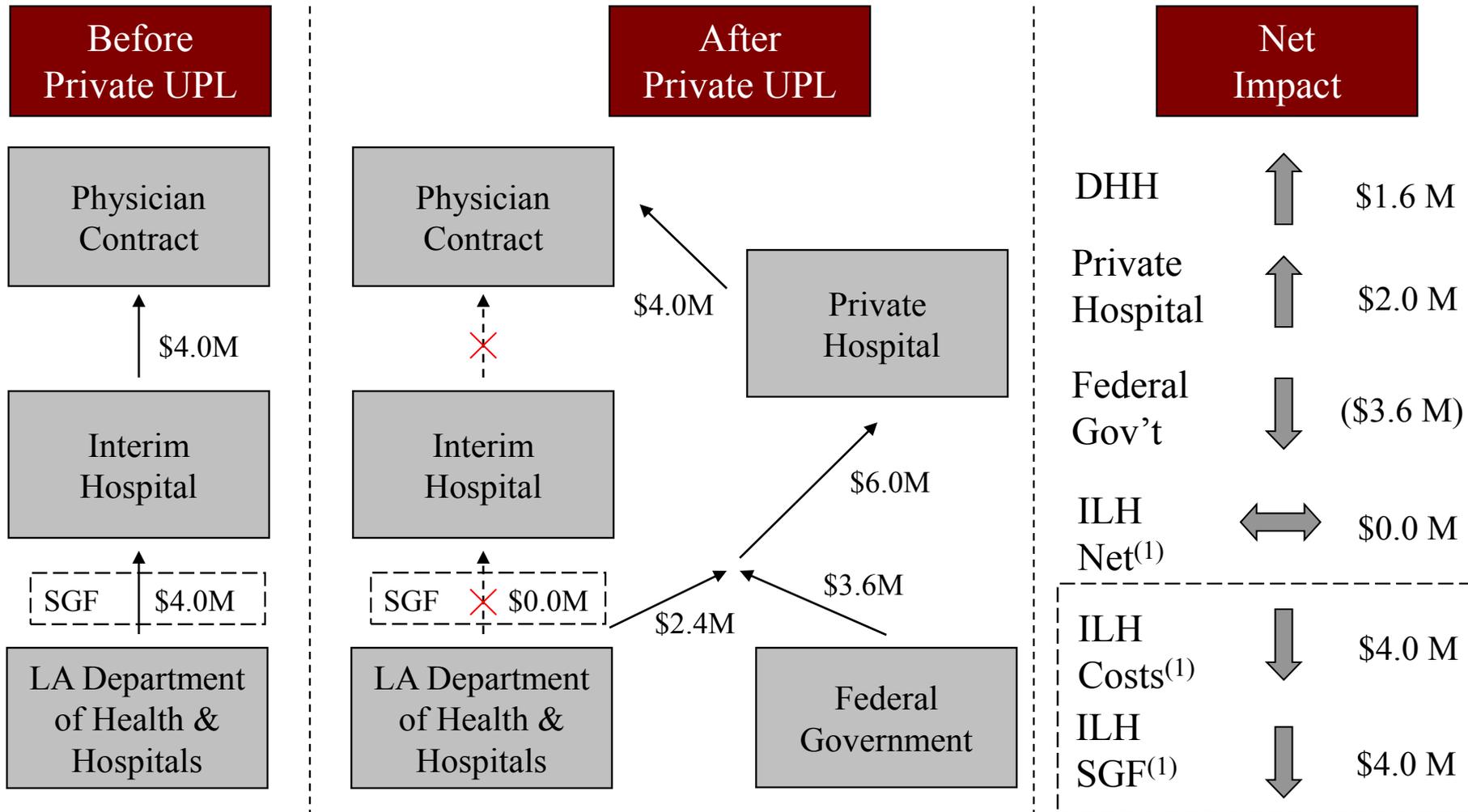
- ILH contracts for outpatient services assumed by private hospital
- DHH makes UPL payment to private hospital and eliminates previous SGF payment to ILH
- DHH saves money through the use of a federal match for the UPL payment (vs. no match for SGF payment to ILH)
- ILH's need for SGF is reduced; however, the impact on its bottom line is a "wash" in the long-run given that avoided costs are offset by lost SGF (unless the State returns a portion of its savings to ILH)

3) State General Funds

- Incremental SGF is allocated to ILH

Private Hospital Upper Payment Limit (UPL) Program

Illustrative Example Only

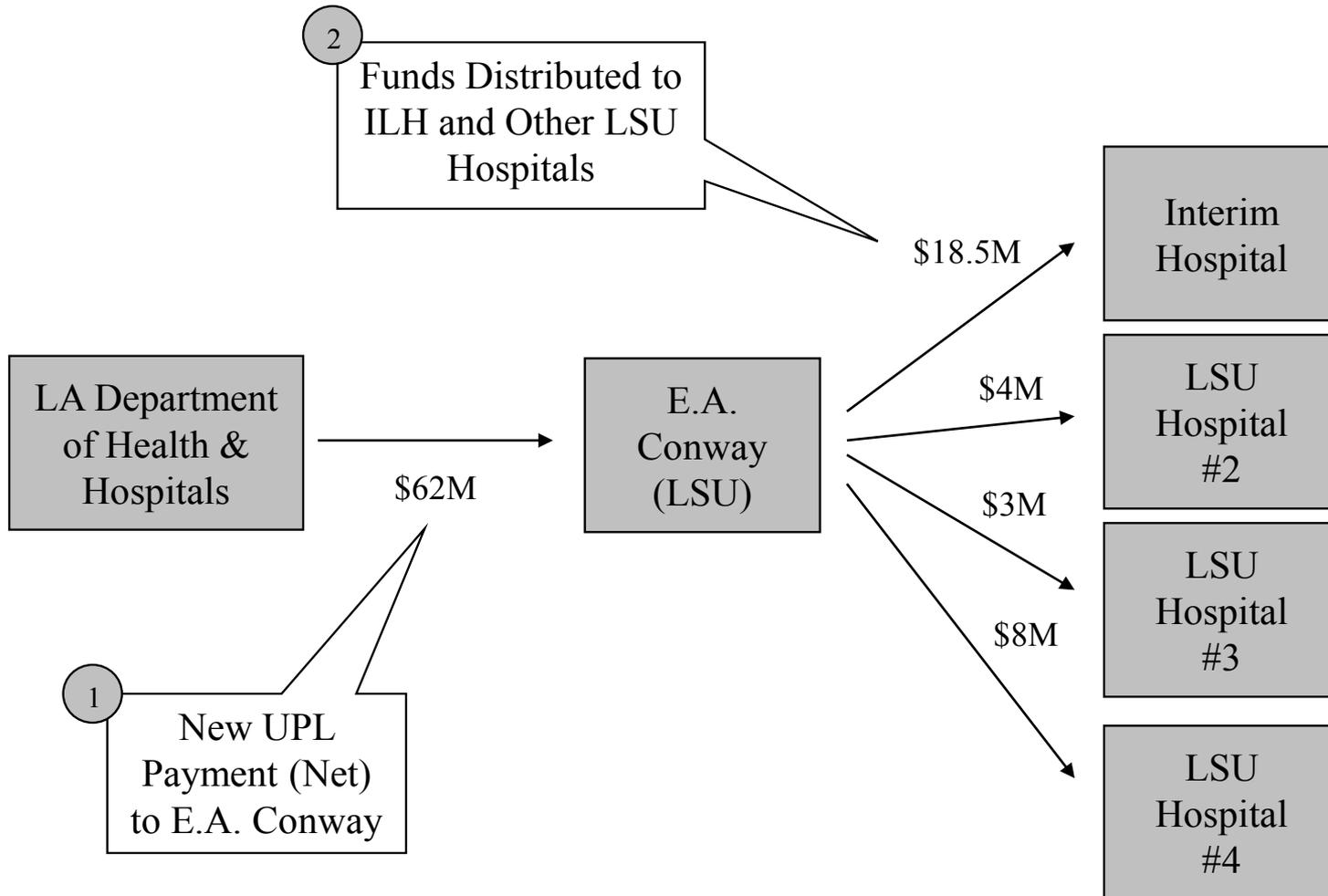


Note (1): Private UPL reduces ILH's non-allowable expenses (this example is illustrative only due to contract sensitivities; actual ILH cost avoidance in FY12 expected to be \$8.9M). As non-allowable expenses fall, so does the need for SGF. Therefore, unless DHH shares some of its savings from the program with ILH, the bottom line impact to ILH (after SGF) is a wash because cost reductions are offset by reduced SGF revenue.

Sources: Discussions with LSU management and Department of Health and Hospitals Office of Management and Finance.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

State Hospital Upper Payment Limit (UPL) Program



Note: All fund distributions but those for ILH are illustrative only.

Sources: Discussions with LSU management and Department of Health and Hospitals Office of Management and Finance.

Copyright 2011 Kaufman, Hall & Associates, Inc. All rights reserved.

Long-Term Uncertainties Regarding Private Hospital UPL

- There are uncertainties regarding the long-term viability of provider tax programs
 - The Federal Deficit Commission proposed that the provider tax be eliminated⁽¹⁾
 - President Obama’s FY12 budget proposal would constrain the use of provider taxes beginning in FY15⁽¹⁾
 - Moody’s stated in February 2011 that “the long-term benefits [of provider tax programs] are uncertain.”
- The Private UPL plan is technically not a “provider tax”, but it has the same net effect – drawing down additional federal matching funds without incremental state spending
- Therefore, we believe there is long-term uncertainty regarding the size of the federal match for the Private Hospital UPL program
- Health reform will also reduce uninsured volumes and the related non-allowable professional services (Part B) expenses that are at the center of many Private UPL contracts between private and public hospitals. For example, the baseline UMC model already reduces non-GME professional services expenses by \$12.5M before Private UPL is taken into account.

Note (1): Though the Deficit Commission’s recommendations and President Obama’s FY12 budget proposal had not been approved at the time this document was published, they speak to the awareness of the provider tax issue among policymakers in Washington.

Sources: Moody’s Investors Service, 2011 U.S. Not-For-Profit Healthcare Sector Outlook; The National Commission on Fiscal Responsibility and Reform, The Moment of Truth; Office of Management and Budget, Fiscal Year 2012 Terminations, Reductions, and Savings – Budget of the U.S. Government; Discussion with LSU management.

Long-Term Uncertainties Regarding State Hospital UPL

- As an affiliate of LSU and part of the LSU Health System, UMC will be eligible to participate in the State Hospital UPL Program when it opens in FY15
- However, the total amount of funds that will be available for distribution to UMC and other LSU hospitals at that time – and in future years – will depend on a number of unknowns, including (but not limited to) Medicaid fee-for-service volumes at E.A. Conway and across the LSU system
 - UPL payments are based on Medicaid fee-for-service inpatient days; managed care enrollees paid on a pre-paid (i.e., capitated) basis are not counted in the UPL calculation
 - The Medicaid Managed Care (Coordinated Care Network) initiative will reduce fee-for-service (FFS) inpatient days as a percentage of total inpatient days in Louisiana from 100% (current) to 66% in FY15
 - If LSU were to further rationalize its hospital network, fee-for-service volumes would decrease and the mix of hospitals available to participate in the State Hospital UPL Program would change
- Therefore, there is uncertainty regarding the long-term outlook of the State Hospital UPL Program

Sources: The Lewin Group, Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion; Mercer, LA Inpatient Days Forecast by Type of Coverage (courtesy of DHH); Discussions with LSU Management and DHH; Greenstein B, Reinventing Health Care in Louisiana; State Hospital UPL State Plan Amendment.

DSH Replacement Fund Projections

- Due to the aforementioned uncertainties, the baseline scenario assumes \$9.3M non-SGF (UPL) DSH Replacement after UMC opens in FY15. In the optimistic scenario, all (\$27.4M) non-SGF DSH replacement funding is maintained, and in the conservative scenario, no such funds are assumed.
- The State is assumed to continue funding DSH replacement in all scenarios; however, because the funding mechanism is State General Funds, they do not reduce UMC's need for SGF (they only "reclassify" it from general SGF to DSH Replacement SGF)

Scenario	Projected Annual DSH Replacement Inflows (\$M)		
	2011	2012 - 2014	2015 - 2020
Conservative Scenario			
DSH Replacement - SGF	\$32.8	\$11.1	\$11.1
DSH Replacement - Non-SGF ⁽¹⁾	<u>\$6.0</u>	<u>\$27.4</u>	<u>\$0.0</u>
DSH Replacement - Total	\$38.8	\$38.5	\$11.1
Baseline Scenario			
DSH Replacement - SGF	\$32.8	\$11.1	\$11.1
DSH Replacement - Non-SGF ⁽¹⁾	<u>\$6.0</u>	<u>\$27.4</u>	<u>\$9.3</u>
DSH Replacement - Total	\$38.8	\$38.5	\$20.4
Optimistic Scenario			
DSH Replacement - SGF	\$32.8	\$11.1	\$11.1
DSH Replacement - Non-SGF ⁽¹⁾	<u>\$6.0</u>	<u>\$27.4</u>	<u>\$27.4</u>
DSH Replacement - Total	\$38.8	\$38.5	\$38.5

Note (1): Non-SGF DSH Replacement consists of UPL funds for all years but 2011, in which the Federal share of a Medicaid cost report settlement accounts for \$6.0M of DSH Replacement funds.

Sources: Discussions with LSU management and Department of Health and Hospitals Office of Management and Finance.

Appendix

Medicaid Reimbursement

Medicaid Reimbursement – 2012 Changes

- As previously discussed, ILH is expected to receive \$18.5M from the State Hospital UPL Program in 2012
- However, the plan will also have a separate and significant impact on how ILH is reimbursed by Medicaid
 - During FY11, ILH was reimbursed for inpatient care at 100% of allowable cost
 - In FY12, inpatient payments will be reduced to 60% of allowable cost as a part of the State Hospital UPL Program
 - DSH will increase by approximately \$29M as a 1:1 offset for diminished claim revenue
 - Therefore, total Medicaid claim and DSH reimbursement will remain unchanged, but the mix will shift toward DSH

Medicaid Reimbursement – 2015 to 2020

- The state will have the discretion to establish a new Medicaid fee-for-service reimbursement methodology for UMC when it opens in FY15
- Medicaid Managed Care Reform will constrain the level of new rates
 - The state had been planning a “go live” date of 1/1/12 for the new Coordinated Care Network (CCN) initiative; current budget proposals may delay launch⁽¹⁾
 - Rates paid by CCN insurers to providers are not permitted to be below fee-for-service rates
 - Fee-for-service rates will need to be set at a level that allows UMC to compete effectively for patients covered by CCN insurers

Note (1): At the time this document was published, the Louisiana House had recently approved a \$25 billion budget blueprint that would delay the launch of Medicaid managed care until 2012-2013.

Sources: Discussions with LSU management and the DHH Office of Management and Finance; Greenstein B, Reinventing Health Care in Louisiana, 2011; Moller J, House Approves \$25 billion budget with new health-care cuts, The Times-Picayune 26 May 2011.

Medicaid Reimbursement – 2015 to 2020 Scenarios

- Kaufman Hall evaluated three scenarios for Medicaid fee-for-service reimbursement from 2015 to 2020
 - 1) 0% Inflation – [Sensitivity]
 - ✓ Payments remain at 2012 levels
 - ✓ Reimbursement does not inflate with costs
 - 2) Inpatient Reimbursement 60% of Allowable Cost [**BASELINE**]
 - ✓ Reimbursement as a % of allowable cost set constant at 2012 levels (after State Hospital UPL changes)
 - ✓ Reimbursement inflates with costs
 - 3) Inpatient Reimbursement 100% of Allowable Cost [Sensitivity]
 - ✓ Reimbursement as a % of allowable cost set constant at 2011 levels (before State Hospital UPL changes)
 - ✓ Reimbursement inflates with costs

Appendix

State General Funds

Historical State SGF and DSH Payments to ILH/ MCLNO (\$ millions)

	ILH / MCLNO Fiscal Year Ended June 30,										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
SGF	1.1	0.5	1.0	14.5	21.6	13.9	37.5	36.4	48.7	50.6	26.1
State Share of DSH	77.9	75.2	74.4	71.5	60.2	58.2	33.3	34.0	46.0	41.3	30.6
TOTAL State SGF/DSH Outlay	78.9	75.7	75.3	86.0	81.8	72.1	70.8	70.4	94.8	91.8	56.8
State Match Rate	29.7%	29.5%	29.7%	25.8%	25.4%	29.0%	30.2%	30.3%	27.5%	24.0%	20.0%

- Louisiana's DSH match rate ranged from 20% to 30% from FY00 to FY10
- Federal stimulus legislation temporarily reduced the state match rate in FY09 and FY10

Note: Consistent with previous studies, this report defines Stage General Funds (SGF) as State outlays for which no Federal matching funds are obtained. Therefore, only the first row (titled "SGF") should be considered State General Funds.

Sources: FY08/09/10 MCLNO audited financial statements; Verite UMC Business Plan Analysis, April 2010; Louisiana Department of Health & Hospitals, FMAP Informational Briefing.

State SGF and DSH Outlays – Baseline Scenario (\$ millions)

	Actual	Projected									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
SGF	26.1	56.1	32.5	33.2	33.8	73.1	76.1	78.1	82.9	99.1	96.3
State Share of DSH	30.6	33.2	51.8	53.7	46.6	44.9	47.8	49.1	50.8	47.5	54.6
TOTAL State SGF/DSH Outlay	56.8	89.3	84.3	86.8	80.4	118.0	124.0	127.2	133.7	146.6	150.9
State Match Rate	20%	32%	38%	40%	40%	40%	40%	40%	40%	40%	40%

- Total State General Fund and DSH outlays increase steadily after UMC opens in 2015
- Historically high state match rate (40%) projected by Federal Funds Information for States (FFIS) for FY13⁽¹⁾
- Maintaining this match rate over the projection period results in higher state outlays than normal
 - This increases the state cost for Medicaid/DSH/UPL payments to all Louisiana hospitals, not just UMC
- The total state SGF/DSH outlay would decrease if the match rate were to fall back to the historical norm in the 30% range

Note (1): Kaufman Hall requested DHH's long-term FMAP forecast; however, only the FY13 FFIS FMAP forecast was provided due to inconsistencies between the FFIS projection and the long-term DHH forecasts that were available.

Note: Consistent with previous studies, this report defines Stage General Funds (SGF) as State outlays for which no Federal matching funds are obtained. Therefore, only the first row (titled "SGF") should be considered State General Funds.

Source: FY10 MCLNO audited financial statements; Louisiana Department of Health & Hospitals, FMAP Informational Briefing; LSU HCSD FY12 Budget Request; Federal Funds Information for States, Issue Brief 11-11, FY 2013 FMAP Projections – A Moving Target; Mar 25, 2011.

Graduate Medical Education Reimbursement (\$ millions)

GME Reimbursement Source	2010	2020
Residents & Interns	284	450
Medicare DGME	\$2.2	\$5.5
Medicare IME	\$4.3	\$9.8
TOTAL MEDICARE GME	\$6.5	\$15.4
Medicaid - Direct GME Payment	\$26.2	\$36.3
Medicaid - Estimated Share of DSH	\$29.5	\$22.7
TOTAL MEDICAID GME	\$55.7	\$59.0
TOTAL GME REIMBURSEMENT	\$62.2	\$74.3

- Kaufman Hall projected GME reimbursement referencing federal formulas and conversations with LSU reimbursement team
- Resident counts (absolute and relative to staffed beds) and Medicare share of total inpatient days are primary Medicare GME drivers
- Due to minimal Medicare caseload, vast majority of reimbursement currently comes from Medicaid GME

Appendix

Assumptions Comparison to Prior Studies

Baseline Demand Projections – Assumptions

DHH Report	HUD Report	Kaufman Hall
<p>Service Area/ Population</p> <p><i>Service Area</i> Jefferson, Orleans and St. Bernard</p> <p><i>Population Growth</i> FY10: 823,436 FY16: 850,400</p> <p>Annual growth: 0.5%</p>	<p>Service Area/ Population</p> <p><i>Service Area</i> Jefferson, Orleans and St. Bernard</p> <p><i>Population Growth</i> FY10: 824,320 FY15: 912,824</p> <p>Annual growth: 2.1%</p>	<p>Service Area/ Population</p> <p><i>Service Area</i> Jefferson, Orleans and St. Bernard</p> <p><i>Population Growth</i> CY10: 812,278 (% diff: -1.4% / -1.5%) CY16: 835,905 CY20: 847,653</p> <p>Annual growth: 0.4%</p>
<p>Market IP Utilization Rates (per thousand population)</p> <p>Medicare/ Commercial: 127.1 Medicaid: 184.3 Uninsured: 75.6</p> <p>Utilization remains constant throughout projection period</p>	<p>Market IP Utilization Rates</p> <p>N/A</p>	<p>Market IP Utilization Rates</p> <p>2010: Commercial: 76.9 Medicare: 232.4 Medicaid: 123.8 Uninsured: 71.1</p> <p>Utilization declines 0.2% annually for Medicare and Commercial patients; Uninsured and Medicaid rates remain constant</p>

Baseline Demand Projections– Assumptions

DHH Report	HUD Report	Kaufman Hall
<p>Inmigration (Discharges/ % capture)</p> <p>FY11: 1,602 (12.0%) FY16: 2,837 (15.0%)</p> <p>Note: 18.3% in FY05</p>	<p>Inmigration</p> <p>Assumes unknown percentage capture of patients currently going to TX, FL, MS and AL for care.</p>	<p>Inmigration</p> <p>FY11: 3,373 (22.4%) FY16: 3,946 (22.4%) FY20: 3,972 (22.4%)</p>
<p>Payor Mix (Reform Impact)</p> <p>90% of newly eligible enroll in Medicaid</p> <p>50% of uninsured not newly eligible buys insurance</p>	<p>Payor Mix (Reform Impact)</p> <p>Expansion of coverage beginning in FY14 with 50% decrease in uninsured population by FY17</p>	<p>Payor Mix (Reform Impact)</p> <p>90% of newly eligible enroll in Medicaid</p> <p>50% of uninsured not newly eligible buys insurance</p>

Baseline Demand Projections– Assumptions

DHH Report	HUD Report	Kaufman Hall
<p>Length of Stay</p> <p>FY11: 5.13 FY16: 5.74</p> <p>Assumes 0.4 days reduction between 2010 and 2014 for non-psychiatry volumes and 0.8 days reduction for psychiatry cases</p>	<p>Length of Stay</p> <p>N/A</p>	<p>Length of Stay</p> <p>FY11: 5.56 FY16: 6.05 FY20: 6.05</p> <p>Assumes 0.3 days reduction between 2010 and 2013</p>
<p>Outpatient Volume</p> <p>Modeled as outpatient – adjusted patient days at 34-37% of gross patient charges from 2010-2016 (held constant at 37% from 2013 on)</p>	<p>Outpatient Volume</p> <p>Methodology unknown</p>	<p>Outpatient Volume</p> <p>2010 actual volume = base year; volume growth rate equivalent to corresponding inpatient projections</p>

Baseline Demand Projections– Assumptions

DHH Report	HUD Report	Kaufman Hall
<p>First Year of Hospital Operations</p> <p>Assumes hospital opens in 2014 with two-year construction period</p>	<p>First Year of Hospital Operations</p> <p>Assumes hospital opens in 2014 with three-year construction period</p>	<p>First Year of Hospital Operations</p> <p>Assumes hospital opens in 2015 with three-year construction period</p>

Baseline Financial Projections – Core Reimbursement

DHH Report	HUD Report	Kaufman Hall
<p>Medicare (Annual Inflation)</p> <p>FY11: 1.0% FY12 to 16: 2.0%</p> <p>CMI: 1.39 through FY 13, increasing to 1.52 by FY 16</p>	<p>Medicare (Annual Inflation)</p> <p>FY11: -0.5% FY12: -0.3% FY13 to 17: 1.85%</p> <p>CMI: 10% total increase</p>	<p>Medicare (Annual Inflation)</p> <p><u>IP</u> FY11: -0.4% FY12: -1.1% FY13 to 20: 0.3% to 1.45% <u>OP</u>: FY11-20: 1.45% to 2.35%</p> <p>CMI: 1.5% annual increase (FY15 to 20)</p>
<p>Medicaid (Annual Inflation)</p> <p>FY11 to 13: 0.0% FY14 to 16: 2.0%</p>	<p>Medicaid (Annual Inflation)</p> <p>FY11 to 14: 0.0% FY15 to 16: 2.0%</p>	<p>Medicaid (Mixed)</p> <p>FY12: 40% IP decline FY13 to 14: 0.0% annual inflation FY15 to 20: 2012 % of allowable cost (Inpatient 60%)</p>
<p>Commercial (Annual Inflation)</p> <p><i>Payment to Cost Ratio Improvement</i> 0.65 (FY10) to 1.10 (FY16)</p>	<p>Commercial (Annual Inflation)</p> <p>FY11 to 17: 4.0%</p>	<p>Commercial (Annual Inflation)</p> <p>FY11 to 20: 3.0%</p>

Baseline Financial Projections – DSH/ UCC

DHH Report	HUD Report	Kaufman Hall
<p>Medicare DSH (Calculations consistent with Medicare formulas)</p> <p><i>Net Impact of Health Reform</i> FY11 to FY13: No reduction FY14: 37.5% reduction FY15 to 16: 75% reduction</p>	<p>Medicare DSH</p> <p>N/A</p>	<p>Medicare DSH (Calculations consistent with Medicare formulas)</p> <p><i>Net Impact of Health Reform</i> FY11 to FY13: No reduction FY14: 37.5% reduction FY15 to 16: 75% reduction</p>
<p>Medicaid DSH (Calculations consistent with Pre-Audit Rule methodology)</p> <p>Assumes state match rate of 35.4% to 31.4% after 2011</p> <p><i>DSH Audit Rule Impact: -19.4%</i></p> <p><i>2010 Federal Allotment: \$750M</i> <i>2020 Federal Allotment: \$450M</i></p>	<p>Medicaid DSH</p> <p>N/A</p>	<p>Medicaid DSH (Calculations consistent with Audit Rule Methodology)</p> <p>Assumes state match rate of 40.0% after 2012</p> <p><i>DSH Audit Rule Impact: -30.2%</i></p> <p><i>2010 Federal Allotment: \$750M</i> <i>2020 Federal Allotment: \$450M</i></p>

Baseline Financial Projections – GME

DHH Report	HUD Report	Kaufman Hall
<p>Medicare GME</p> <p><i>Intern/ Resident FTEs</i> FY11 to 13: 300 FY14: 300 (UMC opens) FY15: 400 FY16: 500</p> <p>Reimbursement flexes with FTE count, per resident amounts, and staffed beds</p>	<p>Medicare GME</p> <p>N/A</p>	<p>Medicare GME</p> <p><i>Intern/ Resident FTEs</i> FY11 to 14: 284 (FY10 levels) FY15: 342 (UMC opens) FY16 to 20: 450</p> <p>Reimbursement flexes with FTE count, per resident amounts, and staffed beds</p>
<p>Medicaid GME</p> <p>N/A</p>	<p>Medicaid GME</p> <p>N/A</p>	<p>Medicaid GME</p> <p>Reimbursement flexes with Medicaid days as % of total and GME costs</p> <p>Share of DSH attributable to GME estimated</p>

Baseline Financial Projections – Other Revenues

DHH Report	HUD Report	Kaufman Hall
<p>Other Revenues (Annual Inflation)</p> <p>FY11 to 16: 4.0%</p>	<p>Other Revenues (Annual Inflation)</p> <p>FY11 to 16: 3.0%</p>	<p>Other Revenues (Annual Inflation)</p> <p>FY11 to 20: 3.0%</p>
<p>State Appropriations</p> <p>FY11: \$63.4 M FY12: \$65.5 M FY13: \$68.1 M FY14: \$78.3 M FY15: \$74.1 M FY16: \$70.5 M</p> <p>Plug to achieve 1.2 times debt service coverage ratio</p>	<p>State Appropriations (Annual Inflation)</p> <p>FY11: \$64.2 M FY12: \$64.4 M FY13: \$64.8 M FY14: \$65.5 M FY15: \$66.3 M FY16: \$67.4 M FY17: \$68.8 M</p> <p>2.0% Annual Inflation</p>	<p>State Appropriations (Annual Inflation)</p> <p>FY11: \$56.1 M FY12: \$32.5 M FY13: \$33.2 M FY14: \$33.8 M FY15: \$73.1 M FY16: \$76.1 M FY17: \$78.1 M FY18: \$82.9 M FY19: \$99.1 M FY20: \$96.3 M</p> <p>Plug to achieve stable cash reserves</p>

Baseline Financial Projections – FTE, Salaries and Benefits

DHH Report	HUD Report	Kaufman Hall
FTEs <i>FTE/AOB</i> FY11 to 12: 7.0 FY13 to 16: 6.0	FTEs <i>FTE/AOB</i> FY11 to 12: 7.0 FY13 to 16: 6.0	FTEs <i>FTE/AOB</i> FY11: 6.8 FY12: 6.5 FY13 to 17: 6.5 to 6.0 FY17 to 20: 6.0
Salaries (annual inflation) FY11 to 16: 4.0%	Salaries (annual inflation) FY11 to 12: 0.0% FY13 to 17: 3.5%	Salaries (annual inflation) FY11 to 12: 0.0% FY13 to 20: 4.0%
Benefits (% of salaries) FY11 to 14: 38.8% FY15 to 16: 33.0%	Benefits (% of salaries) FY11 to 14: 38.8% FY15 to 16: 33.0%	Benefits (% of salaries) FY11 to 14: 38.0% FY15 to 20: 33.0%

Note*: Variability based on adjusted patient days unless noted

Baseline Financial Projections – Non-Salary Expenses

DHH Report	HUD Report	Kaufman Hall
Professional Fees	Professional Fees (annual inflation/ variability) 3.5% (20%)	Professional Fees Flexes with resident/ intern count
Other Operating Expenses (annual inflation/ variability) <i>Supplies: 4.0% (100%)</i> <i>All Other: 4.0% (100%)</i>	Other Operating Expenses (annual inflation/ variability) <i>Supplies: 3.5% (70%)</i> <i>Repairs and Maintenance: 3.8%</i> <i>(100% with sf**)</i> <ul style="list-style-type: none"> • 1% efficiency factor <i>Utilities: 6.5% (100% with sf**)</i> <ul style="list-style-type: none"> • 10% efficiency factor 	Other Operating Expenses <i>Supplies: 4.0% (70%)</i> <i>Repairs and Maintenance: 3.0%</i> <i>(100% with beds)</i> <i>Utilities: 3.0% (100% with beds)</i>

Note*: Variability based on adjusted patient days unless noted

Note* *: sf = square feet

Baseline Financial Projections – Balance Sheet

DHH Report	HUD Report	Kaufman Hall
<p>Project</p> <p><i>Uses:</i> \$1.2 B</p> <p><i>Sources:</i></p> <ul style="list-style-type: none"> • State/ FEMA: \$825M • Debt: \$375M (5.5%, 30 yrs) 	<p>Project</p> <p><i>Uses:</i> \$1.2 B</p> <p><i>Sources:</i></p> <ul style="list-style-type: none"> • State/ FEMA: \$795M • Debt: \$400M (6.5%, 25 yrs) 	<p>Project</p> <p><i>Uses:</i> \$1.2 B</p> <p><i>Sources:</i></p> <ul style="list-style-type: none"> • State/ FEMA: \$893M • Debt: \$307M (7.25%, 30 yrs)
<p>Routine Capital</p> <p>FY11 to 16: \$10 million per year</p>	<p>Routine Capital</p> <p>1.3% of Expenses</p>	<p>Routine Capital</p> <p>FY11 to 14: \$4M per year FY16 to 20: Increasing from \$9M to \$25M per year</p>
<p>Working Capital</p> <p>\$150M borrowing for working capital</p> <p>Potential working capital deficit of \$98.5M by FY16</p>	<p>Working Capital</p> <p>N/A</p>	<p>Working Capital</p> <p>\$176M for start-up cash and working capital</p>

Appendix

Stakeholder Interviewees and Works Cited

Key Project Stakeholders and Interviewees

Over the course of the last five months, Kaufman Hall has met or spoken with dozens of stakeholders (listed below) to gather insights and perspectives regarding the UMC project.

Interviewee	Title	Interviewee	Title
Bobby Yarborough	UMC Board Chairman	Roxane Townsend, MD	CEO, ILH
Darryl Berger	UMC Board	Gerry Bellocq	CFO, ILH
Elaine Abell	UMC Board	Adler Voltaire	CAO, ILH
Byron Harrell	UMC Board	Kim Sangari	CAO, ILH
Christopher Rich, MD	UMC Board	Multiple	Finance and Reimbursement Team, LSU-HCSD
Stanley Jacobs	UMC Board	Juzar Ali, MD	CMO and VP/Dir, Physician Services, ILH
Thomas Barfield, Jr.	UMC Board	Martha Smith	CNO and Quality Officer, ILH
David Voelker	UMC Board	Mike Kaiser, MD	VP, Care Mgmt, ILH
Boysie Bollinger	UMC Board	Steve Nelson, MD	Dean, LSU College of Medicine
Alden McDonald	UMC Board	Larry Hollier, MD	Chancellor, LSU-HSC
Lee Kantrow	UMC Board Attorney	Fred Cerise, MD	VP Health Affairs and Medical Education, LSU-HSC
Bruce Greenstein	Secretary, LA Dept of Health and Hospitals	John Cole, MD	LSU-HSC, Acting Section Chief, Hem/Onc
Jerry Phillips	Undersecretary, LA Dept of Health and Hospitals	William Risher, MD	LSU-HSC, Section Chief, Cardiovascular Surgery
J.T. Lane	Chief of Staff, LA Dept of Health and Hospitals	Robert Batson, MD	LSU-HSC, Interim Chair, Dept. of Surgery
Debbie Gough	LA Dept of Health and Hospitals	John England, MD	LSU - Neurology
Karen DeSalvo, MD	New Orleans Health Commissioner	Keith Hearle	Verité Healthcare Consulting
Ben Sachs, MD	Sr. VP and Dean, Tulane School of Medicine	Multiple	Causey, Demgen & Moore, Inc.
Mark Peters, MD	CEO, East Jefferson Hosp	Mike Romano	Phase 2 Consulting
Nancy Cassagne	CEO, West Jefferson Hosp	Jerry Jones	Facility Planning and Control, State of LA Div. of Administration
Pat Quinlan, MD	CEO, Oschner	Stephen Barnes	Asst. Professor, Dept. of Economics, LSU Ourso College of Business
John Finan	CEO, Franciscan Missionaries of Our Lady HS	Allison Plyer, ScD	Deputy Director, Greater New Orleans Community Data Center
Bill Holman	CEO, Baton Rouge General	Mitch Landrieu	Mayor, City of New Orleans

Works Cited

Causey Demgen & Moore, LSU-UMC Debt Capacity Analysis, Oct 28, 2010.

Federal Funds Information for States, Issue Brief 11-11, FY 2013 FMAP Projections – A Moving Target; Mar 25, 2011.

Fisher K, Medicare Financing of GME and the other Special Missions of Teaching Hospitals, Oct 14, 2010.

Greenstein B, Reinventing Health Care in Louisiana: Problems and Solutions, 2011; available at www.lidi.state.la.us

HealthLeaders Interstudy, Managed Market Surveyor for Orleans, Jefferson, and St. Bernard Parishes, July 2010.

JPMorgan, University Medical Center Management Corporation HUD Application, Parts I and II, Oct 2010.

Katc.com, Freeze on Medicaid Provider Rate Reductions, 10 Jan, 2011; available at: www.katc.com.

Krupa, M, The Times-Picayune, New Orleans' Official 2010 Census Population is 343,829, agency reports, Feb 3, 2011.

The Lewin Group, Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion, Nov 13, 2006.

Louisiana Department of Health & Hospitals, available at <http://new.dhh.louisiana.gov>.

Louisiana Department of Health & Hospitals, Notice of Intent: Coordinated Care Network Proposed Rule, Jan 2011.

Louisiana Department of Health & Hospitals, FMAP Informational Briefing, available at: <http://new.dhh.louisiana.gov> .

Louisiana Department of Health & Hospitals, Medicaid Enrollees by Parish, Dec 2010, available at <http://www.dhh.la.gov/reports> .

Louisiana Department of Health & Hospitals, State Hospital UPL State Plan Amendment.

Louisiana Department of Health & Hospitals, 2009 Louisiana Health Insurance Survey, available at: <http://www.dhh.la.gov/reports>.

Works Cited (continued)

Louisiana Health Information Network, State Inpatient Database, 2007-2nd Quarter 2010.

Louisiana State University Health System – Health Care Services Division, Audited Financial Statements (FY08/09/10).

Louisiana State University Health System – Health Care Services Division, Audit Rule DSH Worksheet (FY11).

Louisiana State University Health System – Health Care Services Division, Budget Request for FY12.

Louisiana State University Health System – Health Care Services Division, GME Revenue and Expense Analysis (FY10).

Louisiana State University Health System – Health Care Services Division, Medicare Cost Report (FY09/10).

Louisiana State University Health System – Health Care Services Division, MAP Distribution Analysis (FY10).

Louisiana State University Health System – Health Care Services Division, Medicaid Cost Report (FY10).

Louisiana State University Health System – Health Care Services Division, Payor Mix Statistics (FY10/09).

Louisiana State University Health System – Health Care Services Division, Revenue & Expense Analysis (FY10/11 YTD).

Louisiana Department of Administration, Louisiana Department of Health and Hospitals, Louisiana State University, and Tulane University, UMC Memorandum of Understanding, August 29, 2009, www.newhospital.org/plans/MOU_signed-complete.pdf

Mercer, 10 Year Medicaid Expansion Estimates, Prepared for DHH, 28 Aug, 2009.

Mercer, Medicaid Expansion Estimates (Jan 1, 2014 to June 30, 2018), Prepared for DHH, 7 Dec, 2009.

Mercer, Days Projections_v2, Prepared for DHH 9, Feb, 2011.

Works Cited (continued)

- Moller J, The Times-Picayune, Gov. Bobby Jindal's Medicaid Changes Attacked, Jan 18, 2011.
- Moller J, "House Approves \$25 billion budget with new health-care cuts," The Times-Picayune 26 May 2011.
- Moody's Investors Service, Negative Outlook for U.S. Not-For-Profit Healthcare Sector Continues for 2011, Feb 3, 2011.
- The National Commission on Fiscal Responsibility and Reform, The Moment of Truth, Dec 2010.
- Nielsen Claritas, 2010-2015 Population Projections by ZIP Code, Jun 2010.
- Office of Management and Budget, Fiscal Year 2012 Terminations, Reductions, and Savings-Budget of the U.S. Government, Released 14 Feb 2011.
- Patient Protection and Affordable Care Act : Health-Related Portions of the Health Care and Education Reconciliation Act of 2010, As Amended Through May 1, 2010.
- Phase II Consulting, MCLNO Physician Analysis updated april 2011 3.0, Apr 19, 2011.
- Standard & Poor's, U.S. Not-For-Profit Stand-Alone Hospital Sector Performance Shows Gradual Improvement, July 19, 2010.
- State of Louisiana, *Louisiana Population Projections Series, 2010-2030*, available at www.louisiana.gov/Explore/Population_Projections
- U.S. Census Bureau, *American Fact Finder*, available at factfinder2.census.gov
- Verite Healthcare Consulting, Business Plan Analysis, University Medical Center, New Orleans, April 2010.

Statement of Limiting Conditions

All information, analysis and conclusions contained in this report are provided “as-is/ where-is” and “with all faults and defects.” Neither Kaufman Hall nor any third party sourced for any data or other information contained in this report makes any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this report or any of the data contained herein, whether such damages are claimed under contract, tort, strict liability or otherwise, are direct, special, indirect, incidental, exemplary, punitive or consequential, are for lost profits, loss of data, loss of use, loss of goodwill, are for damage to either hardware or software, or represent any other form of damages whatsoever, whether known or unknown, foreseeable or unforeseeable.

Kaufman, Hall & Associates, Inc.

5202 Old Orchard Road

Suite N700

Skokie, Illinois 60077

(847) 441-8780

www.kaufmanhall.com