Acute and PAC Partnership: Themes and Trends
February 26, 2019

Presented by Bill Pomeranz of
Cain Brothers

Post-Acute Ownership

<table>
<thead>
<tr>
<th></th>
<th>SNF</th>
<th>Home Health</th>
<th>IRFs</th>
<th>LTCHs</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>For profit</td>
<td>70%</td>
<td>80%</td>
<td>55%</td>
<td>70%</td>
<td>67%</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>30%</td>
<td>20%</td>
<td>45%</td>
<td>30%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Sources:
- MedPac analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2016
- MedPac analysis of Medicare cost reports, Medicare Provider of Services file, and the 100% hospice claims standard analytical file from CMS.

Acute-Post-Acute Care Market Themes

- Clinical control without hospital cost structure
- Narrow PAC networks – to Joint Ventures
- Patient engagement 30 – 90 day post-acute
- Super SNF vs LTCH substitutes for LTACH/IRF
- MA/ACOs and VBP – less $$$/little sharing
- PAC/vider major target – home care to in a low
- One way to two-way communication
- Relationship building – EPIC/Medical Control
- Hospitals expand to PAC

Interoperability/IT Relationship
- Narrow PAC networks – to Joint Ventures
- Clinical control without hospital cost structure
- Patient engagement 30 – 90 day post-acute
- Super SNF vs LTCH substitutes for LTACH/IRF
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- One way to two-way communication
- Relationship building – EPIC/Medical Control
- Hospitals expand to PAC
Why CMS Sees PAC as a Cost-Saving’s Opportunity

Proportion of variance attributable to each Medicare service category

<table>
<thead>
<tr>
<th>Adjusted Total Medicare Spending Remaining Variance</th>
<th>Reduction in Variance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No Variation in Post-Acute Care Only</td>
<td>1,864</td>
</tr>
<tr>
<td>If No Variation in Acute Care Only</td>
<td>5,085</td>
</tr>
<tr>
<td>If No Variation in Either Post-Acute or Acute</td>
<td>793</td>
</tr>
<tr>
<td>If No Variation in Prescription Drugs</td>
<td>6,378</td>
</tr>
<tr>
<td>If No Variation in Diagnostic Tests</td>
<td>5,696</td>
</tr>
<tr>
<td>If No Variation in Procedures</td>
<td>6,230</td>
</tr>
<tr>
<td>If No Variation in Surgical Department</td>
<td>6,672</td>
</tr>
<tr>
<td>If No Variation in Other</td>
<td>6,882</td>
</tr>
</tbody>
</table>

Note: Variance is reported with and without post-acute care and acute care. The variance is calculated using a nested or hierarchical linear model. The variance is based on the total Medicare spending in 2007. The variance is calculated using a nested or hierarchical linear model. The variance is based on the total Medicare spending in 2007. The variance is calculated using a nested or hierarchical linear model. The variance is based on the total Medicare spending in 2007.

Source: Variation in Health Care Spending, Institute of Medicine, July 2013


CMS/MA/ACOs are Taking Aim at Inefficient Post-Acute Care

- PAC payment based on venue, not patient conditions
- No coordination of patients over episode of care
- PAC referral patterns – highly random

CMS Readmission Penalties have reduced readmissions from 29% to 19%-23%, slightly offset by rise in Observation Days

<table>
<thead>
<tr>
<th>Hospital Discharges to Post-Acute</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers to 2nd Post Acute Venue</td>
<td>29%</td>
</tr>
<tr>
<td>Transfers to 3rd Post Acute Venue</td>
<td>15%</td>
</tr>
<tr>
<td>Transfers to Other</td>
<td>15%</td>
</tr>
</tbody>
</table>

CQMS is Questioning Usage of Specialty Hospitals

- CMS is moving to patient condition/venue neutral pricing
- CMS finds little correlation between costs and outcomes
- Reducing IRF/LTACH volume through increased Home Health and Super SNF volume

Source: CMS funded research project mounted
PAC – FFS to VBP Under PDGM

Reality of Operating Under Two Operating Models (next 5 years)

<table>
<thead>
<tr>
<th>Current Business Model</th>
<th>Future Business Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ by inputs</td>
<td>$ defined by outcomes</td>
</tr>
<tr>
<td>$ tied to process</td>
<td>$ tied to results</td>
</tr>
<tr>
<td>Manage costs at facility level</td>
<td>Manage costs at patient level</td>
</tr>
<tr>
<td>Emergent patients</td>
<td>Managed in PAC setting</td>
</tr>
<tr>
<td>Patient management ends at discharge</td>
<td>Extended into community</td>
</tr>
<tr>
<td>Hospitals, MDs, PAC Providers all separately reimbursed</td>
<td>Shared Risked Payments</td>
</tr>
</tbody>
</table>


Hospital Opportunity – Integrating Acute-PAC Delivery Systems

Key Takeaway: Shared governance facilitates acute to PAC transfers

Source: https://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/HealthLaw@Manatt/LTC-PAC%20Webinar%20FINAL%2011%2003%2014.pdf

Market Response – As Hospitals Consolidate PAC Relationships


CMS Forces SNFs to Focus Only on Short-Stay Patients, Requiring MD-EPIC Affiliations

## Payment Source

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Medicaid</th>
<th>Private</th>
<th>Medicare</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Custodial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term Health &amp;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Custodial Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Skilled Nursing: Medicaid
- Skilled Nursing: Private
- Skilled Nursing: Medicare
- Skilled Nursing: HMO
- Short-term Health & Custodial Facility: Medicaid
- Short-term Health & Custodial Facility: Private
- Short-term Health & Custodial Facility: Medicare
- Short-term Health & Custodial Facility: HMO

## Operating Margins

- Breakeven to modest profit
- High teen's to low twenties
- Same

- Skilled Nursing: Breakeven to modest profit
- Short-term Health & Custodial Facility: Same

### SNF ALOS Reduction – Advocate ACO Narrow Network Results

- **10-day ALOS >**
- ACO savings of $5,100 per episode
- Reduced LTAC/IRF $$$ by 24%

### Advocate

- Average SNF Medicare Revenue per Day: $610
- Average SNF Medicare Length of Stay (days): 27
- Average SNF Medicare Revenue per Episode: $15,120
- Medicare ALOS of Relatively Efficient SNFs: 17
- Potential Savings from Using Efficient SNFs (10 day reduction in ALOS): $5,600
- Convener Program Mgmt Costs (1% of Target Cost): ($151)

| Total Gain Share Savings | $5,449 |

### Beyond Readmissions – SNF Partnerships Improve Acute Profitability

- **AMCs/Tertiary Care** have abundance of "parking lot patients"
- PAC Reimbursement is insufficient for placement
- Joint Governance allows for patient subsidies
- Moving "parking lot patients" generated $24+ million in bottom line profit
- Clinically Wrapped Super SNF – EPIC Linkage

### Example: Avoidable Day Contribution for AMC

<table>
<thead>
<tr>
<th># of Inpatient Avoidable Contribution Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Parking Lot Patients (CMI between 1.05-2.00)</td>
</tr>
<tr>
<td>Higher Acuity (CMI between 2.00 to 2.50)</td>
</tr>
<tr>
<td>Super Users (CMI &gt; 2.50)</td>
</tr>
</tbody>
</table>

| Total Avoidable Days | 3,200 | 12,000 | $24,000,000 |
SNF/TCU Partnerships with Acute Care Hospitals

Moving long stay "Parking Lot" patients to super SNF partner

New Patients ("Backfill") A

Patients Ready for Discharge to SNF

Transitional Care Unit

Acute Care Hospital

Total Patient Days Utilized = 10,000

10,000 Avoidable Acute Care Days:

Patients currently spending extra days in the acute care setting due to lack of SNF bed availability or social, logistical and other clinical-linked placement issues

~$0 (breakeven) for illustration

Total Contribution $24 Million

Contribution from TCU operations

10,000 Patient Days Utilized by New Acute Care Patients:

New patients "backfilling" the availability created by moving medically appropriate patients to TCU in a timely manner

Additional Margin from TCU Operations

Additional Margin from TCU Operations

Additional Margin from TCU Operations

An Acute Super SNF Partnership

• Health Services Park – Acute Hub and Spoke
  ✓ SNF as Anchor Tenant
  ✓ ASC, MOB, and Urgent Care
  ✓ Hybrid Care level between med-surg and SNF
• Partnership structures (OpCo – PropCo)
  • Joint Operating Company OpCo (51%+ SNF / <49% Acute)
  • Management Agreement with SNF operator
  • Shared Governance with mutual reserve powers and acute clinical control

An Acute Super SNF Partnership (cont.)

• Key issues to consider in structuring the partnership include:
  ✓ Community cost structure
  ✓ OpCo financially neutrality – FFS vs. VBP Worlds
  ✓ IT/EMR investment by hospital
  ✓ Property ownership at lowest cost of capital
  ✓ System maintains full clinical control
Compelling ~$120bn Home Health Industry with Multiple Tailwinds

Provides significant cost savings to the payers

<table>
<thead>
<tr>
<th>Home Health/Medicare Cost Per Day</th>
<th>Hospice Medicare Cost Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>IRF</td>
</tr>
<tr>
<td>LTACH</td>
<td>$5,346</td>
</tr>
<tr>
<td>IRF</td>
<td>1,452</td>
</tr>
<tr>
<td>SNF</td>
<td>1,756</td>
</tr>
<tr>
<td>Home Health</td>
<td>1,452</td>
</tr>
<tr>
<td>Hospice</td>
<td>1,452</td>
</tr>
</tbody>
</table>

Sources: Company Analysis, U.S. Census Bureau, Public Company Investor Relations Presentation, Medicare Payment Advisory Commission Reports to Congress, U.S. Department of Health and Human Services

1. LTACH defined as Long-Term Acute Care Hospital, IRF defined as Inpatient Rehabilitation Facility, SNF defined as Skilled Nursing Facility

Referrals

Hospital agencies drive 90%+ of its admissions from acute referrals, while community-referrals represent a much higher percentage of referrals

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of episodes not preceded by hospitalization or PAC stay (in millions)</th>
<th>Cumulative % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1.9</td>
<td>53%</td>
</tr>
<tr>
<td>2011</td>
<td>2.2</td>
<td>67%</td>
</tr>
<tr>
<td>2017</td>
<td>2.2</td>
<td>66%</td>
</tr>
<tr>
<td>2001-2011</td>
<td>14.8%</td>
<td></td>
</tr>
<tr>
<td>2011-2017</td>
<td>2.4%</td>
<td></td>
</tr>
</tbody>
</table>

Referrals Note: PAC (post-acute care). “Episodes preceded by a hospitalization or PAC stay” indicates the episode occurred fewer than 15 days after a stay in a hospital (including in a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. “Episodes not preceded by a hospitalization or PAC stay” indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Numbers may not sum to totals due to rounding. (Source 2017 Med-PAC Data)

Health System Partnerships with Post-Acute Providers

A number of health systems have already partnered with post-acute care operators to further expand on their ability to manage the patient throughout the continuum of care
Strategic Partnership Models
Potential transaction structures: Alternatives & Trade-offs

Health System – SNF – Acute JV Proposal Structure

Experience from UNM Health System Engagement*

Select Transactions

*Similar to UCLA/ Cedars in Los Angeles
Experience from UNM Health System Engagement (cont.)

Transaction Structure

Critical Elements of a Successful Affiliation

Overview or transaction process
- First step is to establish each party’s objectives – Can’t Short-Cut
- Identify the optimal affiliation structure to support this shared vision
- Develop a governance/management structure to maximize success
- Develop a plan to realize overhead efficiencies early in the process
- Involve key decision-makers early to avoid negative adverse surprises
- Establish achievable, but realistic, transaction timeline
  - Find the right cadence for the affiliation process, then maintain that pace through closing

Role of Investment Banker vs. Lawyers

Our primary responsibility is to manage the transaction process and negotiate key economic and business terms

Cain Brothers
- Guide transaction process
- Negotiate key transaction terms
- Assist financial due diligence
- Define strategic considerations
- Oversee outside due diligence consultants
- Identify potential structures
- Seek feedback from all sides
- Provide ongoing transaction support to C-Suite and board of directors

Legal Counsel
- Discuss implications of various structuring options and propose alternatives to address legal, regulatory, and tax challenges
- Draft and advise legal documentation with negotiated terms
- Conduct legal due diligence
- Advise on regulatory implications
- Provide closing and post-closing support
- Advise and manage antitrust concerns
  - Prepare regulatory filings, as necessary

(1) These responsibilities are primarily related to activities that occur after the signing definitive agreement.
Home Health and Hospice M&A Market Update

- M&A activity in the sector has accelerated significantly in the last 24 months driven primarily by Hospital JVs
- Valuations for home health/hospice companies at or near peak levels, impacted by desire for Hospital JVs and a growing scarcity of "platform" companies available for acquisition
- Notable recent CB transactions include:

Leading Strategic Advisor to Health Systems and Hospitals

Home Health & Hospice Valuation Summary

Preliminary viewpoints on valuation of a typical home health & hospice business
- Home care valuations have averaged 1.25x to 1.5x for Hospital Based JVs or Sales
- Hospital based Agencies are highly attractive to strategic operator/investors, and often trade on a multiple of net revenue, doubling volume through community referrals

Key Valuation Drivers

- Existing CMS in both X and Y Counties allows for consolidation across the area
- Add scale as CMS/MA requires more sophisticated and administrative expertise
- Tied by referrals to a leading system
- University as Agency Sponsor
- Platform for financial improvement: geographic and referral source expansion