Town Hall Meeting

February 22, 2012

SVMHS Process Update

Salinas Valley Memorial Healthcare System

Process Summary

- 57 potential parties approached by Cain Brothers
  - 10 strategic partners (in market or in contiguous markets)
  - 7 not-for-profit systems
  - 22 for-profit systems
  - 18 private equity or financial investor partners
- 29 potential interested parties reviewed the non-disclosure agreement (NDA)
- 21 Potential interested parties received the Offering Memorandum (OM)

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Key Dates and Timeline

Deadline for Initial Indications of Interest	March 7th
Selection of Second Round Potential Affiliation Partners	March 22nd
Second Round of Affiliation Process Commences	March 23rd
Deadline for Final Second Round Offers	May 4th
Period to Clarify and Refine Second Round Offers	May 7th to May 24th
Board Meeting to Select Final Affiliation Partner	May 24th
Negotiate Definitive Agreements	May 25th to June 15th
Board Meeting to Approve Definitive Agreements	June 21st
Regulatory Approvals	July – September
District Election to Approve Transaction	Fall 2012
Completion of Affiliation	Late Fall 2012

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Key Themes for Health Care Providers

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Key Themes For Health Care Providers

- Decades of cost inflation has resulted in an unsustainable cost level for US health care
- Governmental payors are experiencing severe budget pressure
- Macro economic trends suggest a long period of slow growth which exacerbate the challenge
- Cost shifting to private insurance can't continue
- Bending the cost curve will require a shift from fee for service to new payment models
- Managing care under these models will require new levels of coordination between physicians, hospitals, ambulatory care and post-acute care providers
- The information technology requirements to create integrated models are very expensive
- Health care providers will need to operate with greater transparency to serve more cost conscious and value driven health care purchasers
- These forces are driving an unprecedented level of consolidation activity in the health care industry and will likely lead to much larger regional and multi-regional systems
- These pressure are also resulting in many new forms of organizations with affiliations between hospitals, payors, physicians and other provider organizations

Overview of Health Care Industry and Trends

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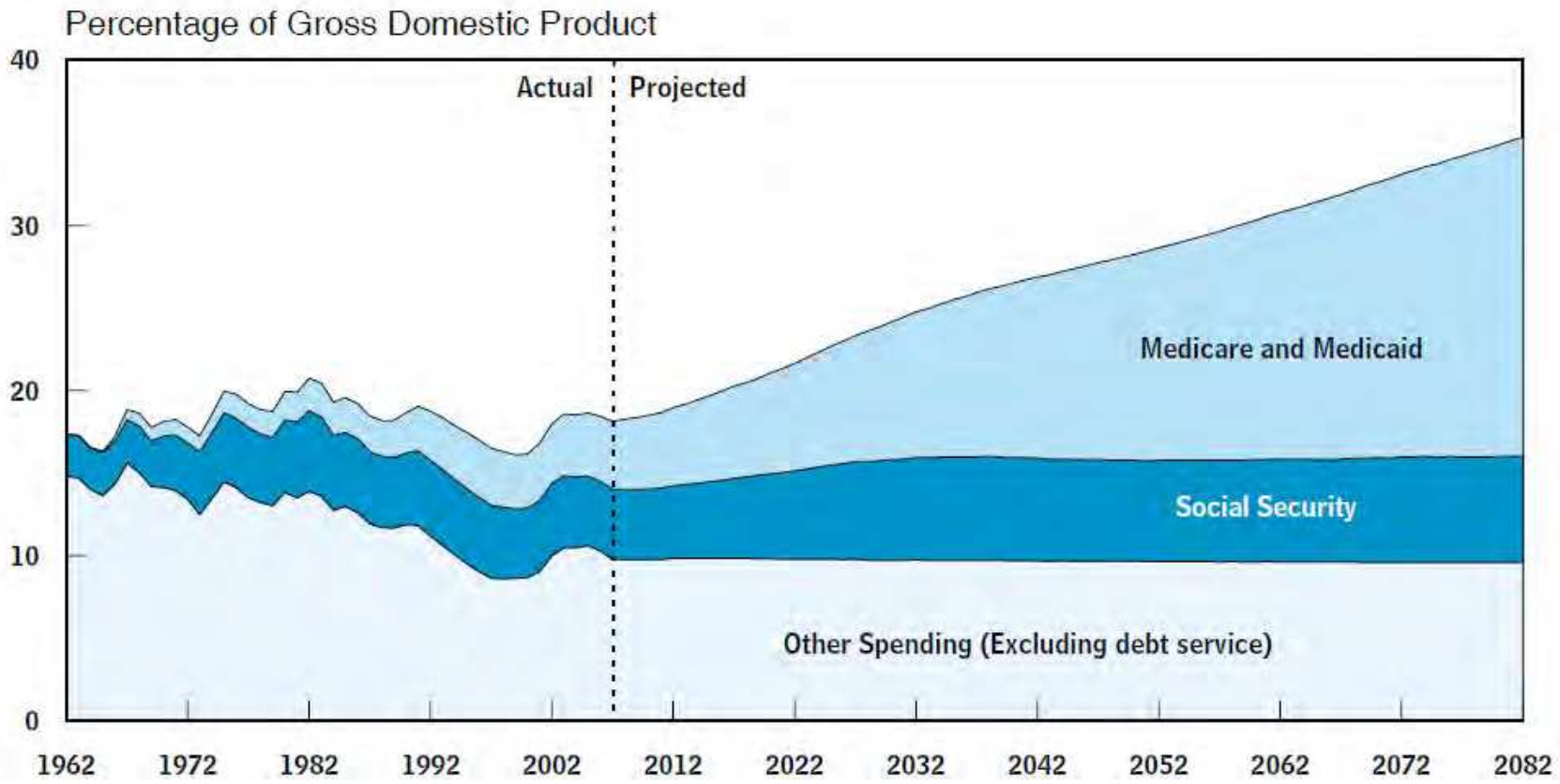
Entitlement Program Costs and Projected Federal Budget

- The structural challenge of health care programs on the federal budget becomes the key driver of federal deficit growth by 2030 at which time Social Security peaks as a percentage of GDP.
- In addition to the challenge at the federal level, the Medicaid program has and is expected to continue to challenge state budgets.



Source: Congressional Budget Office

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Private Insurance Premiums and the Growth of the Uninsured

- Like public health programs, private insurance costs have grown at an unsustainable rate with health premiums growing at a an average rate of 8.5% since 1999 versus general CPI of 2.4%.
- Providers with strong market positions have been able to achieve rate increases substantially in excess of general inflation from private payors to maintain margins and cover their cost increases which have also been in excess of general inflation.
- The growth in private insurance costs significantly exceed employees' productivity gains which "crowd's out" wage increases and is galvanizing employers to identify more effective ways to control costs.

Average Annual Premiums for Covered Workers with Family Coverage

Source: Kaiser / HRET Survey of Employer-Sponsored Health Benefits, 1999-2011

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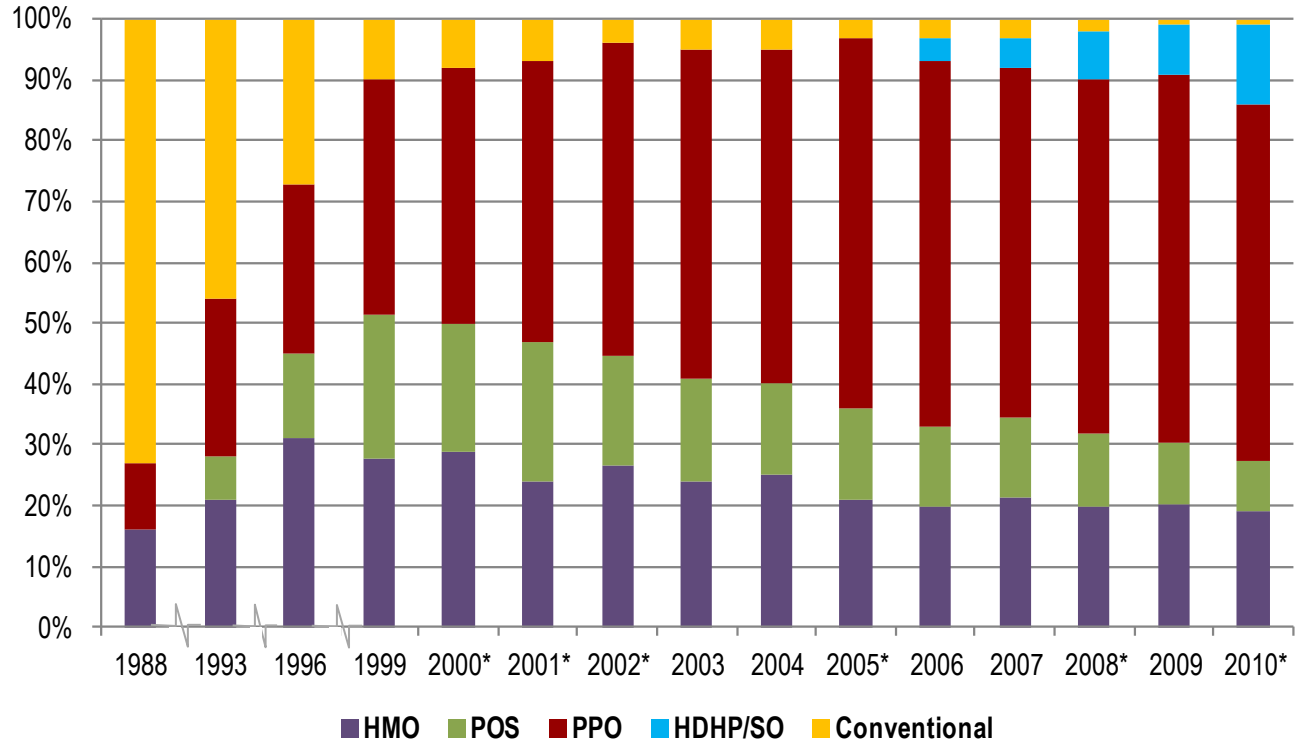
Evolution of Managed Care Plans Design

- After the rapid increase in penetration rates for restrictive HMO plans through the middle 1990s, there was a distinct shift to more flexible, open models – most notably PPOs.
- PPOs grew to dominate the managed care market because they avoided restrictive HMO plan benefit designs and could effectively cost shift from employers to employees.
- The rapid increase of insurance premiums suggests that there will be a shift back toward more restrictive plan designs and smaller more exclusive networks.

Distribution of Health Plan Enrollment for Covered Works by Plan Type
1988-2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.

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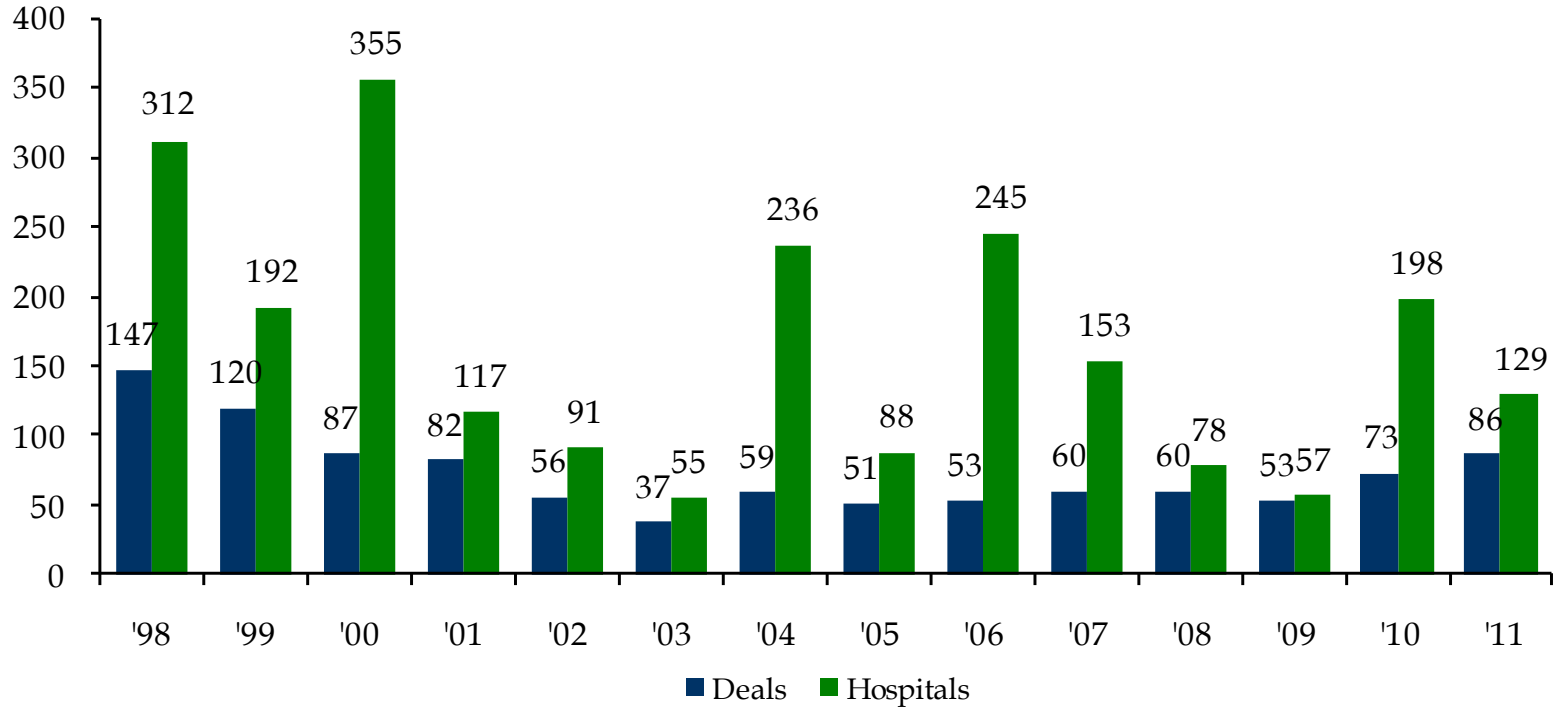
Acute Care Hospital M&A Market Activity

Hospital M&A Volume (# of Deals and Hospitals)(1)



Source: Irving Levin Associates, Inc.

(1) Does not include HCA, Inc.'s purchase of the remaining 40% JV stake in HCA-HealthONE for $3.625bn

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Proliferation of Transaction Models

Hospital Mergers/Affiliations

- Saint Joseph's affiliation with Emory Healthcare
- Northwestern Memorial HealthCare's acquisition of Lake Forest Hospital and merger talks with Elmhurst Memorial Hospital
- Sun Health merger with Banner Health
- Vanguard's acquisition of Detroit Medical Center
- Ascension's acquisition of Alexian Brothers
- Vanguard's joint venture partnership with Valley Baptist Health System
- Acquisition of Moses Taylor Hospital by Community Health Systems

Hospital Physician Affiliations

- California Cancer Specialists' affiliation with City of Hope Medical Center
- Acquisition of Medical Edge by Texas Health Resources
- Acquisition of Hematology Oncology Patient Enterprises by UVA Health System
- Alexian Brothers' alignment with Cardiovascular Associates
- Brookwood Medical Center's (Tenet) partnership with CardioVascular Associates

Payor / Provider Affiliations

- Highmark's acquisition of West Penn Allegheny Health System
- Formation of a new health plan by Banner Health Network (Banner's ACO) and Aetna
- Humana's acquisition of Concentra
- WellPoint's acquisition of CareMore
- UnitedHealth's acquisition of Monarch Healthcare

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Examples of Organized Provider Models

- Successful health systems will be creating organized models of care which integrate the physicians, ambulatory care, inpatient acute care and post-acute services into clinically integrated care models
- This may be accomplished by acquisitions or contractual relationships that are connected by robust IT systems and economic linkages that are sensitive to cost and quality and align the incentives of all parties
- Examples of systems that are beginning to create (or have created) such systems of care:
  - Kaiser Permanente – fully integrated Hospital (501(c)3), Health Plan (NFP) and physician organization (FP) system with nearly 8 million members nationwide and a well developed branding campaign. Kaiser is the quintessential example of pre-paid, organized medicine.
  - Cleveland Clinic – has built an internationally renown health care organization that is fully integrated and is driving care models that achieve excellent quality at very competitive costs.
  - Banner Health – the largest hospital system in the greater Phoenix area with a quickly growing physician group totaling more than 800 physicians and post acute services services and is one of the Pioneer ACOs recently granted by CMS.
  - Steward Health – Has grown to 10 acute care hospitals from the original acquisition of 6 from Caritas Christi. Have nearly 1700 physicians in its affiliated physician model and accepts capitation on nearly 90% of its commercial lives and is one of the Pioneer ACOs recently granted by CMS.
  - HealthCare Partners – One of the largest organized physician models in southern California which includes a staff model (Group) with approximately 700 physicians and an IPA model with approximately 3,900 physicians. HCP typically contracts for the the acute care services on the "spot" market and is one of the Pioneer ACOs recently granted by CMS.

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Key Transition Challenges

- Physician Integration
- Clinical Integration
- Economic Alignment
- Cost Culture not a Revenue Culture
- Post Acute Services
- Governance and Executive Leadership
- Access to Capital

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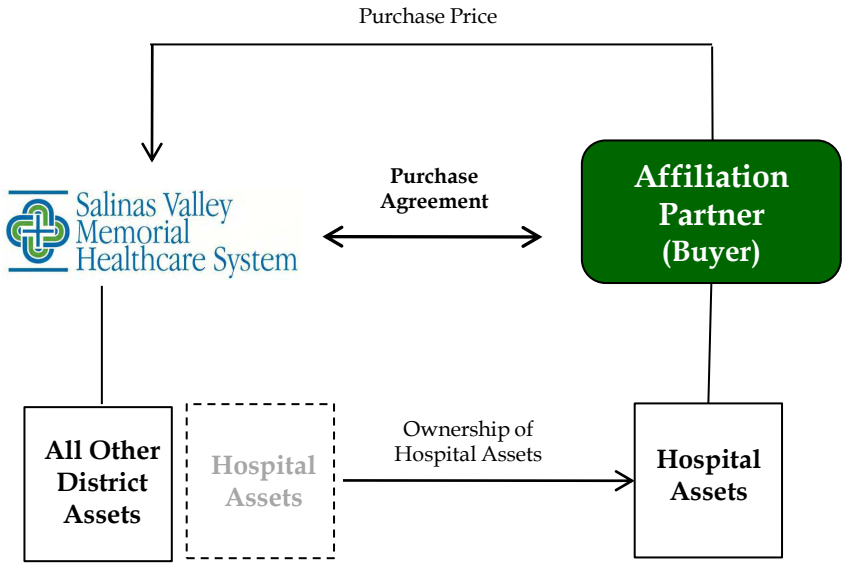
Potential Models of Affiliation

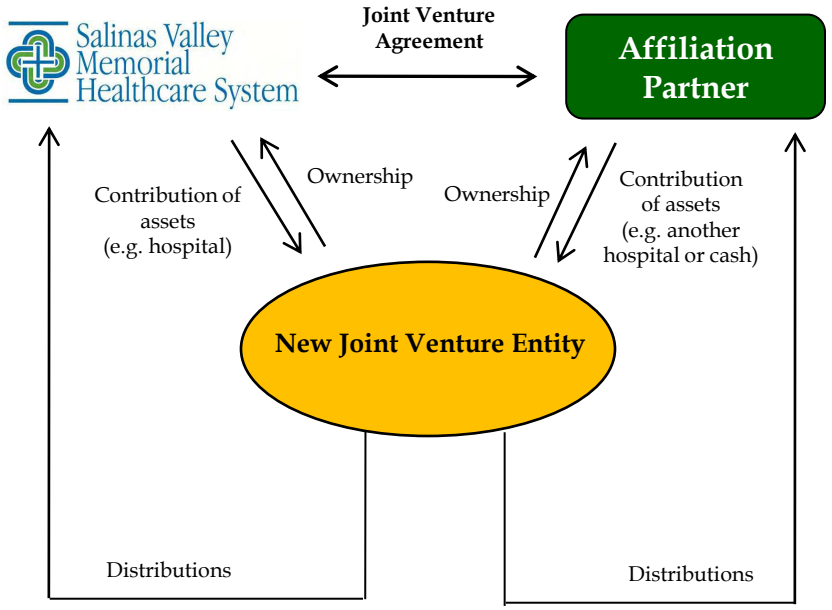
Acquisition of Hospital Assets

- We anticipate that some potential affiliation partners will propose an acquisition of SVMH assets for the form of transaction.
- This is the form that is preferred by many investor-owned hospital management companies.
- Key elements of an acquisition of assets:
  - SVMHS would sell the hospital real estate and improvements and other assets that are fundamental to the operation of the hospital for cash or other consideration;
  - Other assets typically included would be working capital (except for cash), ownership interests in joint ventures (e.g., surgery center business), any physician affiliation arrangements.



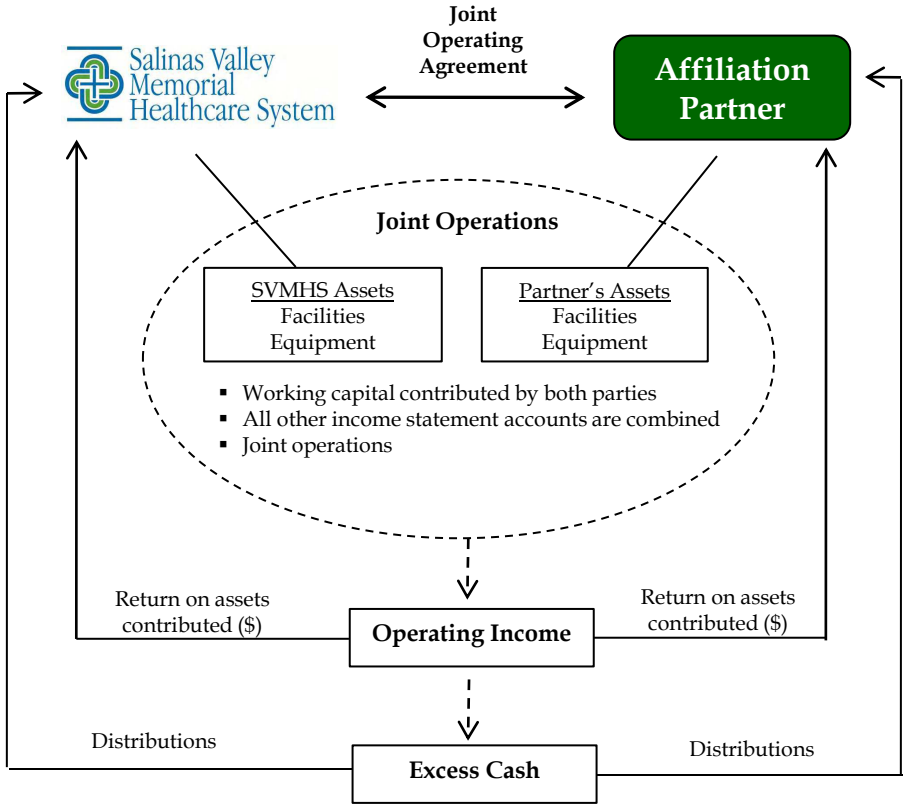
Joint Venture

- Some potential affiliation partners may propose a joint venture with SVMH as the form of transaction.
- In a joint venture, SVMH would contribute assets to a new not-for-profit or for-profit entity (depending on the tax status of the affiliation partner)
- The affiliation partner may contribute cash, operating assets (e.g. a hospital) or both
- The partners will agree on the respective ownership percentages based on contribution value
- The joint venture allows continuing involvement by SVMH while generating some cash proceeds
- Key elements of an acquisition of assets:
  - Management of Joint Venture;
  - Governance of Joint Venture;
  - Value of each parties contributions;
  - Conflict resolution and exit rights (Buy/Sell agreements, put rights etc.)



Joint Operating Agreement

- Joint Operating Agreements (JOA) are a version of a joint venture which were common structures in the 1990s and which allow each party to retain ownership of their respective assets.
- Each party retains ownership of their assets but create a new company to jointly manage and operate the hospitals.
- Typically the JOA model is used for in-market consolidation not for out-of market combinations.
- JOAs proved to be fragile models because the on-going ownership of each parties assets facilitated the unwind of the venture, subsequent capital needs often required contributions by each partner and the incomplete merger suggested an incomplete commitment to the venture.
- JOAs have very similar management and governance structures as joint ventures except that each party often has certain reserved powers over actions impacting their hospital assets.
- Examples of Joint Operating Agreements:
  - Centura (Catholic Health Initiatives/Adventist)
  - BayCare (Tampa)
  - Health Alliance of Greater Cincinnati



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Affiliation of Clinical Program(s)

- The affiliation of clinical programs such as the programs operating in conjunction with Stanford (heart program, NICU, perinatology, etc.) might be proposed by some partners.
- The key benefits of this form of affiliation is to enhance the quality and financial performance of select clinical programs.
- These programs could provide some of the other benefits with respect to the relevant clinical programs such as access to capital to fund specific equipment needs or recruitment costs.
- However, these arrangements do not provide many of the benefits of a larger affiliation such as achieving overhead savings, access to capital, full alignment of the economic interests or comprehensive physician affiliation.
- Also, a piece meal affiliation of certain clinical programs could complicate the ability of SVMHS to shift to prepaid (risk-based) contracting for care to patient populations.

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Management Agreement

- While unlikely, some affiliation partners might propose a management agreement model.
- Under a management agreement, SVMH would retain ownership of its assets and would enter into a contract with a hospital management company to manage the operations.
- The management agreement could involve a broad range of options with respect to the payments to/from the management company and the amount of operating risk retained by SVMHS.
- This model could provide a strong management team but would not provide many of the potential benefits of an affiliation:
  - Does not provide access to capital
  - Short term of most agreements (5 years or less) does not provide long-term alignment for key strategic initiatives
  - The ability to terminate or not renew the contracts make these agreements vulnerable to changes in market conditions or leadership vision

Future of SVMHS After an Affiliation

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Future Role of SVMHS

- SVMHS is a public health care district, which is a political subdivision of the State.
- Regardless of the transaction structures that might be proposed or selected by the District, SVMHS will still be a public health care district post-transaction.
- Assuming the SVMHS sold the SVMH and all related operating assets of the District, SVMHS would still be in a position to have a meaningful impact on health care services in the community.
- SVMHS could have meaningful resources after a transaction including approximately $3 million in annual tax revenues, net proceeds from the affiliation transaction, the value and cash flow of retained assets (e.g. commercial real estate) and earnings on the investment assets of the District.
- Examples of potential roles that SVMHS could serve after a transaction:
  - Health education programs;
  - Community clinics or other primary care outreach to vulnerable community populations;
  - Mobile health clinics to homeless or workers that have limited access to basic medical services;
  - Subsidized care for low income residents of the District;
  - Programs to support educational programs for nursing and other health professional;
  - Other?

Questions and Comments