ARNOLD & PORTER LLP

Jeffrey R. Ruggiero
Jeffrey.Ruggiero@aporter.com
212.715.1089
212.715.1399 Fax
399 Park Avenue
New York, NY 10022-4690

September 4, 2008

VIA PDF AND FEDERAL EXPRESS

Mr. James Clyne
Deputy Commissioner
Office of Health Systems Management
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Jim:

In furtherance of our meeting on August 13, 2008, enclosed for your review and consideration is the Restructuring Plan submitted on behalf of the Organized Medical Staff of the Long Island College Hospital. We look forward to the opportunity to discuss the Plan after your review.

Very truly yours,

Jeffrey R. Ruggiero

Enclosure

cc: Ronald Gade, M.D.
The Medical Executive Committee

PROPOSAL
TO
RECONSTITUTE AND RESTRUCTURE
LONG ISLAND COLLEGE HOSPITAL

Submitted to: New York State Department of Health

Submitted by: The Medical Executive Committee of the Organized Medical Staff of
Long Island College Hospital
Strategic Programs, LLC
Arnold & Porter LLP

SEPTEMBER 2, 2008

Summary

The Medical Executive Committee of the Organized Medical Staff of Long Island College Hospital ("MEC"), its turnaround/restructuring experts and legal counsel have prepared this restructuring plan for consideration by the New York State Department of Health ("DOH"). Based upon information and belief, Continuum Health Partners, Inc. ("CHP") has, or will soon be submitting its restructuring plan. According to their public statements, their turnaround plan has two general components:

- Close The Long Island College Hospital ("LICH") maternity program. CHP states that it cannot afford medical malpractice costs under the current arrangements it maintains at LICH. Should CHP be permitted to close LICH's maternity program, such closure will result in the inevitable closure of gynecology programs and other women's health programs, neonatal intensive care programs, and general and specialty pediatrics programs. If approved, the closure of the LICH maternity program by CHP and these resultant closures would reduce LICH to a 100-bed medical surgical hospital with psychiatric and rehabilitation medicine programs. Vital primary care programs located in the surrounding communities of Brooklyn such as PCAP and WIC will undoubted face disruption as other institutions outside the service area vie for these services.

- Sell more LICH real estate to subsidize deficits rather than stem deficits that chiefly result from abnormally high overhead, bad debt expenses and its current medical malpractice program. CHP has been employing this short-term strategy for some time, having already sold over $50 million in LICH real estate holdings, but it fails to address the underlying causes for the deficits. It is also important to note that the buildings CHP intends to sell next (Polhemus and 340 Henry Street) are not only historically significant but currently house essential clinical and administrative services. Since there is no articulated plan for relocation of these services, the sale of the buildings would lead inevitably to additional program closures and/or costly outsourcing of services.

While CHP believes reducing LICH beds is sustainable, it is a shortsighted approach that fails to address the many other financial problems that have brought LICH to the brink of financial insolvency. Chief among them are the dismantling of LICH's primary care services through the closure of all of LICH's five community based clinics that has resulted in the loss of patient volume, reduction of clinical staff and loss of revenue.

In contrast to the CHP plan, the MEC plan contemplates rehabilitation of all aspects of institutional and financial operations:

1. Rebuild former clinical strengths and primary care programs in the community. This will initially stem and ultimately reverse losses in patient volume and associated revenue.

2. Realign clinical affiliations with a different and other prestigious academic medical center.
3. Implement turnaround plan to reduce operating deficits by $20 million annually, principally through reductions in overhead, bad debt and medical malpractice expenses.
4. Secure financing from private sources.
5. Reconstitute the LICH Board of Trustees with individuals from the Brooklyn community LICH services, recruit an executive leadership team and rebuild an appropriately sized administrative infrastructure (at a fraction of the cost of the current CHP charge back arrangements).

Strategic Programs, LLC led by Ronald Gade, M.D., has been working with the MEC to design the corporate, clinical and financial restructuring. Jeffrey Ruggiero, Esq. of Arnold & Porter LLP has been working on behalf of the Organized Medical Staff in its ongoing efforts to terminate LICH's arrangement with CHP and reconstitute its legal and governance structure. The MEC plan retains and reconstitutes the clinical leadership, once the hallmark of LICH prior to the effective dismantling of LICH by CHP. The proposed corporate restructuring of LICH will restore LICH's independence and autonomy by terminating the relationship with CHP and reconstituting the LICH Board.

As indicated in the Summary Tables provided, while LICH inpatient volume has declined 2.5 percent since 2006 and ambulatory care volume has declined 5.8 percent, LICH annual deficits have increased 89.3 percent. As the attached summary tables and Proforma Table 1 indicate, the losses sustained by CHP are reversible. The bad debt and overhead expenses alone have contributed significantly to the financial losses.[1]

The MEC plan for the turnaround of LICH will stabilize the decline in patient volume, maintain the maternity program and not require the sale of LICH real estate. The MEC restructuring plan will instead focus on and remediate the three root causes of the losses at LICH:

1. ***Reduce the amount of bad debt expense annually from its current $26 million to approximately $10 to $12 million annually in the next three years.*** This will be accomplished by reducing the bad debt expense from $26 million to $20 million in 2009, while increasing net patient revenue by $6 million in year one.

- The current arrangement between CHP and LICH does not require CHP to be responsible for collection targets. As a result CHP is unnecessarily writing off $26 million in bad debts, an inexplicably high amount given the size and payor mix of LICH. Under the MEC plan, the net impact of improved revenue collections on operations is $12 million to the bottom line. In the next two subsequent years, bad debt expenses will continue to be reduced through more effective collection efforts, resulting in continued improvement in net operations. In addition, under new leadership, LICH accounts receivable balances will be reduced from the current June

[1] All data used in this turnaround plan are derived from audited and unaudited financial statements provided by CHP in summary form.

2008 levels of $38 million. As a benchmark, the newly reorganized institution will maintain its receivables in the $25 million range, a more acceptable benchmark than that currently employed by CHP. (See tabular information in Proforma Tables).

2. ***Elimination of $28 million in overhead and shared services arrangements currently charged by Continuum Health Partners.***

The $6 million allocated to pay CHP corporate executives will be replaced with LICH's own executive/administrative leadership for which $3 million will be sufficient. Regarding shared expenses related to billing, IT, human resources, etc., the reconstituted LICH will require $10 million to restore its infrastructure to self-sufficiency and use vacant space on its campus to house these back office functions rather than pay CHP to lease more costly space in Manhattan.

- In 2007, LICH lost an average of 20 percent on every discharge and 10 percent on every ambulatory care visit.[2] In Table 3 the financial trends of the CHP controlled hospitals are compared. It is projected that LICH losses per discharge in 2008 will reach $2,342, up from $1,504 per discharge in 2006, an increase in the *loss rate* of 53.4 percent per discharge. Under the MEC five–point turnaround plan, these losses will be eradicated.

3. ***Reopen contracts with insurance carriers.***

LICH has not had access to the rates it is paid for clinical services by the major commercial insurance carriers, as CHP staff negotiates these contracts and the rates are not shared with the LICH departments. Restoring LICH will require that it renegotiate rate provisions in its insurance contracts. In this regard, LICH's location, service configuration and lower cost profile give it a market advantage.

- LICH revenue per discharge has increased only 4.5% from $11,117 in 2006 to $11,613 in 2008, well below the rate of medical inflation. This financial result is also surprising considering that LICH generally treats a sick population as measured by both its Medicare and Medicaid case mix. (See Table 1). This measure is a gauge of acuity and relative reimbursement. Given LICH's patient acuity, it is anticipated that its revenue per discharge should be similar to that of its peer hospitals. It is significantly lower. This suggests that revenue is not being properly collected and payor rates are below acceptable benchmarks. (See Table 3)

- LICH financial losses from operations have grown from a deficit of $17.5 million in 2006 to a projected $33.2 million in 2008, an increase of 89.3%. LICH has maintained a relatively high and sicker patient population, which should result in a larger increase in the revenue generated by inpatient admissions. (See Proforma Table 3).

[2] This loss factor is calculated as follows: average per discharge deficit divided by average per discharge revenue. See Table 3 for statistical information.

LICH has sustained declines in volume but not in the range that its financial losses would indicate.

4. ***Medical Malpractice Insurance will require restructuring.***

A different approach to insuring for medical malpractice exposure will be put in place that includes a wholesale restructuring and development of effective, comprehensive risk management and loss control programs. A combination of self insured retention and establishment of offshore captives will be implemented to fund loss reserves. Going forward, annual medical malpractice costs will be reduced from $25 million to $15 million.

5. ***Reconstitute primary care programs in the community***

CHP has closed all five community-based primary care programs at LICH so that the real estate that housed those programs could be sold to subsidize deficits. As part of the restructuring of LICH, primary care programs will be reintroduced into the community. MEC seeks a partnership with DOH to rebuild these programs to address critical health disparities in LICH's surrounding communities and to provide increased access, particularly for low-income populations. As part of its renegotiations with Medicaid managed care programs, the reconstituted LICH will seek to build important programs to provide increased access, and establish a direct relationship with the managed care programs consistent with DOH goals and objectives. These new approaches will add approximately 20,000 new primary care visits annually to the revitalized LICH campus.

LICH Proforma Model

With the implementation of this five pronged approach, it is expected that operating losses can be completely stemmed by close of 2009 as reflected in the attached Proformas and statistical documentation. We note that at this early stage in turnaround planning, assumptions are conservative regarding growth in volume and renegotiation of contract rates. The focus in the first year of the turnaround will be on stabilization of volume and rebuilding clinical capacity while achieving cost savings from significant expense reductions. The assumptions guiding inpatient census projections are derived from the current profile of LICH patients and payor mix from data provided by CHP.

During the next few months of the turnaround planning, skill mix FTE data will be analyzed and benchmarked against current and projected turnaround volumes to determine staffing needs. Physicians will be submitting plans to revitalize respective departments and strategic initiatives will be modeled and implemented so that no departments will require closure as envisioned by the CHP plan.

A series of five Proforma tables follow that reflect the proposed turnaround plan. The CHP/LICH data used to formulate the MEC plan was provided to the MEC by CHP as part of a presentation upon the announcement of its proposed closure of the maternity service.

Proforma findings include:

1. Operating revenue will increase from an estimated $321 million in 2008 to $337.6 million in 2009. The increase in revenue will be achieved from the following: a reduction in the receivables and bad debt expenses that accounts for $8 million in increased revenue; the increase in commercial carrier contract rates; and, the stabilization of inpatient and outpatient volume.

2. As indicated in Proforma Table 1, operating expenses will be reduced from $352.2 million to $334.5 million in 2009. This reduction will be achieved chiefly by reducing the bad debt expense from $26 million to $20 million, reducing CHP corporate expenses by $3 million from $6 million, and reducing shared services by $12 million from $28 million. Finally a new Medical Malpractice program will be put in place that will save another $10 million in premium costs in the first year. Salaries and benefits will remain unchanged and increase in the out years.

LONG ISLAND COLLEGE HOSPITAL

TURNAROUND PLAN

Proforma Model

PROFORMA TABLE 1: Long Island College Hospital
Projected Five Year Statement of Revenue and Expenses

	2006	2007	2008 June Year to Date	2008 Projected Based On Current CHP	Stand Alone 2009	Stand Alone 2010
Average Daily Census	287	290	271	273	281	289
Average Discharges Per Day	57	57	54	54	56	57
Total Patient Days Excl. Newborns	104,830	105,953	49,896	99,448	102,538	105,454
Discharges	20,531	20,601	9,896	19,743	20,265	20,836
Average Length of Stay (ALOS)	5.1	5.1	5.0	5.0	5.0	5.0
Revenue:						
Net Patient Revenue	*$ 289,719,000*	*$ 306,027,000*	*$ 142,258,000*	*$ 287,842,300*	*$ 295,626,378*	*$ 303,610,641*
Inpatient Revenue	$ 228,254,000	$ 230,549,000	$ 116,288,000	$ 232,576,000	$ 239,124,500	$ 246,238,725
Outpatient Revenue	$ 47,671,000	$ 50,827,000	$ 25,970,000	$ 55,326,300	$ 56,501,878	$ 57,371,916
Investment Income	$ 5,514,000	$ 9,479,000	5,000,000	$10,000,000	$ 10,000,000	$ 10,000,000
Other Revenue	32,220,000	22,524,000	$ 11,949,000	$ 23,898,000	$ 24,000,000	$ 24,000,000
Revenue Recovery from Receivable (See Bad Debt Expense)					$ 6,000,000	$ 7,000,000
Increase in Contracted Rates					$ 2,000,000	$ 2,000,000
Total	**$ 329,305,000**	**$ 338,654,000**	**$ 159,207,000**	**$ 321,800,300**	**$ 337,626,378**	**$ 346,610,641**

Expenses:	2006	2007	2008	2008	Stand Alone 2009	Stand Alone 2010
Salaries and Wages	$ 142,793,000	$ 151,058,000	$ 74,165,000	$ 148,330,000	$ 149,000,000	$ 150,000,000
Employee Benefits	$ 41,494,000	$ 41,856,000	$ 21,747,000	$ 43,494,000	$ 43,000,000	$ 43,000,000
Insurance	$ 21,462,000	$ 26,088,000	$ 13,100,000	$ 26,200,000	$ 15,000,000	$ 15,000,000
Supplies & Other Expenses	$ 64,896,000	$ 64,172,000	$ 22,669,000	$ 45,338,000	$ 55,000,000	$ 57,000,000
Shared Services Expenses	$ 22,855,000	$ 22,018,000	$ 11,000,000	$ 22,000,000	$ 10,000,000	$ 10,000,000
(Continuum) Corporate Exec Fees	$ 5,532,000	$ 5,872,000	$ 3,000,000	$ 6,000,000	$ 3,000,000	$ 3,000,000
Bad Debt Expense	$ 24,001,000	$ 26,026,000	$ 13,000,000	$ 26,000,000	$ 20,000,000	$ 20,000,000
Depreciation	$ 18,229,000	$ 18,382,000	$ 9,013,000	$ 18,026,000	$ 18,000,000	$ 18,000,000
Working Capital LOC Interest					$ 2,500,000	$ 2,000,000
Legal Fees					$ 2,000,000	$ 1,000,000
Interest	$ 17,350,000	$ 16,991,000	$ 8,390,000	$ 16,780,000	$ 17,000,000	$ 17,000,000
Total Operating Expenses	**$ 358,612,000**	**$ 372,463,000**	**$ 176,084,000**	**$ 352,168,000**	**$ 334,500,000**	**$ 336,000,000**
Net Surplus/ Deficit	**$ (29,307,000)**	**$(33,809,000)**	**$ (16,877,000)**	**$ (30,367,700)**	**$ 3,126,378**	**$ 10,610,641**
Non-Recurring						
Unrestricted Contributions	$316,000	$507,000				
Non-Recurring G/L	$1,812,000	$(15,000,000)				
Net P/L	**$(27,179,000)[3]**	**$(48,302,000)[3]**	**$(16,877,000[4])**	**$(33,754,000)[4]**	**$ 3,126,378**	**$ 10,610,641**

[3] Agrees with Audited Financial Statements prepared by Continuum Health Partners presented to the LICH MEC dated August 12, 2008

[4] Based on trended monthly unaudited financial statements through June 2008 prepared by Continuum Health Partners