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September 30, 2015

VIA HAND DELIVERY

Mr. Stephen J. Johnson, CPA
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Pennsylvania Insurance Department
1345 Strawberry Square
Harrisburg, PA 17120

Re: Order No. ID-RC-13-06 Condition 15
June 19, 2015 Approval Letter, Section III (H)

Dear Deputy Commissioner Johnson:

Pursuant to Condition 15 of the above-captioned Order and Section III (H) of the above-captioned Approval Letter, Highmark Health is filing with the Department the attached non-confidential AHN Corrective Action Plan.

Very truly yours,

Jack M. Stover

JMS/gmt
Enclosure
cc: Lawrence J. Beaser, Esquire (via email: Beaser@BlankRome.com)
Patrick T. DeLacey (via email: Pat.DeLacey@RaymondJames.com)
Eric Coburn (via email: Eric.Coburn@RaymondJames.com)

Final Allegheny Health Network Corrective Action Plan

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Introduction

Introduction

In accordance with the Approval Letter, Highmark Health has developed this Corrective Action Plan which outlines a strategy that will enable AHN to enhance its financial performance and further enhance its ability to deliver choice and access to the highest quality healthcare services to the residents of Western Pennsylvania.

Changing the way health care is delivered

The goal of the Highmark Health enterprise is to change the way health care is delivered in the markets which the companies within the organization serve in a financially responsible manner. With the Department's approval of the transactions necessary to allow Highmark's affiliation with WPAHS and with the commitment and under the oversight of the Boards of Directors and management teams of Highmark Health, Highmark and AHN, the enterprise acquired the necessary foundational elements to maximize the benefits to the residents of these communities, including Highmark subscribers and policyholders. The Highmark Health enterprise consists of a health plan that serves 5.3 million subscribers with deep customer insights, a delivery system that includes 8 hospitals, 4 comprehensive outpatient Health and Wellness Centers, 8 Ambulatory Surgery Centers, dozens of outpatient sites for various diagnostic and therapeutic services, over 2500 affiliated physicians including 1100 employed physicians in over 40 specialties and subspecialties, a regional/national educational function through partnerships with Pennsylvania state educational institutions including Temple University, Drexel University and Lake Erie College of Osteopathic Medicine (LECOM), national diversified businesses that offer financial diversification and unique consumer insights, and a leading clinical research operation. Combined, these organizational assets comprise one of the largest IDFSs in the country that serves as a laboratory to foster clinical quality and incubate change and is committed to nothing less than being transformative as it seeks to deliver the right care in the right settings and at the right price.

Patients and consumers benefit from Highmark Health's integrated delivery model

At its core, the strategy of the Highmark Health's IDFS is to provide comprehensive care and population health management by coordinating the activities of physicians and other caregivers and operational and integrated financing capabilities. The IDFS understands community needs and provides services not only to treat illnesses, but to keep the population healthy. Importantly, as the IDFS evolves it will align incentives that hold it clinically and fiscally accountable for the clinical outcomes and health status of the people served.

The reasons for moving to an IDFS are clear and indisputable. First, the nature of medical risk is increasingly shifting to chronic conditions, and current financing and delivery incentives are fundamentally flawed. Second, health care is becoming more retail and with that trend there is a growing need to deliver superior value to the consumer who has greater financial risk and increased level of choice. Finally, new care models enabled by technology, and accelerated by new reimbursement designs, are changing how care is delivered. Implementation of a truly integrated IDFS, however, involves navigating the natural tension between traditional payer and provider incentives. The traditional payer's goal to reduce the cost of health care to its lowest possible level to assure its competitive position is at odds with the traditional provider's need to maximize revenues to assure its ability to continue to deliver

care. In an IDFS, the payer and provider goals must coexist and the parties must work together to deliver on the same goal: to deliver the highest quality of care possible at the lowest possible cost. As a result, the strategies and tactical decisions of the IDFS from time to time may be at odds with the financial interests of its constituent providers.

AHN is a critical part of transforming health care in Western Pennsylvania

AHN is a critical part of Highmark Health's strategy of transforming the way health care is delivered. When Highmark took steps to affiliate with WPAHS in 2013, it did so for the purpose of maintaining competition in the health care market in Western Pennsylvania and to offer consumers meaningful health care choice. This was not a step that Highmark took lightly, but it was the right thing to do for the people of Western Pennsylvania, including Highmark policyholders and subscribers who were facing the threat of unreasonable price hikes being demanded by the dominant provider network in the region or exclusion from that network's facilities and the likelihood that, without intervention, WPAHS would fail. For the two and one-half years since the affiliation was consummated, management of Highmark Health and the health system have been singularly focused on turning around the system which had been starved of investment for more than a decade, while simultaneously making critical investments in order to meet new challenges and demand.

Health system improvements over the past two years, including more than $400 million in capital investments

Since the closing of its affiliation with Highmark, AHN has delivered on its promise of improving the delivery of healthcare in Western Pennsylvania. Residents of the region, including Highmark policyholders and subscribers, have been the direct beneficiaries of these improvements as they have preserved and expanded choice and competition in the healthcare delivery market while enabling Highmark to continue to offer competitively priced health insurance products. In addition, the creation of the IDFS has allowed valuable community assets, in the form of viable AHN hospitals and facilities, to remain open while maintaining approximately 11,000 jobs. In just the past two years, AHN, with the assistance of Highmark, has made capital investments at AHN facilities totaling more than $400 million.

Tangible examples of these investments can be seen across the communities of Western Pennsylvania, including:

- Investments in technology:
    - Forbes Hospital became the first of the AHN hospitals to go live with Epic Systems (Epic) software, a fully integrated health records system that is the first of its kind in Western Pennsylvania. The investment in Epic, the best-in-class of integrated health records, will improve efficiency, quality, cost of care, and the patient experience. More AHN hospitals are currently going live on Epic in the near future, and eventually all AHN hospital campuses, outpatient facilities and doctors' offices will use Epic.
- Clinical and operational collaborations:
    - In late 2014, Highmark Health, Highmark and AHN and The Johns Hopkins University and The Johns Hopkins Health System Corporation (collectively, Johns Hopkins) signed a master

collaboration agreement that complements the formal oncology collaboration AHN began with Johns Hopkins at the beginning of 2014. These collaborations aim to leverage the collective strengths of the organizations and improve the availability and affordability of health care to Pennsylvania patients. In addition, AHN is working jointly with Johns Hopkins' Armstrong Institute, a top rated organization focused on healthcare quality, safety and value.

- In June 2013, Highmark, AHN and Carnegie Mellon University jointly announced a research partnership to mine health care data for advances in science and engineering that will reduce the cost and improve the quality of health care.

- Also in 2014, Highmark and LECOM announced that Forbes Hospital will host 26 third-year LECOM students for their clinical rotations. The number of students will increase to approximately 50 over time. AHN is building classroom space and a new student lounge at Forbes to accommodate the students. This is in addition to a scholarship program for LECOM students that Highmark established in 2013, with the ultimate goal of increasing the supply of physicians in rural parts of Pennsylvania.

- Investments in facilities:

  - A 23,000-square foot Women and Infants Center at Jefferson Hospital in which AHN invested, bringing obstetrical (OB) services back to the South Hills of Pittsburgh so families can have their babies closer to home.

  - A new 20-bed ICU at Forbes Hospital, which began admitting patients in March 2015, and the Level II trauma center there – all part of an effort to strengthen and grow capabilities at Forbes.

  - A new urgent care center in Braddock which brought medical care back to that community which had been abandoned by other health providers and left without adequate care outlets.

  - Wellness pavilions in Wexford, Peters Township and Bethel Park and under construction in Erie

  - Expansion of specialty programs at AHN community hospitals

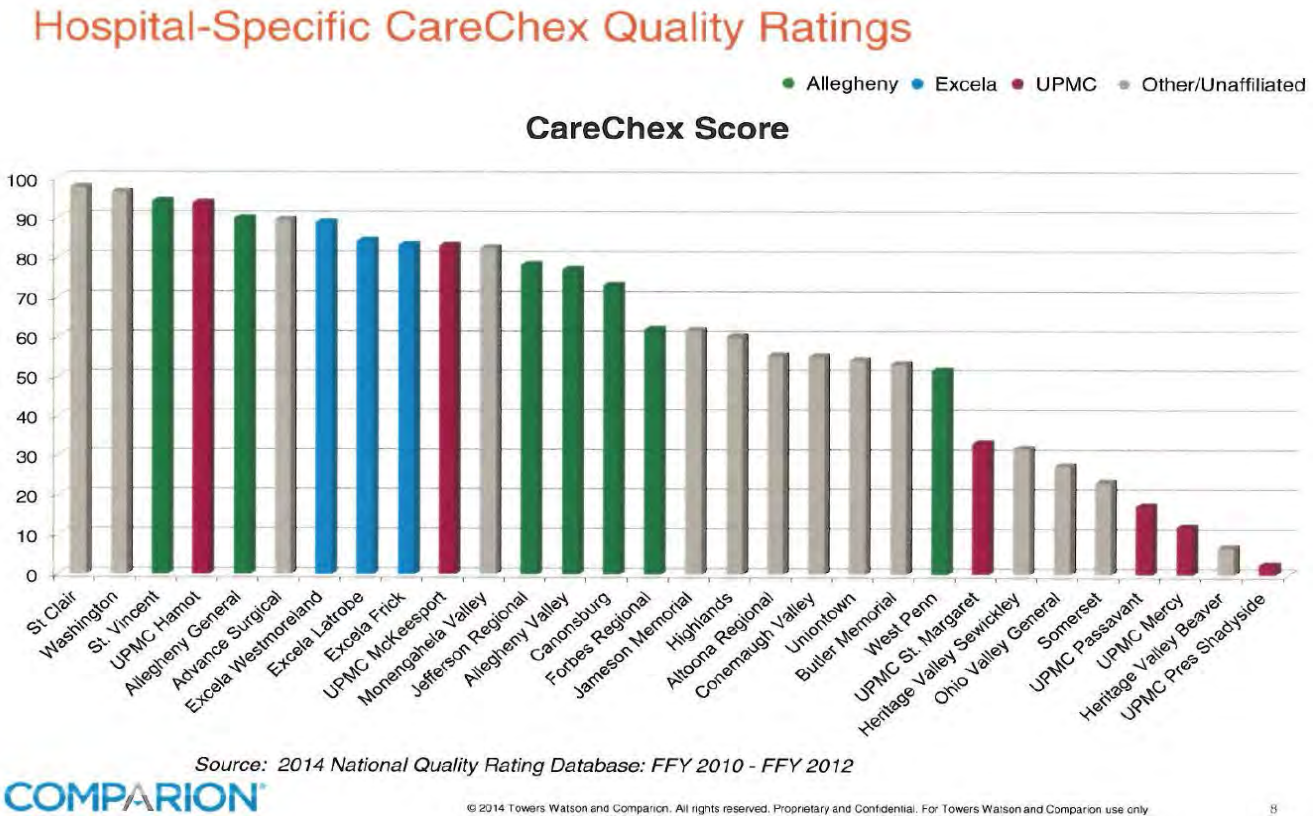
- Investments in home health and community-based services:

  - In 2014, AHN formed a joint venture with Celtic Healthcare Inc. (Celtic) to combine home health and hospice assets in Western Pennsylvania. This venture also helps AHN prepare for changes in reimbursement models in which government and health insurers will pay a lump sum for such things as joint replacement surgery, which will then include rehabilitation and home care for the patient.

  - Also in 2014, AHN announced the acquisition of a majority ownership interest in respiratory and home medical equipment supplier Klingensmith Healthcare, complementing the four core areas of home health services: home infusion therapy, durable medical equipment, home health, and hospice.

- Care innovation:
    - Physicians, researchers and other medical practitioners at AHN are making medical discoveries in many disciplines, including allergy, asthma and autoimmunity; biofilms; cancer; cardiovascular diseases; esophageal diseases; orthopedics; psychiatry; and the neurosciences. AHN currently has more than 400 active research trials in progress; nearly 150 of its clinicians are serving as principal investigators.
    - In addition, AHN offers patients opportunities to participate in a wide array of clinical trials, providing access to promising new treatments that are not yet available to the general public. Current AHN research institutes include: Asthma, Allergy and Autoimmunity Institute; Cancer Institute; Cardiovascular Institute; Center for Excellence in Biofilm Research ; Esophageal and Lung Institute; Neuroscience Institute; Orthopedic Institute; and Psychiatric Research.

AHN's key investments have led to significant progress in improving patient quality, safety and cost effectiveness in the region. For example, Comparion Medical Analytics, Inc. (Comparion), a health care information services company, released information in 2014 using a composite rating of the value of hospital and physician care, taking into account both quality and cost. Comparion compared this information to state and national standards. AHN's Saint Vincent Hospital (SVH) and Allegheny General Hospital (AGH) both scored near the 90th percentile out of the 30 area hospitals in the report.



AHN has formed a number of partnerships that offer residents of the region expanded care options. AHN's partnership with Johns Hopkins' Sidney Kimmel Comprehensive Cancer Center brings an opportunity for patients to extend their care to the Hopkins network. AHN's partnership and recognition as a U.S. Olympic Regional Medical Center expands AHN's treatment of some of the most elite athletes in the country and promoted continued expansion of AHN's orthopedic and sports medicine programs. Also, AHN's partnership with Carnegie Mellon University continues to produce innovative care ideas geared toward improved care.

Improvements over the past two years

AHN has seen an increase in patient volumes in the two years since the affiliation with Highmark became effective. These volumes have increased across AHN, particularly at WPAHS and Jefferson Hospital, as a result of investments that have expanded AHN's capabilities and improved access to its physicians and programs. This increase is notable given AHN's focus on directing care to the appropriate setting and cost for the patient, thereby moving care from the more expensive inpatient hospital setting to ambulatory and lower cost outpatient sites. Outpatient registrations at AHN hospitals increased 2% and inpatient discharges increased 1% in 2014 compared to 2013 (assuming AHN results had been incorporated for the full year ended December 31, 2013), even while AHN was opening new non-hospital outpatient sites that have experienced dramatic growth and while Highmark and UPMC entered into two separate Consent Decrees in June 2014 that contained continuity of care provisions which allowed Highmark subscribers continued in-network access to UPMC hospitals for many services through June 2019. These increases come at a time when discharges and outpatient registrations within the Western Pennsylvania market have declined by 6% and 5%, respectively, from 2013 to 2014.

AHN's financial performance has improved significantly especially in light of evolving strategies and priorities

AHN's financial performance has improved significantly since the closing of the Highmark affiliation. For the year ended December 31, 2014, AHN recorded an operating loss of $37 million***, representing a more than $130 million improvement*** in the first full year of AHN's operation over the year ended December 31, 2013. Financial performance improved even though AHN was constrained by conditions in the Order limiting its ability to terminate or renegotiate payer contracts with uncompetitive market terms. Additionally, in alignment with the IDFS strategy, AHN continues to focus on shifting care to the right setting closer to home, reducing costs and improving patient experience while also rolling out the new Epic system. These efforts, while providing value to the community, put pressure on current operating earnings.

A summary of key metrics showing demonstrable improvement in AHN's financial performance and hospital volumes in the past two years follows:

Metrics of Success - AHN Turnaround	2013 A	2014 A	2015 P
Inpatient Discharges	82,593	83,171	85,817
Outpatient Registrations	1,242,671	1,270,270	1,271,509
Surgical Cases	80,872	83,681	85,355
Acute Length of Stay	4.96	4.93	4.49
Operating Results (in millions)	(174)	(37)	(48)

Adding value to the community

There are certain key initiatives that AHN has undertaken or chosen not to undertake which have affected the speed of its financial turnaround. Its decisions on these items have resulted in additional savings to the communities in which AHN operates. The following are a few of these initiatives:

- AHN has invested in and focused on developing programs which keep patients out of the hospital even though these programs lower AHN revenues. The value to the community from these programs is seen in improved patient experience and lower cost of care to payers and the community.

- AHN has elected to shift care from more expensive facility outpatient settings to freestanding settings that provide increased value. This decision has resulted in lower claim costs for payers and reduced cost sharing for patients.

- AHN has its specialists travel to over 20 outlying communities to provide patient care in the community in non-AHN settings even though these activities have reduced AHN's revenues. These efforts have kept care in the community while providing benefits to patients and families through reduced travel and convenience. They also have generated revenues for non-AHN facilities.

- Unlike some hospitals or hospital systems, AHN has elected not to maximize its revenue by changing billing for services from physician-based to facility-based sites of service. Despite the loss of revenues, AHN has elected not to follow this approach in the majority of cases as it generates no benefit to patients. The value to the community of this one item is estimated at over $150 million per year.

- AHN is undergoing a system-wide technology standardization that will enable the flow of patient information between providers and eliminate duplication, thereby reducing the cost of care.

Additional investment in AHN will continue to benefit patients and consumers

In the summer of 2014, AHN and Highmark Health embarked on a capital planning process which resulted in Highmark's December 2014 request for approval to commit an additional $175 million to

AHN for capital projects that will directly benefit patients and consumers. As detailed within, the capital projects for which the $175 million has been or will be used are necessary in order to continue to enhance the level of services, capabilities and access for AHN patients, including, but not limited to, Highmark policyholders and subscribers.

Building upon and improving the healthcare experience in a dynamic environment

This Corrective Action Plan is designed to continue to develop and build AHN and its constituent organizations while improving the overall healthcare experience of patients. The financial projections demonstrate improved cash flow and earnings, along with a significant decrease in operating losses, since AHN was formed. To be clear, the enhancements outlined in this Corrective Action Plan are not a prescription for a complete financial turnaround of AHN during the projection period. They do, however, reflect a continued moderation of losses. Expected changes in the market following the projection period (e.g., expiration of the Consent Decrees) will affect performance of AHN in the future.

At the same time, it is important to note that, while the CAP presents objectives and financial projections that Highmark Health and AHN management and Boards of Directors consider to be reasonable, the healthcare marketplace in Western Pennsylvania has been and remains dynamic. It has evolved considerably since the formation of the IDFS, and its further evolution represents a significant variable in the organization's plans for the future. Outstanding issues such as the definition of "continuity of care" in the Consent Decrees, litigation currently pending before the Pennsylvania Supreme Court related to the identity of providers available to 180,000 Highmark Medicare Advantage subscribers and mediation relating to irrational charges by third parties for oncology drugs all remain unsettled and create circumstances which are neither easily controlled nor predictable. Additionally, volatility with regard to Highmark health plan enrollment as well as industry consolidation represent potential further challenges.

This volatility will lead to variation in the underlying assumptions in the projections, and Highmark Health and AHN leadership will continue to monitor performance and make adjustments in levels of investment and priorities as developments dictate.

In addition, the Highmark Health enterprise currently is in the process of refining and finalizing a long term strategy and, in so doing, is continuing to assess the impacts of the highly fluid market environment noted above and changing demands and expectations of policyholders and subscribers. Highmark Health is submitting this Corrective Action Plan in advance of the finalization of this long-term strategic planning process. It is important to view the Corrective Action Plan in the context of the evolving business strategy. It is possible that Highmark Health's strategic decisions will affect assumptions or the projections included in this CAP, including with respect to volumes, alternative strategic growth options, capability or technology investments or divestments that Highmark Health and/or AHN determines are necessary for success.

Highmark Health is fully committed to keeping the Department fully informed of all relevant developments.

Committed to ensuring a robust, highly functioning IDFS

The Highmark Health Board of Directors and leadership remain committed to the strategy for the development of a robust, highly functioning IDFS with a vibrant and forward-looking AHN at its core. The strategy is in the best interest of the residents of Western Pennsylvania, and specifically Highmark subscribers and policyholders. AHN is on a trajectory of success as the metrics demonstrate and in a relatively short period of time. This Corrective Action Plan sets forth the critical elements necessary to allow the Board and company leadership to continue to deliver on the promises made to the Department and the public at the time of creation of the IDFS.

Background and Investments/Initiatives Undertaken to Develop the IDFS

Background

As has been well documented, in the spring of 2010, Highmark opened contract negotiations with UPMC, the dominant provider system in Western Pennsylvania, in an attempt to arrive at a new contract which would assure Highmark members in-network access to UPMC facilities in the region. UPMC advised that it would continue to contract with Highmark, but only if Highmark agreed to a 40% increase in its reimbursement rates, a demand which Highmark found to be unacceptable. Business leaders in the community supported Highmark's position that UPMC's demand was unreasonable, but UPMC was inflexible. Simultaneous with these developments, the five hospitals in the WPAHS system, the second largest health care system in the region, were experiencing such poor financial performance that the system was on the verge of insolvency. Business leaders in the region, as well as community hospitals which were attempting to maintain their independence from UPMC, strongly encouraged Highmark to enter into discussions with WPAHS to attempt to save the system and its 11,000 jobs and to provide a counter-balance to UPMC.

In December 2010, Highmark and WPAHS entered into negotiations regarding how the two parties could work together to assure that consumers in Western Pennsylvania would have choice in health care providers. These negotiations culminated in October 2011 with the parties' entry into an agreement which contemplated an affiliation between them under a common parent, today known as Highmark Health. Following a thorough review process, including a review of a series of projections provided by Highmark under various scenarios, in April 2013, the Department entered the Order approving the transactions necessary to allow Highmark and WPAHS to affiliate, subject to a series of conditions. Neither the conditions nor any of the projections which Highmark had submitted to the Department fully anticipated the changes which were forthcoming in the Western Pennsylvania market.

Upon learning of the discussions between Highmark and WPAHS, UPMC publicly announced that it would no longer contract with Highmark to provide in-network access at UPMC hospitals to Highmark commercial subscribers after the then current contract ended in June 2012, with a one year run out provision. In May 2012, under intense pressure from political and business leaders in the community, in an arrangement mediated by the administration of then-Governor Corbett, Highmark and UPMC entered into an agreement that extended all UPMC hospital and physician agreements until at least December 2014, and, recognizing local community needs and unique medical services available at certain UPMC facilities, continued in-network access to sole community hospitals, UPMC Bedford and UPMC Northwest, and Western Psychiatric Institute and Clinic, and continued access to UPMC for certain oncology services and for those in a continuing course of treatment. In June 2014, through discussions facilitated by the Governor's Office, the Office of Attorney General, the Department and the Department of Health, the parties entered into the two Consent Decrees which provided for continued in-network access to UPMC for Highmark members in various categories and under various circumstances, including access for seniors and other vulnerable populations, access for emergency and trauma services and oncology treatment, access to additional local hospitals outside the Pittsburgh area and access for

Highmark members in a continuing course of treatment with UPMC (continuity of care provisions). The Consent Decrees also provided a "safety net" for Highmark subscribers who had used UPMC providers in 2014 to allow them to continue with these providers in 2015 while they located alternative care, and balance billing protection for subscribers who chose to use UPMC on an out-of-network basis in the

future. The Consent Decrees run until June 30, 2019. During the open enrollment period which followed entry of the Consent Decrees, UPMC ran a series of advertisements advising consumers that, if they wished to continue to have guaranteed in-network access to UPMC facilities after December 2014, they would have to purchase their insurance from an insurer other than Highmark. Following the close of the open enrollment period, UPMC reversed its message and communicated that the Consent Decrees entitled a broad range of Highmark subscribers to continued in-network access to their UPMC doctors and hospitals even after December 2014. The precise scope of the continuity of care provisions of the Consent Decrees remains a subject of ongoing dispute between Highmark and UPMC and is unresolved at this time.

Investments/Initiatives Undertaken to Develop the IDFS (Including Costs/Benefits)

Since the closing of the WPAHS affiliation in 2013, Highmark has committed over $1 billion to AHN to assist in the development and growth of the IDFS. These investments were undertaken with careful consideration of how such funds and projects would benefit AHN patients and the community as a whole, including Highmark policyholders and subscribers. They have also led to significantly improved financial performance and increased patient volumes at AHN. For the year ended December 31, 2014, AHN recorded an operating loss of $37 million**,** representing a more than $130 million improvement over 2013.

Volumes have increased across AHN, particularly at WPAHS and Jefferson Hospital, as a result of investments that have expanded AHN's capabilities and improved access to its physicians and programs. Outpatient registrations increased 2% and inpatient discharges increased 1% in 2014 compared to 2013 (assuming AHN results had been incorporated for the full year ended December 31, 2013), despite Highmark's entry into the Consent Decrees which, as noted above, allow Highmark subscribers continued in-network access to UPMC hospitals for many services through June 2019. These increases come at a time when discharges and outpatient registrations within the Western Pennsylvania market have declined by 6% and 5%, respectively, from 2013 to 2014, and AHN has moved care to other outpatient, non-facility sites as appropriate.

Key investments made and initiatives undertaken to-date (refer to Appendix B) to implement and develop the IDFS have taken place across the Highmark Health enterprise, including those below at AHN:

- **AHN Capital Investments -** When Highmark affiliated with WPAHS, WPAHS had a dedicated workforce and owned valuable community assets. Its assets, however, were in dire need of upgrades and enhancements due to years of deferred maintenance while WPAHS's future remained uncertain. Since the closing of the Highmark affiliation, AHN has made significant investments in these facilities to improve the quality of patient care and expand services and capabilities for the community, including Highmark's policyholders and subscribers. Many of these investments have led to no financial return but are required to sustain the system, provide the appropriate infrastructure, improve the quality and prepare it for the influx of future volume upon expiration of the Consent Decrees. Other investments that expand access and care will provide a return over the longer term. These capital investments through August 2015 have included, but are not limited to, the following:

- **Allegheny General Hospital –** Significant investments at AGH were focused on renovations and repairs and maintenance, including information technology (IT) upgrades, that had been deferred for years due to financial constraints. Additionally, older equipment was replaced with newer models.

  AGH is the only facility in Western Pennsylvania to house a dedicated cardiac magnetic resonance imaging (MRI) center for the evaluation of complex cardiovascular diseases. Among a number of pioneering discoveries made by the cardiac MRI team, AGH researchers were also the first to demonstrate that cardiac MRI is better than conventional diagnostics for predicting heart attacks in women. Additionally in 2014, AHN opened a state-of-the-art hybrid operating room at AGH to better equip surgical teams to perform the latest generation of complex, minimally-invasive cardiovascular procedures. The new hybrid operating suite is equipped with a robotic imaging system that gives physicians real-time 3D images of internal organs and blood vessels with unprecedented precision and clarity. Introducing new tools that facilitate less invasive procedures that can potentially be offered to sicker patients has been a critical strategy for advancing cardiovascular care.

- **Forbes Hospital –** Renovations and repairs and maintenance were made to improve the quality and safety of Forbes Hospital.

  In addition, a Level II trauma center and state-of-the-art intensive care unit was opened at Forbes Hospital to serve a population of approximately 300,000 people who reside in Pittsburgh's Eastern suburbs. This investment proved its value to the community by saving lives in area tragedies that made headlines both locally and nationally. On a day-to-day basis, the trauma center serves to fill a critical service line gap for first responders that community leaders felt was necessary for the safety and protection of community residents.

- **West Penn Hospital -** Residents in the East End of Pittsburgh were positively impacted by the decision of AHN's management team to keep the facility open and to make investments in its sustainability. This included the re-opening of the emergency department as well as additional improvements including a new cardiovascular center, post-partum unit, catheterization labs and renovated and enhanced intensive care units. The effect of these investments was to improve access for community residents.

- **Jefferson Hospital -** Since the closing of the affiliation between Jefferson Hospital and AHN, and based on research that showed several thousand women from the Jefferson Hills area were travelling to the City of Pittsburgh to deliver their babies, AHN has made investments in women's health and OB services at Jefferson Hospital to serve women in the Southern suburbs. Since its recent opening, Jefferson Hospital's OB unit has delivered approximately 600 babies. In addition, recognizing the need for more comprehensive oncology services, AHN opened a new cancer institute at Jefferson Hospital.

- **Wexford Health + Wellness Pavilion (Wexford Pavilion) and Other Geographically-Selected Ambulatory Service Centers -** In 2014, AHN opened the new 174,000 square foot state-of-the-art Wexford Pavilion offering area residents a variety of healthcare specialists and outpatient diagnostic and ancillary services under one roof. The Wexford Pavilion will result in less costly and higher quality care with a greater focus on promoting wellness and preventing disease. As important, community residents, including many Highmark subscribers, benefit from the lower cost site of service. This investment was critical to Highmark as it provides Highmark's policyholders north of Pittsburgh with access to services that became unavailable in that region on an in-network basis following the termination of the UPMC contract or will become unavailable upon expiration of the Consent Decrees. Independent physician practices have found value in practicing at the Wexford Pavilion, which further serves to increase access for area residents at a lower-cost setting.

  AHN also opened a new ambulatory surgery center in Monroeville and has expanded and developed similar facilities in Bethel Park and Peters Township. Such outpatient facilities in lower-cost settings deliver value to the healthcare consumer and create access to healthcare for those residing in the Northern, Eastern and Southern suburbs of Pittsburgh and are representative of the IDFS goal to keep care in the community.

- **Saint Vincent Hospital, Allegheny Valley Hospital, and Canonsburg Hospital –** Efforts at these locations were mainly focused on repairs and maintenance that had been deferred for years due to financial constraints, including IT infrastructure upgrades. Additionally, older equipment was replaced with newer, more reliable models.

- **Recruitment of Properly-Incented Physicians -** AHN has added high-quality physicians across various specialties and service lines to grow total physician alignment to over 2,500 physicians in over 40 specialties. Working with Highmark on Highmark-developed incentive arrangements, AHN physicians are incented to work toward the best health outcome for the patient with an emphasis on the right care in the right setting – a divergence from the traditional "heads in beds" model. AHN has recruited approximately 300 physicians from January 2014 to June 2015.

- **Group Purchasing Organization (GPO) -** AHN developed a successful GPO that serves AHN and more than 60 other hospitals in supply chain management. The GPO also has a relationship with an affiliate of Johns Hopkins. The GPO is able to leverage the purchasing capabilities of its member hospitals to lower the costs of often costly medical surgical supplies, biomedical engineering, implantable devices, and physician-preference items. In addition to helping IDFS-affiliated hospitals with optimized purchasing, the GPO provides inventory management, warehousing, distribution, receiving, and customer service.

- **Epic implementation –** Highmark Health made a key investment in the Epic electronic health record technology beginning in 2014. To date, Epic has been installed within AHN at Forbes Hospital, Wexford Pavilion, and many of the Allegheny Clinic physician offices. The remaining physicians will go live during 2015, with West Penn Hospital and AGH planned to go live by the

first quarter of 2016. Epic represents an important investment in technology that enhances the quality, efficiency and safety of the clinical care AHN provides while reducing overall costs to AHN patients. Such technology delivers quantifiable benefits, which have been shown to include: (i) advising physicians (or patients directly) when preventive health maintenance tasks should be performed, (ii) providing guidance and support at the time of ordering for medications, tests, and interventions with communication and follow-up after orders are placed, (iii) wellness registries for organizing preventive care, (iv) and integrated system that connects each member of the care team to a single record and embedded analytics, (v) ensuring use of the most up-to-date information for reliably safe, well-coordinated, and high-quality care, (vi) alerting pharmacists to potential problems and errors, and (vii) access to comprehensive patient information throughout the perioperative episode providing integration at critical points across the continuum of care. At Forbes Hospital, where Epic was most recently implemented, demonstrated benefits have included better coordinated care, increased clinical and financial efficiency, improved practice management and an enhanced patient experience, including the following:

- **Increased efficiency and more time with patients**: Time spent completing nurse admission assessments dropped 30 minutes; time between ordering to administering medications dropped 80 minutes; and time nurses spent administering medications was reduced 7 minutes
- **Real-time data improves patient throughput:** Average time from arrival to inpatient bed has been reduced 70 minutes; average time from bed requested to bed assigned has been reduced 35 minutes; 38% of patients are discharged by 1:00pm (previously less than 10%)
- **Better patient care:** Barcode medication verification scanning is now performed 90% of the time
- **Increased financial efficiency:** 90% clean claim rate

As the Epic system evolves and improves and process changes are embedded into the AHN culture, it is anticipated that benefits in both patient experience and operational efficiency will continue and grow.

- **Post-Acute Care Investments -** Significant investments were made in late 2014 in post-acute care services through the acquisition of and partnering with durable medical equipment, home infusion therapy, and home health providers with further investments expected in 2016 and 2017. Previously, some of these services were included within the hospitals of AHN; however, there is significant value to extracting them from the hospitals and enhancing them with partners that specialize in these services. Such post-acute services help to lower the costs of care by keeping patients at home, if possible, and reducing the need for longer hospital stays or readmits after discharge due to complications. Even though hospitals make up the foundation of the provider arm of the IDFS, the Highmark Health enterprise is committed to ensuring that the lowest-cost, highest-quality care is provided to patients – even if this proves to have a negative impact to the bottom line of the hospital system.

In addition to the investments outlined above, AHN also has undertaken the following initiatives to reduce costs and/or enhance the likelihood of its success:

- **System-Wide Standardization, Consolidation, Expense Reduction and Value Creation Initiatives -** AHN has undertaken a system-wide expense reduction initiative to eliminate or reduce unnecessary expenditures and identify opportunities for cost containment as well as revenue enhancement. Critical initiatives undertaken by AHN include the following: (i) streamlining and simplifying the organizational structure, (ii) optimizing bad debt collections, (iii) consolidating facilities, (iv) terminating or restructuring leases and other contracts, (v) increasing clinical effectiveness by adopting better cost tracking methodologies, (vi) transforming care by creating savings through pharmacy clinical and non-clinical drug cost initiatives that are tracked utilizing purchase history data and calculated on an individual basis, (vii) decreasing care alignment leakage, (viii) cost reduction and revenue enhancement in physician services, and (ix) revenue cycle optimization. AHN's leadership feels that it is imperative to constantly evaluate business practices to see whether there are lower-cost alternatives that can be implemented to reach the same organizational goals.

- **Strategic Partnerships and Collaboration -** AHN has established strategic partnerships and collaborations with academic and healthcare institutions such as Johns Hopkins, Cleveland Clinic, Carnegie Mellon University and Robert Morris University. AHN is also designated as a U.S. Regional Olympics Medical Center. Such strategic partnerships and collaborations allow for AHN professionals and their colleagues at other institutions and organizations to exchange information and experiences to work toward best practices and deliver on an overall better way to meet the healthcare needs of the community and operate effectively and efficiently in the healthcare marketplace.

- **Educating Future Physicians and Healthcare Professionals -** AHN expanded and enhanced a key partnership with LECOM, the largest medical college in the nation and a leader in educating and training the next generation of physicians. With Forbes Hospital as the new clinical campus for LECOM medical students, the goal is to help address the growing national shortage of physicians and increase the number of physicians practicing in Western Pennsylvania. In addition to LECOM, AHN hospitals have long served as clinical campuses for medical students from Temple and Drexel Universities. AHN hospitals also serve as training sites for students pursuing health careers from local colleges and universities. Each year, AHN's two nursing schools train over 250 skilled professionals and its 20 residency and 24 fellowship training programs have produced more than 500 of the country's most talented physician specialists.

- **WPAHS Debt Refinancing -** In 2014, WPAHS and Highmark worked together to successfully refinance approximately $615 million in outstanding bond debt incurred by WPAHS with Highmark as a substantial bondholder. This debt refinancing allows WPAHS to achieve interest rate savings. As a result of the refinancing, Highmark was able to improve its investment portfolio by reducing the amount of non-investment grade bonds by approximately $581 million and reduce its overall financial leverage.

AHN Initiatives to Control Health Care Costs and Provide Access for the Community

AHN Initiatives to Control Health Care Costs and Provide Access for the Community

In addition to its efforts to turn around its system financially, AHN has undertaken various other initiatives which have reduced revenue to AHN but which are in line with Highmark Health's overall vision and strategy to reduce health care costs. Key benefits of these initiatives include:

- **Movement of Care to Lower Cost Settings -** AHN has moved care, as clinically appropriate, from the higher cost hospital setting to lower cost ambulatory surgery centers and other outpatient sites resulting in lower costs to both payers and the community.

- **Physician-Based Billing –** In many cases, AHN has chosen not to pursue the common practice of many hospitals of billing for services as facility-based, which increases the overall cost of care.

- **Focus on Preventable Readmissions -** AHN has focused on treating patients in alternative settings and providing additional care to help keep patients out of the hospital. Since 2014, readmission rates at AHN have been reduced by 9%.

- **AHN Support of Community Hospitals and Independent Physicians -** AHN has supported independent hospitals and the physicians in the region by expanding its scope of services, physician expertise and best practices into the areas of Indiana, Grove City, Titusville, Corry, Mon Valley, Clarion, Altoona, Somerset, Fayette, Armstrong, and other communities. AHN has its specialists travel to outlying communities (i.e., well over 20+ communities) to provide patient care. This provision of care reduces revenue to AHN facilities but results in less travel for AHN's patients and their families as well as benefits non-AHN community facilities. Also, efforts have begun to provide telemedicine capabilities to enable patients to receive expert specialist follow-up care within the four walls of their local community hospitals.

- **Diamond Care and General Shift to Outpatient Setting -** the Diamond Care initiative focuses on improving quality and efficiency by AHN and independent physicians by standardizing clinical protocols and emphasizing the management of the total cost of a clinical case through the selection of high quality, low cost sites of care. Highmark participated in this effort by changing reimbursement of these cases to a bundled payment to incent the physicians to select the high quality, low cost care protocol and sites. The bundled payment eliminated providers' financial incentive to deliver as much care as possible. The result is more standardized care that is higher quality and lower-cost. While the initial focus of the Diamond Care program was on orthopedics, the plan is to extend the program to other subspecialties.

Highmark Health and Highmark Initiatives to Control Health Care Costs and Provide Access for the Community

Highmark Health and Highmark Initiatives to Control Health Care Costs and Provide Access for the Community

Highmark Health and Highmark also have undertaken initiatives aimed at maximizing the inherent benefits of being part of a high functioning IDFS which includes an aligned provider arm. These initiatives have included the introduction of narrow network products (Community Blue), patient centered medical home models, accountable care organizations and the alignment of provider incentives. These programs have led to benefits, either tangible in the form of cost savings by shifting care to lower cost settings or intangible in the form of an overall better patient experience, to persons in the communities in which AHN and Highmark operate. The benefits and cost savings of these initiatives, which continue to be a strategic focus, include the following:

- **IDFS Savings -** Through the IDFS model, Highmark Health continues to be a leader and an innovator by seeking to change the conventional health care paradigm by moving from a reimbursement structure that rewards volumes to one that rewards outcomes and where care is delivered locally in the communities when appropriate. Since closing of the affiliation between Highmark and WPAHS, it is estimated, and an independent actuarial consulting firm has confirmed, that Highmark policyholders have realized IDN savings, as defined in the Order, of nearly $600 million through December 2014. For 2014, it is estimated that these savings amounted to approximately $3,075 in annual savings for a family of four in Western Pennsylvania. These are real and tangible savings that accrue to Highmark policyholders and subscribers that are a direct result of Highmark's decision to affiliate with WPAHS and create an IDFS. Without the affiliation and creation of the IDFS, Western Pennsylvania residents would have been subjected to higher premiums as a result of having only one dominant provider system which could have dictated monopolistic pricing. With the affiliation, these extra costs were averted.

- **Lower Cost Narrow Network Products -** Highmark continues to develop new product offerings that focus on a narrow network of lower-cost, high-quality healthcare providers with an emphasis on keeping care in the community. Through its Community Blue and Community Blue Flex products and its even more narrow network Connect Blue product that will be offered in 2016, Highmark continues to offer competitive and comprehensive coverage with lower premiums to the consumer than a broader network product can deliver. The design of these products includes tier levels of benefits with lower copays, coinsurance and deductibles for services provided by lower-cost, high-quality providers to encourage subscribers to utilize these facilities and affiliated providers. Such products are meeting consumer demand as the inherent value of these offerings are recognized as evidenced by the more than 500,000 subscribers that have chosen Community Blue since its inception.

- **Highmark Support of Community Hospitals and Physicians** - Highmark is pursuing many initiatives that focus on making sure that care is delivered in the appropriate setting and ensuring that a robust and vibrant network of providers is available to consumers, including, as a critical component, community hospitals and independent physician practices that provide meaningful choice in key service lines. Support by Highmark also includes its ongoing offering of various

pay-for-value programs that are designed to ensure, among other things, that hospital-employed and community independent physicians are aligned with the objective of keeping care within a patient/member's local community when appropriate. In addition, Highmark's long-standing Quality Blue pay-for-performance hospital program continues to work with community hospitals to provide financial incentives to encourage the hospitals to improve the quality of care within local communities by following national guidelines to, among other things, reduce infections and readmissions and to improve surgical safety and imaging efficiency.

- **Maintenance of Jobs and Valuable Community Assets -** By affiliating with Highmark, WPAHS was able to maintain its approximately 11,000 jobs in this region that would have otherwise been lost had WPAHS been forced to close its doors. By investing in WPAHS, Highmark also invested in valuable community assets, including the people of the region.

- **Establishment of Care in Underserved Communities** – Highmark has continued to invest in community assets to improve access. Evidence of this can be seen in Highmark's support for the recently opened Braddock Urgent Care Center that returned close-to-home healthcare services to the community in Braddock for the first time in five years since the community was abandoned by other providers.

The goal of the IDFS strategy has not changed since it was first announced in the fall of 2011. The overarching goal of the IDFS strategy is to continue to preserve and promote choice, competition and access in the Western Pennsylvania health care market. The IDFS strategy was made possible with the closing of the WPAHS affiliation as access to a full-service, patient-centered network of lower-cost, high-quality, highly efficient care providers was secured. When analyzing the value and benefits of implementing the IDFS strategy versus the costs associated with not implementing an IDFS, health care consumers would have been negatively impacted if they had been forced into a network with less capacity across the region that was fully controlled by a single, dominant provider. Instead, residents in Western Pennsylvania and elsewhere have seen the direct benefits from competition in the form of controlled health care spending and greater choice and access to care.

Strategic Actions Contemplated / Not Implemented

Strategic Actions Contemplated / Not Implemented

Highmark Health's strategic philosophy is to provide the right care, in the right setting and at the right price. Various actions could have been or could be taken by AHN to enhance financial performance. However, AHN has opted to pass on the savings of these items to payers and the community.

A key example of this relates to hospital-based billing, as discussed previously. AHN has opted not to bill all possible services at higher hospital-based reimbursement levels even though this reduces the revenue to AHN. External constituents have noted that this would be a prime vehicle to enhance the operating margin of the AHN system immediately. Highmark Health and AHN have determined, however, that this practice is not in keeping with their current strategic vision.

Certain initiatives that were contemplated in 2013 were not implemented. For example, AHN did not freeze pensions or salaries or eliminate employee benefits or eliminate unfunded research. AHN did not eliminate physician positions in order to maintain a particular cost structure. AHN did not outsource departments to improve financial performance. In addition, AHN did not undergo a large scale sale of non-core assets that are associated with hospital operations in order to cover operating expenses. In a downside scenario, deferring or reducing capital expenditures would have been considered; however, as evidenced by Highmark's request to the Department for approval to fund an additional $175 million in capital expenditures at AHN, AHN has not adopted this approach.

AHN also has chosen not to grow its footprint through affiliations with additional community hospitals. Although it has had a number of opportunities to participate in such activities, some of which could have offered benefits to it, AHN has not moved forward with those requests due to competing capital demands.

Highmark Health's Strategic Focus and AHN's Plan Objectives

Highmark Health's Strategic Focus and AHN's Plan Objectives

The goal of the Highmark Health enterprise is to change the way health care is delivered in a financially responsible manner. AHN is an integral part of this goal. As such, its focus and plan objectives are directly aligned with Highmark Health's strategic vision. AHN is transforming the delivery of care to patients in support of Highmark Health's mission to make high quality healthcare easily accessible, understandable and affordable. Building a patient-centered, cost effective, best-in-class organization has had obstacles, but significant progress has been made with focus on the following areas:

- Building and implementing a dynamic quality, safety and value structure designed to ensure usage of standardized best practices for clinical and operational processes, front-line problem-solving and performance monitoring and use of controls;
- Focusing on service values and the implementation of a new Press-Ganey contract, expanded to include all physicians, ancillary and ambulatory surgery services;
- Improving patient access, clinical response times and ensuring greater alignment of services by physicians across the system;
- Developing an engaged workforce that is empowered to effect change; and
- Implementing industry-proven technologies to better drive clinical and financial performance, including managing the continuum of care for patient health.

AHN has five plan objectives and supporting initiatives that it seeks to achieve:

- Quality and Safety
- Customer Service
- Growth and Access
- Financial Performance
- People

The key performance indicators on these objectives are established and tracked by management to regularly assess performance of supporting initiatives within each key objective. While not every plan objective can be directly correlated to the financial projections, achievement of these goals is critical to the turnaround plan.

Quality and Safety: Become a top performing healthcare provider that delivers care through optimal performance of priority clinical quality initiatives; ensure patients receive critical preventive health services; engage physicians in value-driven clinical programs; implement point-of-care, real-time problem solving and resolution that is employee driven and leadership supported.

The hospitals and clinicians of AHN have a long history of delivering patient care of the highest quality. Continuing that tradition and indeed further improving clinical performance to achieve and set new industry best standards in quality and safety is critical to the organization's future success. AHN is committed to assuring that maximum performance is achieved and maximum reimbursement received in all pay for value programs, including the Centers for Medicare & Medicaid Services' (CMS) STARS program, Highmark's Quality Blue and Medicare Gain Share initiatives, and other commercial payer pay for performance programs. By closing care access gaps across all segments of its health services, such as

annual wellness visits and recommended diagnostic screenings for patients, the goal is to achieve a minimum of four STARS consistently in the CMS program across all of its entities. AHN is also working diligently with its Accountable Care Organization to further increase the quality and value of the services it provides to Medicare patients and AHN has implemented a system-wide, employee driven operational excellence initiative that elevates quality and promotes value using a balanced score card approach with real-time problem solving and resolution.

Quality goals around core measures, patient safety events and hospital acquired infections are tracked and monitored regularly by 17 teams across AHN using various tracking tools to ensure continuous improvement in quality and patient satisfaction and outcomes. Certain measures have shown improvements including stroke appropriateness of care, venous thromboembolism appropriateness of care, emergency department throughput, pressure ulcers and acute average length of stay.

Customer Service: Enhance the patient, physician and employee experience by focusing on service-value initiatives that engage physicians, staff, patients and families using a robust communication and feedback platform; and improve access and usability of patient resources.

Providing for an exceptional patient experience across all affiliated sites of care and patient touch points is an important component of AHN's strategy for enhancing its brand perception, loyalty and service utilization. By focusing on the core criteria assessed by both the government's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and Press-Ganey and investing in AHN facility infrastructure and capabilities, the goal is to further establish AHN as a world class provider of care through the achievement of top-decile performance for all key patient satisfaction measures. AHN has established a comprehensive, multi-faceted internal campaign to educate and unite employees around this critical objective and to empower the employees to be change agents.

Performance on customer service measures has improved since 2013, as summarized below, with continued improvement expected throughout the projection period.

AHN Hospital HCAHPS Score	2013	2014	2015 *
Communication with Nurses	76.4%	76.4%	78.4%
Communication with Doctors	78.3%	78.4%	81.5%
Responsiveness of Hospital Staff	62.3%	61.2%	65.5%
Communication about Medicines	59.1%	58.9%	62.2%

* 2015 represents metrics as of July 2015.

Growth and Access: Ensure just-in-time patient access to physicians, hospitals and ancillary services through continued focus on care alignment and the expansion of the care continuum through the launch of Healthcare@Home, a program of home health, home medical equipment and supplies, infusion therapy, palliative care and hospice services; provide outlying community hospitals with access to world-class clinical expertise through a dynamic telemedicine program and continue to ensure patients receive care close to home through partnership arrangements with community hospitals.

Central to AHN's long-term success is its ability to grow the volume of patients it cares for through improved access to its facilities and physician practices, better coordination and alignment of that care across AHN's portfolio of services, investment in facilities and programs to expand their reach in the

community, and expansion of capabilities through investment in new diversified services and strategic partnerships. AHN is moving forward swiftly on all of these fronts. Initiatives to increase access and efficiency of services by maximizing throughput of hospital operations are showing demonstrable results across multiple priority areas, including emergency department care, operating rooms and lab and imaging services. Because effective patient care alignment leads to better outcomes, higher satisfaction and lower costs of care, AHN is focused intently on improving care alignment through investment in technology, such as a singular electronic health record, expanded access points for services, and more convenient and timely appointment scheduling protocols, among other initiatives. Care alignment and volume growth are also being positively impacted at AHN by its development of comprehensive post-acute care services, which provide synergistic home and community-based healthcare resources, such as home health, hospice care, home medical equipment, rehabilitation and home infusion therapy. Since launching its Healthcare@Home program in June 2015, AHN has steadily increased its capture of referral volumes for these services from its owned physician practices as well as from independent providers. AHN's growth and access strategy has driven the substantial investments it has made to expand services at its own facilities, such as Jefferson Hospital, Forbes Hospital and the Wexford Pavilion, as well as the collaborations it has established with independent hospitals through both telemedicine and the sharing of on-site physician expertise. AHN, for example, launched a new telestroke program in August 2015 to serve six Western Pennsylvania hospitals, with a goal of reaching nine affiliates by the first quarter of 2016. It also formed a joint venture with Emergency Medicine Partners to manage independent emergency departments at hospitals throughout the Western Pennsylvania region and formed a joint venture with Celtic to grow and expand hospice and home health services.

Goals on increasing access through maximizing throughput of hospital operations were established in 2015 through 2017 for emergency department door to doctor, door to discharge, door to admit and decision to admit timeframes.

Financial Performance: Position AHN to be financially sound and self-sustaining by improving revenue cycle operations to ensure fundamental billing and collection protocols are in place and adhered to; implement Epic in provider offices and hospitals; drive operational efficiencies in critical areas, such as the emergency department, ancillary services and the preoperational division; ensure capital improvement projects are prioritized to maximize growth, access and return on investment.

Achieving improved financial performance and becoming a self-sustaining operation is essential if AHN is to continue fulfilling its mission and realize its vision of becoming an integrated healthcare system that is recognized nationally for the quality, sophistication and scope of services it provides. AHN has taken significant strides to strengthen its financial position since forming in 2013, demonstrating a significant improvement in operations over that relatively short span of time while at the same time increasing the value to payers and the community. To continue and indeed accelerate that progress, AHN is focusing on every facet of its operations to find opportunities for greater efficiencies, best practices and innovations that will further solidify the foundation it has built for long term financial success. Among the key areas of focus are enhancing revenue cycle processes to ensure appropriate reimbursement for the provided care, improving care alignment, continued implementation of the Epic electronic health record to support the revenue cycle process and promote better coordination of care, generating efficiencies of scale in purchasing to reduce supply and pharmaceutical costs, reducing costs by implementing leading

clinical practices across AHN and reducing patient hospital stays through the establishment of best practices.

Revenue enhancement and expense initiatives targets and length of stay reduction goals have been included in the 2015-2017 financial projections. Reduction in length of stay targets by facility to geometric mean length of stay by 2017 have also been included in the financial projections.

People: Develop a physically and culturally safe working environment where leaders and employees are accountable for owning their actions and outcomes; champion problem solving. Focus on employee retention, recruitment and training, engagement and satisfaction.

Healthcare at its essence is about people caring for people, and AHN has worked assiduously over the past two years to unite its workforce around the organization's mission, vision and values. It has also focused on establishing a safe working environment and a culture of responsibility where leaders and employees both are accountable for outcomes and have the ability to champion problem solving and the development of new paradigms. AHN is making investments in the professional development of its workforce and focusing on enhanced programs for employee retention, recruitment and training. Recognizing the importance of having a productive relationship with both represented and non-represented employee groups, AHN is also focused on continuing its positive relations with organized workers through interest based bargaining and collaborations to achieve shared organizational goals and objectives.

Market Dynamics, Financial Projections and Key Assumptions

Market Dynamics

Improvements in AHN's financial performance over the last two years has taken place against a backdrop of a health care marketplace which – both regionally and nationally – has undergone and continues to undergo dramatic change. When Highmark made its initial projections of financial performance and patient volume at WPAHS, it cautioned that the projections would change as environmental factors in the marketplace evolved. That has proven to be true in several key areas:

- The originally projected affiliation timeline was delayed. This delay and market uncertainty afforded competitors the opportunity to acquire high-performing physician practices and hospitals to grow their geographic footprint compromising AHN's ability to compete in certain markets. This impacted projected volumes and increased physician practice acquisition and retention costs at AHN.

- There has been market confusion regarding the contracting status between Highmark and UPMC following UPMC's decision not to renew its contracts with Highmark, and the resulting Consent Decrees. The Consent Decrees included "safety net" provisions which have allowed Highmark subscribers who used a UPMC physician in 2014 to continue to see that provider for any services in 2015 and continuity of care provisions which further entitle many other persons to continue to utilize UPMC facilities. In addition, in 2014 the Consent Decrees were interpreted in a manner which limited Highmark's ability to offer true narrow network commercial products. As a result, the number of patients seeking AHN services has been lower than previously projected.

- An overall trend of low market utilization of health care services in Western Pennsylvania impacting the level of volumes at AHN.

- The conditions in the Order placed unanticipated restrictions on AHN's ability to renegotiate payer contracts. When projections were originally prepared, it was assumed that all payer contracts were at market rates with reasonable increases year-over-year to cover inflation. It was also assumed that payer contracts would be able to be negotiated or renegotiated either upon the occurrence of specified events or at specified intervals. The Order limited AHN's ability to address the above matters. The continuation of these contracts in unanticipated circumstances or beyond anticipated renewal terms has caused AHN's revenue projections to be lower than originally expected.

In addition, there are also various ongoing market factors that will continue to cause significant volatility in AHN's volume capture and financial performance including:

- The Commonwealth of Pennsylvania's ongoing litigation with UPMC involving questions relating to Medicare Advantage subscribers' access to UPMC facilities
- Final interpretation of the Consent Decrees, specifically as relates to the definition of "continuity of care"
- Changes in Highmark's enrollment
- Continued industry and market shifts to lower cost settings

- Payer and provider consolidations

These changing market dynamics make it difficult to predict utilization and volume which are primary drivers of a health system's financial performance.

Detailed Financial Projections and Key Assumptions

The Highmark Health enterprise underwent a significant capital planning process in 2014 that culminated in Highmark's December 2014 request for approval to make an additional $175 million grant to AHN for capital projects. This request was approved by the Department in June 2015 subject to certain conditions, including the completion of an updated set of three-year financial projections and the submission of (a) the Preliminary AHN Corrective Action Plan, filed on July 15, 2015; and (b) this Final AHN Corrective Action Plan.

In response to the conditions in the Approval Letter, Highmark Health is submitting AHN's performance projections over the next three years, incorporating the impact of the evolving market realities and outlining a set of continued improvement action items. The financial projections were prepared using actual results for the five-month period from January 2015 to May 2015 and projected for the remaining seven months of 2015. The 2015 baseline budget was prepared at a facility level based on historical 2014 financial results, industry and actuarial assumptions on inpatient and outpatient volume trends, utilization and acuity, specific payer contract rate adjustments, expected inflation rates, and consideration of specific revenue enhancement and expense reduction initiatives. Assumptions were applied to each component of revenue and operating expense in the 2015 baseline year to develop the 2016 and 2017 projections at each facility. Significant assumptions in the projection period include volumes (industry trend, shift of care between inpatient and outpatient settings and interpretation of the Consent Decrees), contracted and expected payer rates, expense inflation, and continued achievement on revenue enhancement and expense initiatives. Significant drivers within the forecast model include inpatient discharges, outpatient registrations, adjusted patient days, length of stay and historical relationships between volumes and patient care expenses. Such assumptions and drivers are described in detail below.

The updated three-year projections for the Corrective Action Plan display improved operating cash flow and earnings before interest, taxes, depreciation and amortization (EBITDA) along with a significant decrease in operating losses since AHN was formed as well as increased volumes. Management and the Boards of Directors of Highmark Health and AHN consider these projections and their related assumptions to be reasonable and likely attainable, reflecting the significant progress that has been made, while recognizing that more opportunities are available. The 2015 financial results reflected below represent a change from the information included in the Preliminary CAP filed with the Department in July. In the Preliminary CAP for 2016 and 2017, a factor of conservatism was included in the projections to address volatility in the environment; however, this factor was not included for 2015. For purposes of consistency and in line with common forecasting practices, the Final CAP incorporates a factor of conservatism worth 0.5% of revenue in the second half of 2015 to account for unfavorable developments that could occur in the latter part of 2015.

A summary of overarching key financial outcomes and assumptions is included below:

$ in Millions	2015 Plan	2016 Plan	2017 Plan
Total Revenues	$ 2,613	$ 2,735	$ 2,835
Total Operating Expenses	2,661	2,764	2,843
Operating Loss	(48)	(29)	(8)
Interest Expense	(31)	(31)	(31)
Investment Income	20	21	22
Other Non-Operating Activity	13	(4)	(8)
Net Loss	$ (46)	$ (43)	$ (25)
EBITDA	$ 78	$ 107	$ 131
Operating Margin	(1.8%)	(1.1%)	(0.3%)
Net Margin	(1.8%)	(1.6%)	(0.9%)
Cash Flow from Operations	$ 30.2	$ 55.5	$ 61.7
Days Cash on Hand	76.7	73.3	60.7
Hospital Inpatient Discharges	85,817	87,235	88,890
Hospital Outpatient Discharges	1,271,509	1,318,433	1,360,661

AHN's operating performance is projected to improve over the projection period from an operating loss in 2014 of $37 million to an operating loss in 2017 of $8 million, an improvement of $29 million. Cash flows and EBITDA are also projected to improve each year over the projection period. Generally, operating performance is pressured each year by certain inadequate payer rates and inflationary costs. These factors are offset by increased volumes, performance improvement initiatives and investments in the future that begin to provide a return to the system.

Operating Results Assumptions 2015-2017

A summary of key assumptions which are expected to impact AHN's operating performance over the projection period are summarized below:

Volume: Overall, total AHN inpatient volumes are projected to increase by approximately 2% per year from 2015-2017 while outpatient registrations are projected to increase by over 3% per year from 2015-2017. Volumes were projected using baseline volumes for each AHN facility from 2014, evaluated for reasonableness based on actual volumes through August 2015 and adjusted for several key items including market shift and trend, changes in Highmark enrollment and product mix, the impact of the contract termination between Highmark and UPMC and other payer volumes.

Payer Payments: The 2015 projections incorporate commercial payer payments based on contracts currently in place and include anticipated fee schedule reimbursements and anticipated quality incentive and other payments. In future years, the projections assume that certain fee schedule payments increase for inflation and contracted terms and, upon expiration, are renewed at competitive market rates.

In addition, physician affiliation payments from Highmark to AHN, approved in the Order, totaling $30 million in both 2015 and 2016 are included in the projections. No further physician affiliation payments are projected beginning in 2017.

Expense Inflation: Operating expenses for 2015 have been projected based on actual run rates through August 2015 and aligned to the inpatient discharges and outpatient registration volume assumptions noted above.

Case mix index, which represents the weighted average diagnosis-related group case weight for each hospital's inpatient volume, is assumed to remain consistent throughout the projection period.

Projected salaries and benefits are comprised of fixed and variable components for each hospital, physician organization and outpatient center and include an inflator per year in 2016 and 2017 which is in line with industry trend and market conditions.

Supplies and drugs include implants and other medical/surgical supplies, blood and pharmaceuticals and are projected to increase in both 2016 and 2017, also in line with industry trends.

Other operating expenses include insurance expenses related to risk-prevention, professional fees and purchased services and system-wide service expenses that represent costs incurred by AHN and allocated to each hospital and other entity. These items are expected to remain reasonably consistent during the projection period.

Expense reduction through efficiency and revenue improvement initiatives

In light of the uncompetitive market rates from payers and ongoing inflation of expenses, improvements in AHN's financial projections over the projection period are driven by revenue enhancement and expense reduction initiatives.

Enhanced revenue cycle processes and improved care alignment processes to keep referrals within the AHN system are expected to drive higher net patient revenues. Care alignment improves care by increasing referral retention across AHN. There is significant improvement included within the revenue cycle related to accelerated cash collections and designing and implementing leading practice revenue cycle processes and operating models, which increase payments from both government and commercial payers by providing more accurate and complete billing records to facilitate the appropriate contracted payment. Revenue cycle improvement also includes identifying and capturing reimbursement related to unpaid coinsurance and deductible amounts.

Expense reduction initiatives are also planned to generate margin improvement over the projection period. These savings include various labor, non-labor, and merit initiatives. In addition, savings are obtained through optimizing AHN's operating model and reducing costs in physician services and facility support services.

Significant efforts to decrease length of stay, including the establishment of a dedicated multi-specialty rounding team at each facility, a standardized approach to a patient's diagnosis, care plan and discharge planning, and establishment of a length of stay system-wide task force responsible for monitoring of

service line metrics, individual provider outliers and corrective action plans will increase patient satisfaction and decrease expenses.

The GPO is expected to generate improvement via volume purchasing discounts and standardization of products and devices. The GPO expects to continue contributing savings to the CAP, although many categories with the largest savings opportunity have been addressed; implants, janitorial services, transcription as examples. In future years, savings are projected to be seen in a larger number of smaller value initiatives.

Investments in the future: AHN is investing heavily in the near term to better serve AHN's existing patient base and to strategically reach new populations. In 2015, these types of investments are expected to negatively impact results when compared to 2014, pressuring results in the near-term prior to volumes associated with these investments ramping up to full capacity. These investments include new physicians in the Allegheny Clinic, the implementation of Epic and duplicative costs associated with operating multiple operating platforms during implementation of the Epic system and investments in and the growth of diversified businesses within AHN.

AHN is investing in the Epic electronic health record technology, as noted earlier. To date, 80 physician practices and 220 office locations are live on Epic, as is Forbes Hospital, the Wexford Pavilion and the AHN Urgent Care Center in Braddock. Epic installation and rollout is anticipated at AGH and West Penn Hospital in early 2016. The business case for the installation of Epic at SVH and Jefferson Hospital and the other remaining facilities is currently being evaluated and is not included in the projections.

Diversified businesses are and will continue to be an important part of AHN's growth strategy. Currently, diversified business includes durable medical equipment, home health and hospice, infusion therapy and rehabilitation businesses. AHN expects to increase market share for patients requiring these services with the continuum of care shift from acute care to post-acute care and a focus on increased physician care alignment. At the same time, AHN expects to realize efficiencies in the diversified business operating structure. AHN continues to evaluate opportunities to diversify its business operations.

Other investments include various systems and staffing to make corporate services more efficient, and are a necessary investment as processes consolidate. Examples include centralized call center build out and software such as purchasing, timekeeping, budgeting and enterprise resource planning. Advertising and branding is also a significant but necessary expense.

Non-Operating Activity Assumptions 2015-2017

A summary of key assumptions that are projected to impact AHN's non-operating activity over the projection period are summarized below.

Interest Expense: Projections assume interest expense based on terms of existing debt agreements throughout the projection period.

Investment Income: Investment results are projected to increase slightly each year over the projection period as a result of an expected increase in interest rates and portfolio updates partially offset by a decrease in average investment balances due to capital expenditures. AHN treasury functions have been centralized and consolidated at Highmark Health and, in 2014, an asset allocation evaluation was

undertaken which in combination with increasing active management and higher yields will increase investment income as a percentage of total asset base.

Other Income (Expense): AHN has realized one-time gains in 2015 associated with settlement of debt and the sale of minority interest in a joint venture, offset by miscellaneous other expense. These one-time items are not projected to recur, but there is an expectation that some miscellaneous expense will continue, although at a lower level.

Net Income Attributable to Non-Controlling Interest: This amount is projected to grow each year in the projection and represents minority interest of AHN's growing investments in diversified businesses. The bottom line impact is favorable as total operating gains exceed the portion of the non-AHN share represented in non-operating expense.

Projected Capital Expenditure Assumptions 2015-2017

	2015 Plan	2016 Plan	2017 Plan
CAPEX	$ 213	$ 155	$ 139
Depreciation	$ 126	$ 137	$ 139
CAPEX as a % of Deprec.	170%	113%	100%

In addition to the $175 million earmarked for capital expenditures noted earlier, AHN has a broader capital investment plan based on available cash and focused on quality and safety, customer service, growth and access, financial performance and sustainability.

The level of expected capital investment by year as a percentage of depreciation is slightly lower than industry benchmarks in 2017 and excludes the investment in Epic as that technology is funded by Highmark Health and charged to AHN.

Given the historically low level of investment prior to the WPAHS affiliation, AHN will continue to evaluate the ability to expedite capital investment in the facilities. Additional strategies are being explored to identify external sources of capital funding via donations or other sources. To the extent that available operating cash flow changes from the current projections, the capital expenditure plan will adjust accordingly. The $175 million grant from Highmark to AHN will be provided in installments based upon actual AHN capital expenditures and in alignment with intended uses as provided to the Department. Additionally, if immediate investments are required for critical care issues, days cash on hand (DCOH) may vary from current projections.

The Highmark Health enterprise is committed to offering health care provider choice to the subscribers and patients it serves and will continue to partner with community hospitals and physicians to enable them to continue to operate independently. As such, the projections do not assume the expansion of hospital assets through acquisition. In addition, the capital projections do not include any expansion or closure of AHN facilities. To the extent that additional capital investment is required, these needs and the source of funding will be identified, and, if necessary, submitted to the Department.

Balance Sheet and Assumptions 2015-2017

The projected balance sheets as of December 2015-2017 and key assumptions are as follows:

	2015 DEC	2016 DEC	2017 DEC
ASSETS			
Cash & Cash Equivalents	$ 102,295	$ 93,964	$ 96,293
Net Patient Accounts Receivable	258,683	244,783	247,283
Other Receivables	65,431	66,527	67,223
Inventory, Net	47,700	48,700	49,400
Prepaid Expenses & Other Current Assets	45,110	45,070	45,030
Total Current Assets	519,219	499,044	505,229
Unrestricted - Board Designated Funds	165,620	159,620	153,620
Temporarily Restricted	19,400	19,500	19,600
Permanently Restricted	268,500	268,634	268,768
Total Assets Restricted As To Use	453,520	447,754	441,988
Property, Plant & Equipment - Net	1,071,832	1,090,104	1,089,984
Investments	271,100	280,100	205,100
Goodwill and other intangible assets, net	118,400	118,400	118,400
Other Assets, Net	173,700	175,700	173,700
Total Long-Term Assets	1,635,032	1,664,304	1,587,184
TOTAL ASSETS	**$ 2,607,771**	**$ 2,611,102**	**$ 2,534,401**

	2015 DEC	2016 DEC	2017 DEC
LIABILITIES & NET ASSETS			
Accounts Payable and Accrued Expenses	$ 219,600	$ 222,100	$ 224,600
Accrued Salaries and Benefits	98,800	98,800	99,300
Total Debt	1,427,025	1,420,134	1,414,613
Benefit Plan Liabilities	379,772	333,861	286,949
Other Liabilities	253,300	253,300	250,800
Total Liabilities	2,378,497	2,328,195	2,276,262
Unrestricted Net Assets	(58,626)	(5,227)	(30,229)
Temporarily Restricted Net Assets	19,400	19,500	19,600
Permanently Restricted Net Assets	268,500	268,634	268,768
Total Net Assets	229,274	282,907	258,139
TOTAL LIABILITIES & NET ASSETS	**$ 2,607,771**	**$ 2,611,102**	**$ 2,534,401**

- Assets
  - Days in accounts receivable is projected to decrease as revenue cycle operations are optimized and projected cash collection delays associated with Epic and ICD-10 normalize.
  - Capital spend on fixed assets is projected to increase partially offset by incremental depreciation
  - Investment balances are projected to decline over the projection period as assets are sold to fund projected capital spend.
  - Goodwill is projected to maintain its carrying value over the projection period.

- Liabilities
  - No incremental debt is projected
  - Benefit plan contributions are assumed to be slightly higher than minimum funding requirements based on current funding levels and investment results

- Net Assets
  - Net losses on the income statement are projected to be partially offset by Highmark equity transfers in 2015 and 2016 related to the approved $175 million in capital investments and remaining equity transfers contemplated by the Order. No equity transfers from Highmark are projected in 2017.

Cash Flow Statements and Assumptions 2015-2017

A condensed summary of the projected cash flow statements in 2015-2017 and key assumptions follows:

$ In Thousands	2015 Plan YTD DEC	2016 Plan YTD DEC	2017 Plan YTD DEC
Cash Flow From Operating Activities	$ 30,223	$ 55,460	$ 61,661
Cash Flow From Investing Activities	(205,421)	(158,132)	(58,534)
Cash Flow From Financing Activities	143,893	94,341	(798)
Net Cash	(31,305)	(8,331)	2,329
Beginning Cash	133,600	102,295	93,964
Ending Cash	$ 102,295	$ 93,964	$ 96,293

- Cash flow from operations is projected to increase each year in the projection period, as noted above, based on projected improvement in operating results, EBITDA and volumes across AHN.

- Cash flow from investing activities is projected to decline each year in the projection period as the level of investments focused on enhancing access and capabilities across AHN in 2015 shifts to system sustainability and patient satisfaction/access as additional volumes migrate, subject to available cash flow.

- Cash flow from financing activities remains high in 2015-2016 driven by capital transfers from Highmark as part of the $175 million capital grant along with remaining capital transfers contemplated by the Order. The amount in 2017 is close to breakeven with no equity transfers from Highmark projected.

Days Cash on Hand Assumptions 2015-2017

DCOH is directly impacted by the capital funds provided by external sources (i.e., grants, donations, etc.), Highmark Health investments, operating results and AHN capital expenditures. Funds scheduled to come from Highmark as described in the originally filed projections have been incorporated, some of which are reflected as equity transfers per applicable accounting guidance. Based on the aforementioned assumptions, DCOH is projected to be as follows:

	2015 Plan	2016 Plan	2017 Plan
Days Cash on Hand	76.7	73.3	60.7

DCOH is projected to decline over the projection period as investments in the system are made and capital is managed to maintain adequate / prescribed levels while AHN's operating results improve. The projections assume that capital expenditures and operating results approximate identified levels on an annual basis. To the extent that operating cash flow is limited and capital expenditures are required beyond estimated levels, DCOH will be negatively impacted.

Additional key assumptions related to DCOH and cash flow projections include the impact of IT investments. The projections assume a cash delay related to the Epic conversion in the near term as staff and physicians orient to a new electronic health records system and associated revenue cycle processes.

AHN expects those delays to stop following the completion of the conversion process. To date, 80 physician practices and 220 office locations are live on Epic, as is Forbes Hospital, the Wexford Pavilion and the AHN Urgent Care Center in Braddock. Epic installation and rollout is anticipated at AGH and West Penn Hospital in early 2016. The cost and timeline for the installation of Epic at SVH and Jefferson Hospital and the other remaining AHN facilities is currently being evaluated and is not included in the projections.

The projections incorporate costs of additional coding resources related to the conversion of the government-mandated ICD-10 medical billing coding system in order to manage the potential for cash delays associated with the change. Uncertainty in the governmental requirements and provider / payer preparedness could impact AHN's ability to manage this conversion and its cash impact.

Risks and Opportunities to Financial Performance

Risks and Opportunities Applicable to Financial Performance

AHN is providing a reasonable estimate of its projected financial performance; however, uncertainty continues in the local market and significant market disruption from broader industry impacts such as national healthcare reform remains a risk. As such, a summary of key risks and opportunities that could impact the projections is reflected below:

Risks

- A general decline in claim trend could lower AHN volumes across all service lines
- Higher than anticipated expense inflation
- Large scale system implementations which could cause temporary inefficiencies as staff become experienced with new systems and procedures. Cost estimates could vary from what is included in the projections.
- Achievement of improvement initiatives
- The projections are subject to various market fluctuations, including changes in interest rates that could have an impact on various financial statement areas including goodwill, investments and benefit plans. The projections do not assume any material change related to these market fluctuations.
- Regulatory changes
- Payer contracting – unfavorable resolution of payer contract rate dispute
- Highmark's ongoing arbitration with UPMC involving questions related to Highmark Medicare Advantage subscribers' access to UPMC facilities
- Changes in the level of Highmark subscribers

Conversely, opportunities could enhance financial performance. Such opportunities include:

- Consent Decrees interpretation – AHN's anticipated increase in volume resulting from the continuity of care provisions within the Consent Decrees has been calculated based on a conservative model. The projections assume UPMC's broad interpretation of continuity of care. If a different definition were used regarding continuity of care, AHN's volumes could change.
- Transfer to value based reimbursement – As AHN pursues a care delivery model that emphasizes shifting care to lower costs settings, including the home, it will be essential that the system shift to a value based reimbursement model with payers that reward AHN for this behavior.
- Higher enrollment in tiered and narrow network products at Highmark
- Expense initiatives
    - Improvement in length of stay reduction initiatives
    - Reduction in advertising and branding costs
- Incremental efficiencies from Epic implementation, including improved care alignment
- Expense inflation is lower

Impacts of Volatility

AHN has evaluated various scenarios and modeled potential ranges of outcomes, both favorable and unfavorable, relative to the baseline projections. Based on this evaluation, AHN could see outcomes of +/- $50 million in 2016 and + $100 million to - $50 million in 2017 relative to the amounts that are included in the CAP.

The downside outcome does not include the impact of any actions to be taken by management (e.g., scale back capital spending, sell non-core assets, further reduce cost structure). However, even without any management actions, AHN is still projected to show positive EBITDA.

Financial Commitments

Financial Commitments

No additional Financial Commitments (including Donations) (each as defined in the Order) are included in the Corrective Action Plan. Highmark Health is currently engaged in a comprehensive five year strategic planning process. The outcomes of that process will not be known for several months. As the company gains clarity regarding the strategic direction for the next five years, and the tactics and actions to be taken in conjunction with this work, the projections contained in this Corrective Action Plan will be updated. Specific items currently being evaluated include:

- Expansion of pre- and post-acute care, site of service shifts, asset rationalization and further insurance product introductions
- Expansion of settings, services and technology for further market coverage
- Epic expansion at Jefferson Hospital and SVH

To the extent that Highmark Health's updated strategy results in the identification of any additional Financial Commitments, such information will be communicated to the Department in a timely fashion. To the extent that any such Financial Commitments require that notice be provided or obtained from the Department under the Order, Highmark will seek such approval in a timely fashion.

Quality and Innovation Enhancements

Quality and Innovation Enhancements

While the primary focus of this document is financial improvement, it is critical to understand the advancements AHN has made and continues to drive in the community regarding access to the highest quality care today and for the future. AHN has aligned with Highmark in its mission to improve access to care in the community whenever medically appropriate. Not only does this enhance the economic viability and quality of life in local communities but studies show that care closer to home leads to better medical outcomes and fewer readmissions and medical complications. AHN continues to support this effort to provide more accessible and affordable care by moving many of its specialists out of its central quaternary facilities and into community settings, including owned facilities and independent community hospitals. AHN also is moving more care, again where medically appropriate, from higher-cost in-patient settings to lower-cost outpatient settings. Importantly, AHN is doing all this even though it receives less revenue from these strategies.

AHN has also worked effectively to recruit leading physicians from inside and outside the market to address areas of need in the community, including physicians in primary care, orthopedic surgery, neurology, cancer, women's health, diabetes and cardiology, among others.

Technology improvements are vital in making the Highmark-AHN integrated delivery model work. The implementation of Epic, the best-in-class of integrated electronic health records, will improve efficiency, quality, cost of care, and the patient experience.

AHN has taken significant steps to further enhance the high quality, comprehensive scope and availability of its clinical, research and academic programs through collaborations with leading national organizations. AHN actively engages in various collaborative programs and initiatives with thought-leading and ground-breaking provider organizations and education systems such as Johns Hopkins, Carnegie Mellon and LECOM to evolve care to the betterment of our community.

Additionally, physicians and researchers at AHN are advancing quality of care and innovation in many disciplines, including allergy, asthma and autoimmunity; biofilms; cancer; cardiovascular diseases; esophageal diseases; orthopedics; psychiatry; and the neurosciences. AHN has more than 400 active research projects in progress; nearly 150 clinicians are serving as principal investigators. In addition, AHN is offering patients the opportunity to participate in a wide array of clinical trials, giving these patients access to promising new treatments that are not yet available to the general public.

Diligence Process of the
Highmark Health Board of Directors

Diligence Process of the Highmark Health Board of Directors

The Boards of Directors of Highmark Health and AHN receive regular reports with respect to the financial condition of AHN and its planned or intended strategies to address the same. The Boards have been kept apprised of the need to produce this CAP. The Boards have reviewed and approved the CAP as submitted.

Review of Corrective Action Plan
By Independent External Financial Expert

Review of Corrective Action Plan by Independent External Financial Expert

Outside counsel for Highmark Health engaged Grant Thornton to perform an independent external financial expert review of the final Corrective Action Plan as required by the Department. Based on its review, Grant Thornton concluded to the best of its knowledge and belief that:

- The Corrective Action Plan appears reasonable;
- The Corrective Action Plan is sufficient to meet the Plan Objectives;
- There will continue to be benefits to Highmark and its policyholders; and
- The value of Highmark's investments in AHN as presented to the Department is reasonable.

Refer to Appendix C for a copy of this report.

Appendices

Appendix A – Financial Statements and Key Metrics

Attached are the following financial statements and key metrics being provided pursuant to the Department's Approval Letter:

- AHN Consolidated Balance Sheets, Income Statements and Cash Flows for 2015-2017
- AHN Consolidated Annual Days Cash on Hand for 2015-2017
- AHN Consolidated Annual Debt Service Coverage Ratios for 2015-2017
- Projected Annual Inpatient Discharges and Outpatient Registrations by AHN Entity for 2015-2017 along with Projected Occupancy Rates
- Schedule of Projected Salaried and Non-Salaried Employees For Each AHN Entity and in Total

Allegheny Health Network
Consolidated Balance Sheet
(Dollars in Thousands)

	2015 DEC	2016 DEC	2017 DEC
ASSETS			
Cash & Cash Equivalents	$ 102,295	$ 93,964	$ 96,293
Net Patient Accounts Receivable	258,683	244,783	247,283
Other Receivables	65,431	66,527	67,223
Inventory, Net	47,700	48,700	49,400
Prepaid Expenses & Other Current Assets	45,110	45,070	45,030
Total Current Assets	519,219	499,044	505,229
Unrestricted - Board Designated Funds	165,620	159,620	153,620
Temporarily Restricted	19,400	19,500	19,600
Permanently Restricted	268,500	268,634	268,768
Total Assets Restricted As To Use	453,520	447,754	441,988
Property, Plant & Equipment - Net	1,071,832	1,090,104	1,089,984
Investments	271,100	280,100	205,100
Goodwill and other intangible assets, net	118,400	118,400	118,400
Other Assets, Net	173,700	175,700	173,700
Total Long-Term Assets	1,635,032	1,664,304	1,587,184
TOTAL ASSETS	**$ 2,607,771**	**$ 2,611,102**	**$ 2,534,401**
LIABILITIES & NET ASSETS			
Accounts Payable and Accrued Expenses	$ 219,600	$ 222,100	$ 224,600
Accrued Salaries and Benefits	98,800	98,800	99,300
Total Debt	1,427,025	1,420,134	1,414,613
Benefit Plan Liabilities	379,772	333,861	286,949
Other Liabilities	253,300	253,300	250,800
Total Liabilities	2,378,497	2,328,195	2,276,262
Unrestricted Net Assets	(58,626)	(5,227)	(30,229)
Temporarily Restricted Net Assets	19,400	19,500	19,600
Permanently Restricted Net Assets	268,500	268,634	268,768
Total Net Assets	229,274	282,907	258,139
TOTAL LIABILITIES & NET ASSETS	**$ 2,607,771**	**$ 2,611,102**	**$ 2,534,401**

Allegheny Health Network
Consolidated Statement of Operations
(Dollars in Thousands)

	2015 YTD DEC	2016 YTD DEC	2017 YTD DEC
Net Patient Revenues	$2,423,282	$2,543,435	$2,669,807
Other Operating Revenues	189,508	191,065	165,483
TOTAL REVENUES	**2,612,790**	**2,734,500**	**2,835,290**
Salaries	1,242,139	1,302,979	1,351,817
Benefits	218,150	229,226	238,473
Professional Fees & Purchased Services	279,701	266,947	266,172
Patient Care Supplies & Drugs	467,205	499,277	527,216
Insurance	33,792	34,150	34,569
Other Operating Expenses	290,557	294,620	285,778
Depreciation and Amortization	125,543	136,626	139,420
Restructuring	3,706	-	-
TOTAL OPERATING EXPENSES	**2,660,793**	**2,763,825**	**2,843,445**
OPERATING INCOME (LOSS)	**(48,003)**	**(29,325)**	**(8,155)**
Interest Expense	(31,342)	(30,857)	(30,505)
Investment Income	19,746	20,770	21,615
Gifts and Donations	1,066	978	978
Other Income (Expense)	10,129	(1,615)	(1,614)
Net Income Attributable to Non-Controlling Interest	(1,084)	(6,388)	(10,660)
Income Tax Benefit	3,150	3,335	3,335
NET (LOSS) INCOME	**$ (46,338)**	**$ (43,102)**	**$ (25,006)**
EBITDA - Using Operating Income	77,540	107,301	131,265
Operating Margin	-1.8%	-1.1%	-0.3%
Net Margin	-1.8%	-1.6%	-0.9%

Allegheny Health Network
Consolidated Statement of Cash Flows
(Dollars in Thousands)

	2015 YTD DEC	2016 YTD DEC	2017 YTD DEC
Cash Flow from Operating Activities			
Increase (Decrease) in Net Assets	$ 108,527	$ 53,633	$ (24,768)
Depreciation & Amortization	125,543	136,626	139,420
Gain on Extinguishment of Debt	(7,500)	-	-
Provision for Doubtful Accounts	83,117	87,085	90,426
CAPEX Equity Transfer from Highmark	(96,400)	(78,600)	-
Other Equity Transfers	(40,100)	(17,900)	-
Restricted Contributions	(4,734)	(4,732)	(4,723)
(Increase)/Decrease in:			
Accounts Receivable	(104,000)	(73,185)	(92,926)
Other Receivables	27,669	(1,096)	(696)
Inventories, Prepaid Expenses & Other Current Assets	(14,210)	(960)	(660)
Other	(13,500)	(2,000)	2,000
Increase/(Decrease) in:			
Accounts Payable & Accrued Expenses	15,300	2,500	3,000
Accrued Pension Liabilities	(41,489)	(45,911)	(46,912)
Other Noncurrent Liabilities	(8,000)	-	(2,500)
Cash Flow from Operating Activities	30,223	55,460	61,661
Cash Flow from Investing Activities			
Capital Expenditures	(213,101)	(154,898)	(139,300)
(Purchases)/sales of investments	7,680	(3,234)	80,766
Cash Flow from Investing Activities	(205,421)	(158,132)	(58,534)
Cash Flow from Financing Activities			
Payment of Debt	(29,341)	(6,891)	(5,521)
CAPEX Equity Transfer from Highmark	96,400	78,600	-
Other Equity Transfers	40,100	17,900	-
Restricted Contributions	4,734	4,732	4,723
Additional Financing	32,000	-	-
Cash Flow from Financing Activities	143,893	94,341	(798)
Cash Summary			
Beginning Cash Balance	133,600	102,295	93,964
Net Change in Cash	(31,305)	(8,331)	2,329
Ending Cash Balance	$ 102,295	$ 93,964	$ 96,293

Allegheny Health Network
Consolidated Days Cash on Hand
(Dollars in Thousands)

	2015 YTD DEC	2016 YTD DEC	2017 YTD DEC
Cash and cash equivalents	$ 102,295	$ 93,964	$ 96,293
Investments	271,100	280,100	205,100
Board designated	165,620	159,620	153,620
Total	$ 539,015	$ 533,684	$ 455,013
Total operating expenses	$ 2,660,793	$ 2,763,825	$ 2,843,445
Add: interest expense*	31,342	30,857	30,505
Less: depreciation and amortization	(125,543)	(136,626)	(139,420)
Total	$ 2,566,592	$ 2,658,056	$ 2,734,530
Days in period	365	365	365
Operating expense per day	$ 7,032	$ 7,282	$ 7,492
DAYS CASH ON HAND	**76.7**	**73.3**	**60.7**

*Note: Interest expense included in accordance with Master Trust Indenture

Allegheny Health Network
Consolidated Debt Service Coverage Ratio
(Dollars in Thousands)

	2015 YTD DEC	2016 YTD DEC	2017 YTD DEC
Net (Loss) Income	$ (46,338)	$ (43,102)	$ (25,006)
Add: depreciation and amortization	125,543	136,626	139,420
Add: interest expense	31,342	30,857	30,505
Total	**110,547**	**124,381**	**144,919**
Debt Service Requirement	$ 60,683	$ 37,748	$ 36,026
DEBT SERVICE COVERAGE RATIO	**1.82**	**3.30**	**4.02**

Note: 2015 debt service includes payments on WPAHS Floating Rate Restructuring Certificates of approximately $8 million and balloon payments on the WPAHS 2006 Series B debt of approximately $11 million. The forecast period does not include principal payments on the WPAHS $700 million term loans with PNC as principal payments for that debt are not required prior to December 31, 2017.

Allegheny Health Network
Schedule of Statistical Information by System
Year Ended December 31, 2015

	WPAHS	JRMC	SVH	Other AHN	Total AHN
Inpatient Discharges (Acute/Psych/Rehab)	56,847	14,217	14,753	-	85,817
Outpatient Registrations *	810,838	258,324	202,347	-	1,271,509
Occupancy Rates Using Available Beds	54.60%	52.10%	48.79%	-	53.2%
FTEs (Exempt)	2,892	258	633	180	3,963
FTEs (Non-Exempt)	8,423	1,261	1,801	63	11,548

Year Ended December 31, 2016

	WPAHS	JRMC	SVH	Other AHN	Total AHN
Inpatient Discharges (Acute/Psych/Rehab)	57,859	14,485	14,891	-	87,235
Outpatient Registrations *	842,690	268,230	207,513	-	1,318,433
Occupancy Rates Using Available Beds	55.4%	52.9%	49.1%	-	53.9%
FTEs (Exempt)	2,946	267	643	189	4,045
FTEs (Non-Exempt)	8,583	1,306	1,828	66	11,783

Year Ended December 31, 2017

	WPAHS	JRMC	SVH	Other AHN	Total AHN
Inpatiend Discharges (Acute/Psych/Rehab)	59,021	14,761	15,108	-	88,890
Outpatient Registrations *	870,637	276,630	213,394	-	1,360,661
Occupancy Rates Using Available Beds	56.35%	53.80%	49.70%	-	54.8%
FTEs (Exempt)	2,991	274	648	198	4,111
FTEs (Non-Exempt)	8,725	1,337	1,846	70	11,978

* Note: Outpatient registrations have been revised from the Preliminary Corrective Action Plan. An analysis on the impact of this change to the projected financial statements was performed and did not result in an adjustment.

Capital Investments Detail ($ In Millions)

	2015	2016	2017	Sched. Use
Allegheny General Hospital				
Nursing Unit Renovations	$ 13.5	$ 12.7	$ -	$ 26.2
Lab/Radiology Renovations	1.5	13.8	-	15.3
General Hospital Renovations	28.4	14.6	39.0	33.8
Replacements and Leases	18.2	15.2	27.6	3.6
Total Allegheny General Hospital	**$ 61.6**	**$ 56.3**	**$ 66.6**	**$ 78.9**
Allegheny Valley Hospital				
Outpatient Facilities	$ -	$ -	$ 10.0	$ -
General Hospital Renovations	1.1	0.1	1.3	0.1
Replacements and Leases	4.3	0.5	0.6	0.1
Total Allegheny Valley Hospital	**$ 5.4**	**$ 0.6**	**$ 11.9**	**$ 0.2**
Canonsburg Hospital				
General Hospital Renovations	$ 1.5	$ -	$ 0.1	$ -
Replacements and Leases	4.8	0.5	0.1	0.1
Total Canonsburg Hospital	**$ 6.3**	**$ 0.5**	**$ 0.2**	**$ 0.1**
Forbes Hospital				
ICU Renovations	$ 18.1	$ -	$ -	$ 16.7
General Hospital Renovations	0.3	5.3	1.6	0.3
Replacements and Leases	2.4	1.4	1.3	0.3
Total Forbes Hospital	**$ 20.8**	**$ 6.7**	**$ 2.9**	**$ 17.3**

	2015	2016	2017	Sched. Use
Jefferson Hospital				
Bethel Park ASC	$ 22.0	$ -	$ -	$ -
Strategic Acquisition-Radiation Onc.	4.0	-	-	-
Women's Health	-	3.6	-	-
General Hospital Renovations	3.4	1.7	0.1	1.4
Replacements and Leases	6.6	9.8	0.1	1.0
Total Jefferson Hospital	**$ 36.0**	**$ 15.1**	**$ 0.2**	**$ 2.4**
Saint Vincent Hospital				
Outpatient Facility	$ -	$ 7.8	$ -	$ -
Nursing Unit Renovations	2.8	2.5	-	5.3
General Hospital Renovations	5.7	10.4	5.0	1.9
Replacements and Leases	11.2	2.0	0.9	7.0
Total Saint Vincent Hospital	**$ 19.7**	**$ 22.7**	**$ 5.9**	**$ 14.2**
West Penn Hospital				
NICU	$ 1.4	$ 3.3	$ 21.3	$ 4.7
Autoimmune Specialty Suite	0.3	7.8	-	-
Unit Renovations (Post Partum)	3.9	-	-	3.9
General Hospital Renovations	4.5	0.5	6.2	8.9
Replacements and Leases	9.1	7.2	1.0	1.3
Total West Penn Hospital	**$ 19.2**	**$ 18.8**	**$ 28.5**	**$ 18.8**
Allegheny Health Network/IT				
Renovations	$ 9.2	$ 2.9	$ 1.0	$ 10.1
Strategic Acquisitions	2.0	4.0	4.0	9.3
Replacements and Leases	21.4	23.8	12.8	23.7
Total AHN/IT	**$ 32.6**	**$ 30.7**	**$ 17.8**	**$ 43.1**

	2015	2016	2017	Sched. Use
Allegheny Clinic				
Physician Practice Acquisition	$ 2.0	$ -	$ 5.0	$ -
Physician Office Renovations	4.6	2.2	-	-
Replacements and Leases	2.2	0.2	-	-
Total Allegheny Clinic	**$ 8.8**	**$ 2.4**	**$ 5.0**	**$ -**
ASRI				
Replacements and Leases	$ -	$ 0.2	$ -	$ -
Total ASRI	**$ -**	**$ 0.2**	**$ -**	**$ -**
Bethel				
Replacements and Leases	$ 0.6	$ -	$ -	$ -
Total Bethel	**$ 0.6**	**$ -**	**$ -**	**$ -**
Core Lab				
Replacements and Leases	$ 1.1	$ 0.9	$ -	$ -
Total Core Lab	**$ 1.1**	**$ 0.9**	**$ -**	**$ -**
Monroeville				
Replacements and Leases	$ 0.2	$ -	$ -	$ -
Total Monroeville	**$ 0.2**	**$ -**	**$ -**	**$ -**
Wexford				
Replacements and Leases	$ 0.8	$ -	$ -	$ -
Total Wexford	**$ 0.8**	**$ -**	**$ -**	**$ -**
AHN Combined Total	**$ 213.1**	**$ 154.9**	**$ 139.0**	**$ 175.0**
AHN Spend YTD July 2015	**$ 93.2**			

Appendix B – Timeline of Investments at AHN

Appendix C – Report of Independent External Financial Expert

ALLEGHENY HEALTH NETWORK

ASSESSMENT OF FINAL CORRECTIVE ACTION PLAN

September 30, 2015

Grant Thornton
An instinct for growth™

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LIMITATIONS OF REPORT

September 30, 2015

Mr. Jack M. Stover, Esquire
Shareholder
Buchanan Ingersoll & Rooney PC
409 North Second Street, Suite 500
Harrisburg, Pennsylvania 17101-1357

Re: Highmark Health – Final AHN Corrective Action Plan

Dear Mr. Stover:

This draft report is provided in response to the request by the Pennsylvania Insurance Department ("PID" or "the Department") to have Highmark Health hire a Financial Commitment Reviewer to provide an opinion as to (1) the reasonableness of the Final Allegheny Health Network ("AHN") Corrective Action Plan; (2) the sufficiency of the final AHN Corrective Action Plan to accomplish the Plan Objectives; (3) the specific level of benefits and costs to be borne by Highmark's policyholders and (4) the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investments in AHN.

This report is based on information provided by AHN, Highmark Health, and Buchanan Ingersoll & Rooney PC ("Buchanan") collectively, the "Parties". Grant Thornton LLP ("Grant Thornton", "Us", "Our" or "We") has relied, and is relying, on the accuracy and validity of the information supplied without seeking to independently verify that information.

Our work was performed under the terms of our engagement letter with Buchanan and in accordance with the Statement on Standards for Consulting Services promulgated by the American Institute of Certified Public Accountants and Uniform Standards of Professional Appraisal Practice. Our work does not constitute an audit of the financial statements or any part thereof, the objective of which is the expression of an opinion or limited assurance on the financial statements, or a part thereof, or verification of the accuracy of management responses to our inquiries. Our work should not be relied upon to disclose errors, irregularities, or illegal acts, including fraud or defalcations.

Pursuant to the terms of our engagement by Buchanan, our report, supporting schedules and other materials generated during the engagement are solely intended for the use of Highmark Health, its subsidiaries and affiliates and inclusion in the Final AHN Corrective Action Plan filing with the Pennsylvania Insurance Department. By accepting a copy of this report, each recipient and each of their professionals agree to keep all information contained herein confidential and agree not to distribute the report or any portion thereof to any other party without our prior written approval.

By obtaining and reading this report, the reader acknowledges and agrees to the following terms and restrictions, in addition to the terms and restrictions set forth in any required release letter with Grant Thornton LLP.

The reader of this report understands that the work performed by Grant Thornton was performed in accordance with instructions provided by Buchanan and was performed exclusively for the sole benefit and use of Highmark Health, its subsidiaries and affiliates and Buchanan in Highmark's confidential PID filings. As a result this report may not reflect all procedures deemed necessary for the purposes of the reader. Therefore, the reader is responsible for determining

the scope of, and performing, any other investigative procedures with respect to the matter covered by this report and otherwise.

The reader agrees that he or she does not acquire any rights as a result of such access and acknowledges that Grant Thornton does not assume any duties or obligations to the reader in connection with such access. The reader also agrees to release Grant Thornton and its personnel from any claim by the reader that arises as a result of having access to the report. Further, the reader agrees that this report is not to be referred to or quoted, in whole or in part, in any registration statement, prospectus, public filing (other than any PID related filing), loan agreement, or other agreement or document or in any other matter, and further agrees not to distribute the report without Grant Thornton's prior written consent.

This report includes forecasts which include numerous assumptions, as described herein. The financial analysis is based on assumptions that will usually differ from actual results, because events and circumstances frequently do not occur as expected, and the resulting differences may be material. We will have no responsibility to perform any revised financial analysis unless subsequently engaged to do so.

Sincerely,

Scott B. Davis
Partner

David Tyler
Principal

EXECUTIVE SUMMARY

Overview

BACKGROUND

In 2013, Highmark Inc. ("Highmark") consummated an affiliation agreement together with UPE, now known as Highmark Health and UPE Provider Sub, now known as Allegheny Health Network ("AHN") and West Penn Allegheny Health System, Inc. ("WPAHS") and certain of its affiliates which resulted in the formation of an integrated delivery and financing system ("IDFS"). In 2013, Highmark also affiliated with Jefferson Regional Medical Center and Saint Vincent Health Center each of which is also a part of the Highmark Health IDFS.

AHN owns and/or operates eight hospitals, physician organizations with many office locations, numerous outpatient facilities including surgery centers, urgent care centers, medical malls, and diagnostic testing locations. Significant facilities that are owned and operated by AHN include the following:

- Allegheny General Hospital ("AGH")
- West Penn Hospital ("WPH")
- Canonsburg Hospital ("Canonsburg" or "CGH")
- Allegheny Valley Hospital ("AVH")
- Forbes Hospital ("Forbes" or "FRH")
- Jefferson Hospital ("Jefferson" or "JRMC")
- Saint Vincent Hospital ("SVH")
- Wexford Health + Wellness Pavilion ("Wexford")
- Monroeville Surgery Center
- Peters Township Health + Wellness Pavilion ("Peters Township")
- Bethel Health + Wellness Pavilion ("Bethel")
- Allegheny Clinic ("AC")
- Westfield Memorial Hospital

A principal component of the IDFS strategy has been to build and expand access and service for its subscribers and policyholders to maintain choice and competition in the Southwestern Pennsylvania healthcare marketplace and create

an overall better patient experience.

Highmark Health and AHN continue to invest in the upgrade and expansion of the IDFS service line offerings that serve this community. In order to continue the expansion of service lines and ensure that Highmark's subscribers and policyholders have continued access to affordable and quality healthcare services significant investments are needed at AHN.

On December 23, 2014, Highmark filed a request for approval of a $175 million financial commitment ("Financial Commitment") with the Pennsylvania Insurance Department ("PID"). The PID approved the request on June 19, 2015 ("June 19 Approval Letter"), subject to certain conditions, including, among other things, the filing of a Preliminary AHN Corrective Action Plan (the "Preliminary CAP") and the filing of a Final AHN Corrective Action Plan by September 30, 2015 (the "Final CAP").

OUR ENGAGEMENT

This report (the "GT Report" or "Report") has been prepared in response to the requirement in the June 19 Approval Letter that the Final CAP be reviewed by an independent financial expert experienced in these matters who was not involved with, and who did not otherwise participate in the preparation of or provide any analysis for, the Preliminary CAP or the Final CAP. Grant Thornton LLP ("Grant Thornton") was retained by Buchanan Ingersoll & Rooney PC ("Buchanan") under an engagement letter dated August 6, 2015.

Grant Thornton is one of the largest professional services organizations in the world with $4.7 billion in revenue and over 40,000 people in 130 countries. In the United States alone, Grant Thornton has over 50 offices including one in Pittsburgh. Grant Thornton has a dedicated consulting group of professionals providing services to all aspects of the healthcare and health plan industries and is committed to being at the forefront of healthcare developments and trends around the country. Grant Thornton's suite of comprehensive healthcare services strategic and operational areas including business plan and forecast development, serving as interim management, revenue cycle enhancement, physician practice formation, restructuring, and IT system implementation. Grant Thornton has extensive experience in serving as financial experts and providing testimony.

Grant Thornton was not involved with and did not participate in the preparation of or provide any analysis for the Preliminary CAP or the Final CAP. As described more fully in later sections herein, Grant Thornton reviewed the Preliminary CAP and drafts of the Final CAP through September 29, 2015, requested information, gathered data, performed and/or reviewed analyses and interviewed members of the leadership of Highmark Health, Highmark and AHN to assess the reasonableness and sufficiency of various aspects of the Final CAP.

Specifically, Grant Thornton was asked to provide opinions as to:

1. the reasonableness of the Final CAP,
2. the sufficiency of the Final CAP to accomplish the Plan Objectives,
3. the specific level of benefits and costs to be borne by Highmark's policyholders, and
4. the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investments in AHN.

Our services have been provided in accordance with the standards for consulting and valuation services promulgated by the American Institute of Certified Public Accountants and the Uniform Standards of Professional Appraisal Practice. Accordingly, the services do not constitute a rendering by Grant Thornton or its partners or staff of any tax or legal advice, nor do they include the compilation, review or audit of financial statements, as those terms are defined in guidance promulgated by the American Institute of Certified Public Accountants.

LIMITATIONS ON USE

This GT Report may be used internally by Buchanan, the management of Highmark Health and its subsidiaries and affiliates, and the PID and its consultants for the purpose of addressing certain conditions described in the June 19 Approval Letter.

This Report does not constitute tax or legal advice. This Report is not a compilation, review or audit of the financial statements, statistics, charts, exhibits or numbers contained in the Final CAP. Our work does not include any review of accounting policies or financial controls.

The Report is not intended for the benefit of or to be relied upon by any third parties for any purpose other than as expressly described herein. Our analysis and this Report are invalid if used for any purpose other than that stated herein.

Approach

REASONABLENESS AND SUFFICIENCY OF THE FINAL CORRECTIVE ACTION PLAN

Our approach to develop our opinions on the reasonableness and sufficiency of the Final CAP included reviewing the Preliminary CAP, reviewing strategic and operational plans, analyzing the supporting financial model, performing research, performing analyses, reviewing data, and interviewing management and directors as we deemed necessary. During Grant Thornton's field work, AHN concurrently developed the Final CAP and provided drafts to Grant Thornton when available, highlighting changes to the Preliminary CAP and providing additional supporting data.

Grant Thornton was provided the financial model which captures the anticipated financial impacts of the initiatives related to the Final CAP and management's assumptions.

Grant Thornton interviewed key executives and board members of AHN and Highmark Health. These interviews provided us with an understanding of the Plan Objectives, the development of and approval process for the Plan Objectives and Final CAP, provided an overview of important initiatives underway to achieve the Plan Objectives, and management's perceived risks to achieving the Plan Objectives.

Grant Thornton also interviewed the Chief Operating Officer, Chief Medical Officer, certain business unit leaders, and key finance directors of AHN along with certain actuaries and executives at Highmark Health. These interviews provided a more detailed understanding of key assumptions and support for the forecasts presented in the Final CAP. A list of the key executive is included in Appendix C.

We performed analyses of the significant drivers of the financial model, assessed the consistency of the financial model to management's stated assumptions and initiatives, analyzed the financial statements at a business unit and consolidated level, and analyzed the forecast compared to actual historical performance. In many respects, the Final CAP reflects a continuation and extension of initiatives that are already underway. Many of these initiatives are reflected in the dramatic improvement in AHN's financial performance in 2014 as well as year-to-date through May 2015. In order to develop our opinions on the sufficiency of the initiatives and the reasonableness of the financial forecasts, Grant Thornton requested and received supporting data on achievements to date as well as management's estimates of continued progress. For new initiatives as well as continued progress on existing initiatives, Grant Thornton assessed the proposed benefits and costs in comparison to other similar provider organizations and industry metrics.

As a part of this assessment, we have reviewed many of the formulas and references in the financial model with our main objective being to perform analyses on the underlying assumptions and output of the model. We did not attempt to validate the ability of this financial model to accurately forecast financial results with a different set of initiatives or assumptions.

Our opinion on the reasonableness of the financial forecast is based on our understanding of the regulatory and competitive landscape, management's ability to achieve stated targets, and comparative industry benchmarks. We also sensitized the forecast based on the identified conservative and aggressive assumptions to determine a range of reasonable outcomes. These ranges or variances were then assessed in the aggregate and compared to the forecasts for reasonableness as it relates to the forecasted cash balance at December 31, 2017, and forecasted capital expenditures.

As many of the Plan Objectives will require continued investments to be made, our assessment of sufficiency is predicated on the ability of AHN management to make an adequate level of forecasted investments needed to achieve the Plan Objectives. Management has included a downside scenario to the forecasts in the Final CAP. We analyzed the effect to the forecasted financials, including projected cash balance and the potential for reduction in capital expenditures in the case of the downside scenario. Lastly, in order to develop our opinion on sufficiency, we assessed management's plan and initiatives for additional actions that could be taken to achieve the Plan Objectives and whether current actions were adequate to achieve the Plan Objectives and goals in the Final CAP.

BENEFIT AND COST TO HIGHMARK POLICYHOLDERS

As required by the PID, Highmark Health prepared a report titled "IDN Savings Report for 2014" that addresses value from a Highmark policyholder perspective. While this report is retrospective and does not address the CAP, Grant Thornton believes the IDN Savings Report establishes an essential foundation of methodology, perspective, and benchmarks that can be followed in expressing an opinion on the benefits and cost to Highmark's policyholders as they relate to the Final CAP. Grant Thornton has analyzed the IDN Savings Report and the underlying documents, fact base and related assumptions to obtain sufficient foundational knowledge to conduct our prospective analysis.

Grant Thornton also used a common healthcare framework to assess other benefits and costs to Highmark policyholders. This framework is often referred to as the triple aim. The objectives of the triple aim are often articulated as follows:

1. manage population health, growth and access
2. reduce per capita cost, and
3. improve experience and quality of care

Grant Thornton also reviewed the budgeted capital expenditures that specifically address these areas and the potential benefit which could be realized. In the opinion of benefit and cost to policyholders, Grant Thornton is not seeking to define a specific Highmark per member per month dollar impact. Rather we have developed an opinion on the benefits from a broader perspective of how the Plan Objectives, Final CAP and Financial Commitment would impact the identified cost and benefits to Highmark's policyholders.

REASONABLENESS OF AHN VALUE AS ASSIGNED BY HIGHMARK HEALTH

Highmark Health assigns both a specific numerical value to AHN in its financial statements ("Book Value") and a strategic value of AHN in its business operations in support of the IDFS strategy. This strategic value is both quantifiable (as in the IDN Savings Report) and non-quantifiable in terms of certain benefits to policyholders such as access to care. Grant Thornton is opining on the Book Value as assigned in the financial statements and the reasonableness of the implied Book Value as forecasted in the financial statements at the end of the forecast period. Grant Thornton is also opining on changes to the strategic value based on the Plan Objectives and Final CAP.

Grant Thornton's approach to determine the reasonableness of Highmark Health's assigned Book Value of AHN is based on the generally accepted valuation methods of Market Approach and Income Approach.

- Market Approach – Uses direct comparisons to other enterprises to estimate Fair Market Value. The market approach bases the Fair Market Value measurement on what other similar enterprises or comparable transactions indicate value to be.

- Income Approach – Sometimes referred to as the Discounted Cash Flow ("DCF") method explicitly recognizes that the current value of an investment is premised on the expected receipt of future economic benefits such as periodic income, or sale proceeds. In valuing a business enterprise, indications of value are developed by discounting future net cash flows available for distribution to their present worth at a rate that reflects both the current return requirements of the market and the risk inherent in the specific investment.

Grant Thornton reviewed and analyzed audited and unaudited historical financial statements of AHN and the goodwill impairment tests dated December 31, 2013 and December 31, 2014. The draft of the goodwill impairment test for June 30, 2015 was also provided and analyzed. The forecasted financial statements of AHN included in the Final CAP and the projected Book Value as of December 31, 2014. Grant Thornton is providing an opinion on the end of forecast period Book Value based on the reasonableness of the forecasted financials and the reasonableness of the historical Book Value as of December 31, 2014.

With respect to the strategic value Highmark Health assigns to AHN, Grant Thornton assessed the Final CAP's effect on potential cost savings and downstream value to Highmark Health.

Conclusions

Grant Thornton believes management is focused on the appropriate initiatives and actions in the Final CAP and that these initiatives, along with continued attention to operating the IDFS, are sufficient to achieve the Plan Objectives. Further, in our assessment of sufficiency, we analyzed the potential downside scenario and the ability of the AHN management to take other actions to maintain adequate cash levels in the event that actual performance deviates significantly from the forecasts. We analyzed whether at this lower level of forecasted cash, the Final CAP is still reasonable and sufficient to achieve the Plan Objectives. These contingency plans might include, but are not limited to, a change to provider-based billing, and delaying capital expenditures in later periods, and seeking other sources of external funding. It is Grant Thornton's opinion that management has sufficient levers in its control to respond to the downside scenario and still achieve the Plan Objectives.

It is Grant Thornton's opinion that with the caveats and limitations noted throughout this Report, the projected net income and cash balances in the financial forecasts as presented in the Final CAP appear reasonable.

The Final CAP provides evidence that the plan will continue to support and extend the benefit to Highmark policyholders documented in the IDN Savings Report as well as support the strategic value of AHN to Highmark Health in its execution of the IDFS strategy. The book value of AHN as of July 31, 2015, is $181.0 million. AHN Forecasts book value to increase by $77.1 million through the projection period, to a value of $258.1 million by the end of 2017.

Highmark's investment in AHN and the reasonable value assigned by Highmark Health from an accounting perspective can reasonably be expected to maintain or increase value from multiple perspectives: in the form of increased book value of AHN, through Highmark's enhanced strategic position and competitive profile, which will enable Highmark to compete effectively in retaining and attracting policyholders, and by lowering the cost to patients,

both Highmark members and others, in the communities AHN serves. These actions will support Highmark's competitive profile in the market, allow continued patient access in Southwestern Pennsylvania to the high quality AHN providers and provide value to its policyholders through moderated cost growth of premiums.

As a result of our analysis and methodology described in detail in this Report, we conclude that to the best of our knowledge and belief that:

1. the Final CAP appears reasonable;
2. the Final CAP is sufficient to meet the Plan Objectives;
3. there will continue to be benefits to Highmark and its policyholders; and
4. the value assigned by Highmark Health and/or Highmark to Highmark's investment in AHN as presented to the PID is reasonable.

OVERVIEW AND BACKGROUND

National Trends

DECLINING REIMBURSEMENT AND UTILIZATION SHIFT

Given significant changes in the payor-provider relationship through the emergence of narrow networks, insurance coverage expansion, and mandated changes in the minimum benefits and limits for plans, there has been a shift in reimbursement. The proportion of healthcare costs paid directly by patients has increased. Rebalancing of reimbursement across specialties has also taken place. Payments for primary care and obstetrics/gynecology have increased while payment for surgery, orthopedics, and other specialties have declined. Overall, between 2013 and 2014, reimbursement has increased approximately 1%, but this growth relative to inflation effectively is a decline in reimbursement.[1]

PHYSICIAN SHORTAGE

Demand for physicians continues to grow faster than supply, leading to a projected shortfall of approximately 50,000 to 90,000 physicians nationwide by 2025. Although physician supply is projected to increase through 2025 through the expansion of existing medical schools and establishment of new medical schools, demand is expected to grow more quickly. The shortfall will be disproportionately weighted towards the primary care specialties (including obstetrics and gynecology).

The Congressional Budget Office ("CBO") estimates that 26 million people now have medical insurance who otherwise would have been uninsured in the absence of coverage made possible by the Affordable Care Act ("ACA"). These individuals' access to insurance coverage is changing care utilization patterns in the market and increasing the demand for physician services. Physician retirement patterns – dependent upon work satisfaction, cultural norms, and trends in their health and mortality – may exacerbate the shortage of capacity. Younger and newer physicians have demonstrated a desire to work fewer hours than the previous generation– which also may limit capacity. Increasing supply of physician assistants and advanced practice clinicians such as advanced practice registered nurses (APRNs),

[1] "Tracking Trends in Provider Reimbursements and Patient Obligations," Hempstead et al. Health Affairs. 2015.

certified midwives, and certified registered nurse anesthetists are tempering the shortfall of physicians by absorbing market demand for healthcare services.[2]

INCREASING COST TO PROVIDE CARE

There are many drivers of increasing cost to provide care. Five critical aspects for consideration include continuation of fee-for-service reimbursement ("FFS"), increasing administrative burden, an aging population, increasing drug costs and legal barriers. Nationally, despite an increasing shift towards alternative payment models, fee-for-service reimbursement continues to persist; most healthcare services are still reimbursed through FFS. Healthcare providers reimbursed for each service provided have an incentive to provide as much care as possible. This reimbursement model does not include payment for many services perceived to be paramount for management of serious illness, especially chronic disease, such as patient education and coordination of care with other providers. Lack of reimbursement for emails, telephone calls, or other services provided by physician and non-physician medical professionals makes it difficult to shift away from delivery models that rely on in-person interaction between patients and physicians.

Administrative burden due to fragmented payment and delivery leads to higher paperwork and other administrative tasks, raises provider and payor costs, and consumes a significant amount of physician and patient time. Most providers file claims with numerous health insurance plans, which typically utilize different processes for authorizing services, establishing patient eligibility, and paying claims. Navigating this complex system requires significant administrative resources to complete the necessary paperwork and contact payors about treatments, referrals, and diagnoses.

Healthcare spending growth will also be driven by the aging population with increased longevity; overall spending per capita will increase. The CBO indicates that population aging will be responsible for 52% of the growth in spending on major federal health programs. The elderly, often requiring complex chronic disease management particularly for individuals with comorbidity of disease, must traverse across the continuum of care to access the range of providers necessary to provide their care. Developing linkages between care settings to ease transitions requires investment in information technology and care management staff.[3]

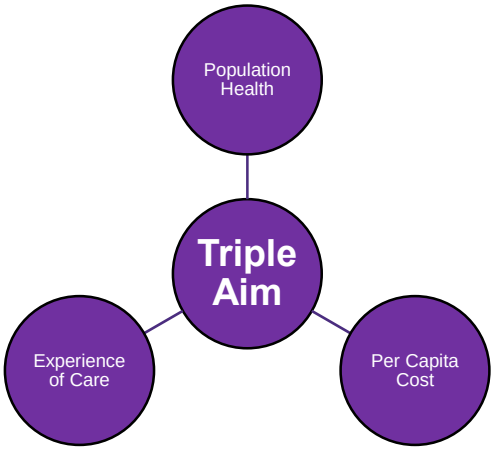
Prescription drug costs continue to rise. According to the Kaiser Family Foundation, increasing drug expenditures are driven by utilization, price changes, and changes in drug types.[4] Specifically, the implementation of Medicare Part B drug benefit and the expansion of health insurance coverage parallel the increase in prescription drug costs in the US.

The current U.S. legal and regulatory environment drives up costs to the healthcare system by preventing transition to more cost-effective systems of care. The current regulatory system is structured to support the FFS model of healthcare delivery and payment. This legal environment indirectly encourages spending growth by making it more difficult for providers and payors to implement more cost-effective systems of care. Antitrust, anti-kickback, and physician referral ethics laws are intended to prevent inappropriate activity within the current payment and delivery systems. In many cases, the concerns that arise under FFS, such as physician self-referral, are reversed under alternative systems. For example, under a capitated system of healthcare payment, fear that providers will withhold necessary services to stay under budget may be a greater concern than overutilization of services. Reforms to current law and regulations do not yet complement the implementation of alternative models of healthcare delivery and payment.[5]

[2] "The Complexities of Physician Supply and Demand," Association of American Medical Colleges. March 2015.
[3] "What is Driving U.S. Health Care Spending?" Bipartisan Policy Center. September 2012.
[4] "Prescription Drug Trends," Kaiser Family Foundation. May 2010.
[5] "What is Driving U.S. Health Care Spending?" Bipartisan Policy Center. September 2012.

HEALTHCARE'S RESPONSE – THE TRIPLE AIM

A recognized healthcare industry construct is commonly referred to as the triple aim. Since its original articulation in the 1990's, the triple aim has become a framework for comparison of healthcare delivery systems globally and the value derived from the resources devoted to them. With a significantly higher percentage of the U.S. economy devoted to healthcare and overall growth rates compared to other developed nations, the value derived from the U.S. investment in healthcare compared to other nations has lagged. The triple aim sets up transformative goals for improving the healthcare delivery model nationally and locally by individual institutions. To achieve this improvement, individual institutions must identify the populations they serve, define actionable and measurable objectives, and develop a portfolio of projects that will address these objectives, and rapidly test and implement these projects. The triple aim, represented as follows, has become a common filter through which healthcare management teams pass strategies and tactics.[6]



In fact, the Centers for Medicare and Medicaid Services ("CMS") has incorporated the triple aim as a foundational element to the Medicare program, the Accountable Care Organization framework and in the CMS Center for Innovation. The triple aim has become an industry standard for focusing efforts around optimizing health system and IDFS performance.

CONVERGENCE

In an effort to achieve the triple aim, healthcare providers are entering the healthcare insurance business and health plans are entering the business of providing patient care. These institutions are choosing to vertically integrate to satisfy mutual needs to reduce cost, sustain operations, improve the quality of outcomes, respond to growing regulatory requirements, and protect against declining reimbursement. Convergence also has a patient-centered focus to better meet the needs of populations served through becoming more efficient and effective at healthcare delivery.[7] These collaborations (often referred to as integrated delivery networks) vertically link payor and provider while horizontally linking community-based ambulatory healthcare services with hospital-based acute care services.[8]

The ACA is the federal government's most recent effort to comprehensively address cost reduction, quality improvement, and healthcare integration. The ACA has multiple provisions that were intended to help healthcare providers create more integrated systems of care through promotion of accountable payment models including bundled payments and the innovation of the accountable care organization ("ACO").

Costs and overall margins are challenging providers as the population increasingly ages, insurance coverage across the population is growing, technology requirements increase (due to ARRA/HITECH Acts), reimbursement declines,

[6] "The Triple Aim: Care, Health, And Cost," Berwick et al. Health Affairs. May 2008.
[7] "Health systems integration: state of the evidence," Armitage et al. International Journal of Integrated Care. June 17, 2009.
[8] "Integrated delivery systems; the cure for fragmentation" Alain Enthoven. American Journal of Managed Care. December 2015.

and provider shortages continue. Minimum medical loss ratios, increased rate regulation, competition in health insurance exchanges, expansion of mandated benefits, along with prohibitions on preexisting conditions and annual/lifetime limits have increased cost and constrained revenue for payors as well.

Programs such as Medicare Advantage, Hospital Value-Based Purchasing Program, and Medicare Shared Savings have tied reimbursement to quality, patient satisfaction, and cost control. This linkage of reimbursement and outcomes has realigned the incentives from producing care to promoting health.

Convergence of payors and providers, disparate subsectors of the healthcare marketplace that heretofore operated separately, has been promoted as a logical solution to transform organizations to compete in this new healthcare and regulatory environment. This convergence has required the creation of new healthcare delivery models across the risk-based contracting continuum (see figure below). The transition to compensating healthcare providers for taking on the full risk for the care of whole populations based on a global capitation payments to provide all the healthcare services for a patient is not as simple as flipping a switch. This transition requires investment in infrastructure, technology, processes, and people to prepare for this reimbursement transition to payments that support population health management.

Grant Thornton has developed a model to help understand the risks associated with reimbursement models.

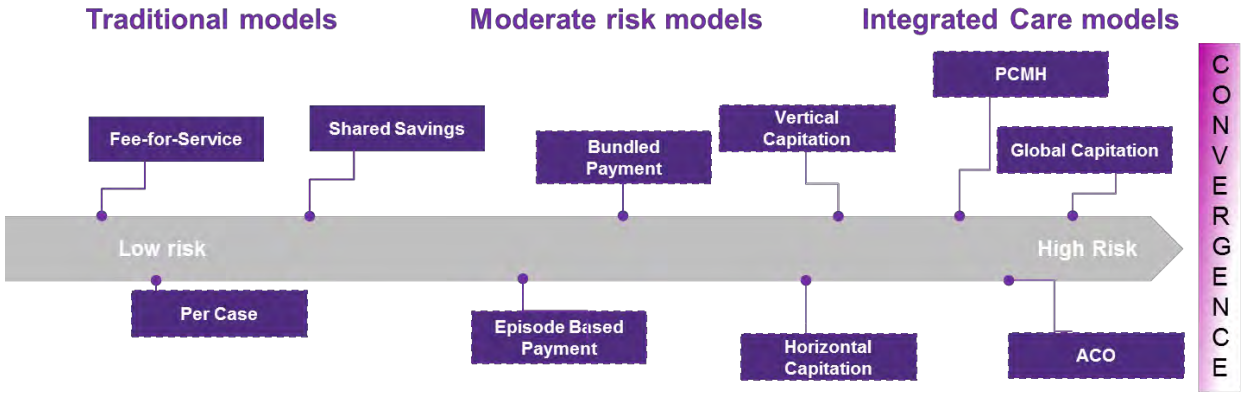


Figure 1: Grant Thornton's proprietary approach to understanding convergence dynamics through healthcare reimbursement models organized by risk.

A fully integrated healthcare finance and delivery system must focus on seven (7) key areas.

1. These organizations must have a value-driven governance and leadership structure. The board, administration, and physician leadership must be committed to promoting integration strategically through financial and operational planning;
2. Clinicians must be aligned with and integrated into hospital administration for decision-making to control costs and improve quality;
3. Contractual relationships with payors must be aligned financially across the organization;
4. Clinical integration and care coordination must be promoted utilizing the most appropriate settings for care while improving care transitions and linkages across the continuum of services offered by the IDFS;
5. Information must be made available to all caregivers by leveraging single electronic health record for each patient across care settings. This integrated health record will allow for information sharing between providers along with data-driven evaluation of quality performance;
6. The focus must ultimately be on population health to reduce the likelihood of severe illness and reduce their overall incidence. This focus will require investments in social services, cultural competency, training patients and caregivers in self-management of disease, and providing access to care through various modes;
7. Continuous quality improvement and innovation through implementation evidence-based practice will be

necessary to reduce costs and promote quality across an IDFS.[9]

There are a variety of organizations across the United States collaborating to integrate the delivery of healthcare services, reduce costs and improve quality (see figure below).

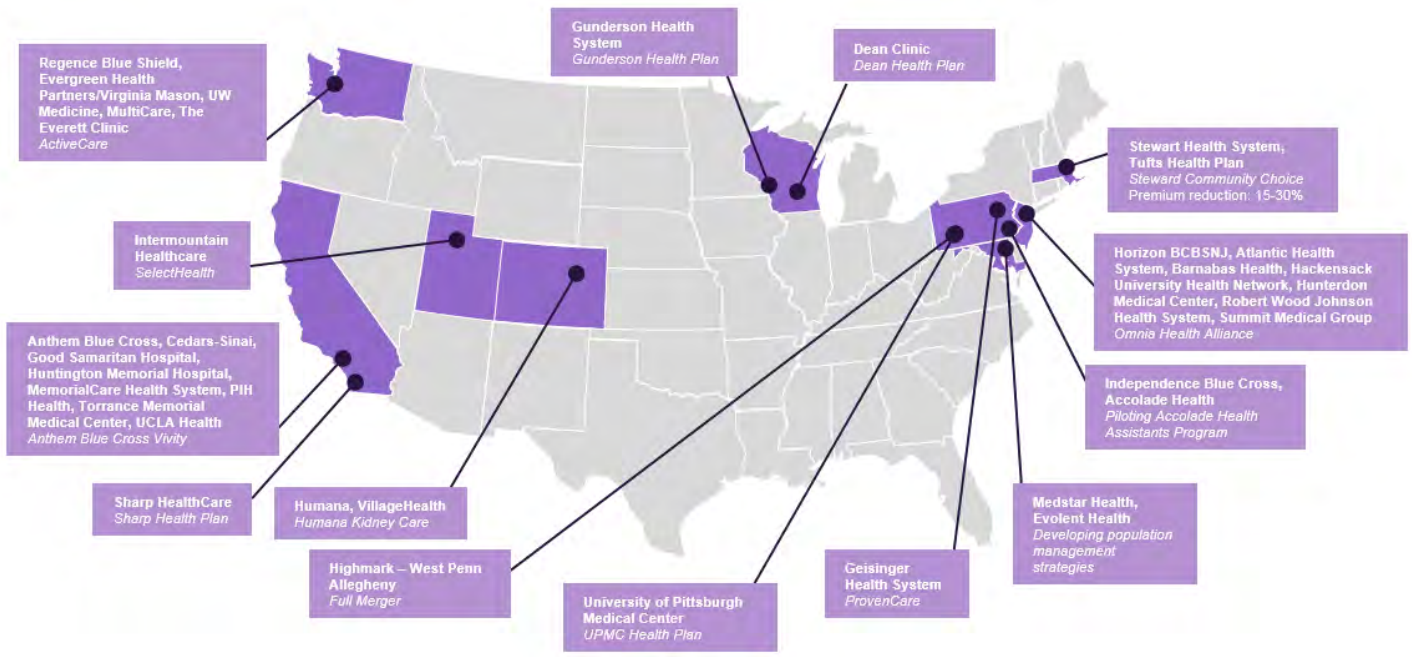


Figure 2: A representative sample map of leading payor and provider organizations collaborating and/or converging to integrate the delivery of healthcare services across the United States.

Sharp HealthCare and Intermountain Healthcare are exemplars of IDFSs developed by health systems. Sharp HealthCare in California manages a care continuum composed of seven acute care hospitals, four long-term care facilities, three skilled nursing facilities, two medical groups, home healthcare and hospice services, and a health plan covering 120,000 members. As an organization led by physicians, Sharp has tightly aligned its clinical staff with the operational focus of the institution. The organization has also focused on management of chronic diseases through the creation of dedicated teams of case managers.[10]

Intermountain Healthcare in Utah operates twenty-two acute care hospitals, a medical group, ambulatory clinics, home healthcare and hospice services, as well as a health plan covering 530,000 members. Utilizing a strong IT infrastructure anchored by an enterprise data warehouse, Intermountain has developed care protocols and approaches to manage the health of the population it serves. Intermountain has also invested in administrative divisions responsible for building up the infrastructure for transition between care settings and case management to partner with patients between care settings. The organization has also invested heavily in shared services of back-office functions and supply chain to continuously limit cost growth.[11]

Payors have also led collaborations spanning the continuum of care. In Pennsylvania, Independence Blue Cross has co-developed "Accolade Health Assistants" to help its members maximize the utility of their benefits through care navigation services.[12] Regence Blue Shield in Seattle has introduced ActiveCare, a health insurance plan that focuses

[9] "Integrated Health Care," Essential Hospitals Institute. May 2013, Pages 7-9.
[10] "The Integrated Nursing Enterprise: Lessons from Leading Cross-Continuum Organizations" Advisory Board. 2013.
[11] Ibid.
[12] "Independence Blue Cross and Accolade collaborate to transform the consumer health care experience." Independence Blue Cross. Press Release, September 2014.

on wellness and promotion of preventive care.[13] Humana has partnered with DaVita Healthcare Partners, Inc. to create VillageHealth Disease Management to provide individual care guidance, patient education, and coordination of care for members with kidney and renal disease.[14] Vivity was introduced to Los Angeles through a partnership between Anthem BlueCross and seven leading hospital systems to create a virtual health system through streamlined access to providers across institutions through a reimbursement methodology that rewards maintaining patient's health.[15] Evolent Health has worked with MedStar Health in the Baltimore/Washington region to develop software for population health management.[16] Omnia Health Alliance, led by Horizon Blue Cross Blue Shield of New Jersey is leading six health systems and a multispecialty medical group through technology driven population health management in order to lower costs and allow Horizon to offer lower premiums to consumers in the marketplace without changing benefits.[17]

Finally, as health plans and provider integration become more prevalent across the country we expect that the sophistication and integration of regulatory agencies will continue to keep pace. Ensuring adequate oversight while keeping a neutral and consistent approach to all IDFSs is going to continue to be a focal point for Center for Medicare & Medicaid Services, State Medicaid Agencies, Departments of Health, Departments of Insurance and the National Association of Insurance Commissioners. These regulatory agencies are all focused on this evolving aspect of the market and will continue to refine their regulatory approach towards converged IDFSs. We see the continued evolution towards a unified regulatory approach to IDFSs in Pennsylvania as a key step in ensuring that Pennsylvanians maintain access to pro-competitive, market-based, and high quality delivery and financing systems.

Pittsburgh Market

Across the ten-county Southwestern Pennsylvania area, there are over thirty acute care hospitals and four health systems. Six of eight AHN-member hospitals are located in this region. University of Pittsburgh Medical Center ("UPMC") has over twenty hospital campuses located in this same region. Heritage Valley Health System ("HVHS" with two acute care hospitals) and Excela Health ("Excela" with three acute care hospitals) also compete in this market. These health systems and other hospitals in the area are collectively responsible for providing care for approximately 1.2 million residents in Allegheny County and 2.6 million in overall ten county region of Southwestern Pennsylvania. From 2011 and 2013, AHN had the second largest market share of approximately 20% of medical-surgical inpatient services. UPMC's market share is approximately 40% for the same region and set of services. Excela (8%) and HVHS (6%) are also important players.[18]

[13] "Regence announces ActiveCare health plan in Washington featuring accountable health networks." Regence Blue Shield. Press Release, December, 2014.
[14] "DaVita HealthCare Partners' VillageHealth and Humana Team up to Create Humana Kidney Care." Humana. Press Release, January 2015.
[15] "Introducing Anthem Blue Cross Vivity." Anthem Blue Cross. Press Release, 2014.
[16] "Evolent Health's use of analytics draws investments – and clients." Dan Beyers. Washington Post, January 2015.
[17] "Meet the OMNIA Health Alliance." Horizon Blue Cross Blue Shield of New Jersey. Press Kit, September 2015.
[18] Pennsylvania Health Care Cost Containment Council, 2014.

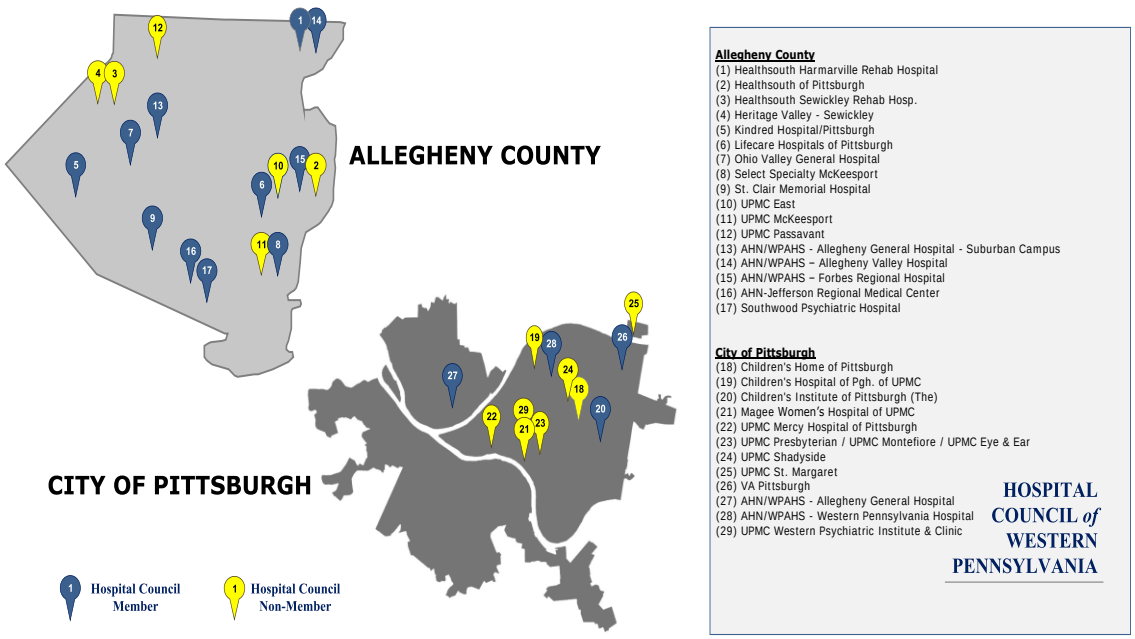


Figure 2: Map of hospitals in Pittsburgh and the surrounding Allegheny County area. Sourced from the Hospital Council of Western Pennsylvania.

Highmark Health's Strategy

In the early 2000s, the metro Pittsburgh region had 3.1 hospital beds per 1,000 residents while the national average was 2.6. This standard metric for measuring relative supply for hospital services meant the city of Pittsburgh was ripe for a market correction to address the supply of healthcare outstripping the needs of the community.[19]

WPAHS had historically been a financially troubled health system with relatively low utilization of its inpatient capacity. In 2007, the health system's troubles garnered national attention when nearly $750 million in bonds were issued to refinance older debt and recapitalize the ailing health system.[20] By 2011, after operating the previous five years with negative margins and accruing an aggregate of over $800 million in debt, WPAHS approached Highmark about an affiliation to form the foundation of an integrated delivery network that would change the way healthcare is delivered in a financially responsible manner.[21] This was and still is an unprecedented transaction. Health plans around the nation had previously acquired clinics and hospitals and were developing payment models that resembled health plans, but no single health plan had affiliated with or acquired a provider with the scale and scope of a complete health system.

By affiliating with WPAHS, Highmark's stated intention was to maintain access to acute and community-based healthcare services for its policyholders and promote competition while restructuring the institution through an employed-physician model to incentivize quality and efficiency as well as carving out costs over the long term through the preventive efforts of primary care to manage population health.

[19] "Pros, cons found in merger of Highmark, West Penn Allegheny Health System," Steve Twedt and Bill Toland. Pittsburgh Post-Gazette. April 9, 2013.
[20] West Penn Allegheny Health System Series 2007A Official Statement.
[21] "Pros, cons found in merger of Highmark, West Penn Allegheny Health System," Steve Twedt and Bill Toland. Pittsburgh Post-Gazette. April 9, 2013.

In 2013, Highmark consummated an affiliation agreement together with UPE, now known as Highmark Health and UPE Provider Sub, now known as Allegheny Health Network ("AHN"), WPAHS and certain of its affiliates which resulted in the formation of an integrated delivery and financing system ("IDFS"). In 2013, Highmark also affiliated with Jefferson Regional Medical Center and Saint Vincent Health Center each of which is also a part of the IDFS.

Since the creation of the IDFS, Highmark Health has focused and continues to focus on providing the right care at the right time in the right setting. AHN has expanded its staff, footprint and services, increased its capacity to treat patients and importantly focused on moving care from expensive, high acuity settings to less expensive and more convenient settings.

OVERVIEW OF THE FINAL AHN CORRECTIVE ACTION PLAN

Plan Objectives

In order to opine on the Final CAP, a clear understanding of the Plan Objectives, as described in the Final CAP, is important. As articulated in the Final CAP, the Plan Objectives are:

1. **Quality & Safety**: Become a top performing healthcare provider who delivers care without harm.
2. **Customer Service**: Enhance the patient, physician and employee experience.
3. **Growth & Access**: Ensure just-in-time patient access to physicians, hospitals and ancillary services.
4. **Financial Stability**: Position AHN to be financially stable and self-sustaining.
5. **People**: Develop a physically and culturally safe working environment where leaders and employees are accountable for owning their actions and outcomes; champion problem solving.

These Plan Objectives are assessed in the context of their roles in supporting Highmark, Highmark Health and AHN's goals related to the foundational framework of healthcare's triple aim of improving patient experience of care (quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. These same

goals that present from the inception of IDFS and have driven management since its formation. These Plan Objectives are best embodied in the AHN forecasts included in the Final CAP ("AHN Forecasts").

Final CAP Improvement Initiatives

Included in the AHN Forecasts and discussed in the Final CAP under Investments/Initiatives Undertaken to Develop the IDFS, starting in 2015 and continuing throughout 2017 are financial improvements associated with key initiatives that have been started and led by AHN management that continue through 2017. These initiatives result in both revenue improvements and expense reductions. We believe that AHN management is focusing on the right initiatives. AHN is undertaking the initiatives to operate a more well run health system and, in turn, address the Plan Objectives. The reasonableness of these initiatives is summarized in the following sections.

Introduction and Methodology

The Final CAP includes a set of projections of AHN's financial results, referred to as the AHN Forecasts in this Report, for the periods ending December 31, 2015 to December 31, 2017. Appendices A and B provide a consolidated statement of operations and balance sheet. The AHN Forecasts start with 2015 as the base year. The 2015 Projection was built by AHN management with five months of actual revenues and expenses from January 2015 to May 2015 and seven months of revised budgeted revenue and expenses from June 2015 to December 2015. The 2015 budget was built from 2014 actual results with the overlay of improvement initiatives led by the AHN management. From the 2015 Projection, AHN management made assumptions on each revenue and expense line item and the respective growth or decline in 2016 and 2017 to form the 2016 and 2017 Forecasts.

Our methodology included performing research, analysis, interviews and data gathering on the AHN Forecasts and AHN management's assumptions and opining on the reasonableness of the Final CAP. Analysis included reviewing supporting documentation, comparing AHN management's assumptions to standard industry benchmarks, and testing the accuracy of the computations in the build-up of the assumptions in the AHN Forecasts. Our findings in this report document our opining on the reasonableness of the Final CAP. Over twenty individuals were interviewed from both the AHN and Highmark Health executive teams. A detailed listing of our interviews is included in Appendix C of this Report.

Sensitivities

During our assessment of the AHN Forecasts we noted a number of areas where there is opportunity for improvement in the modeling process which involve projected reimbursement rates. The net effect of making these improvements would be to reduce earnings over the three-year forecast period and forecasted cash at December 31, 2017, by approximately $15 million, which represents approximately 0.5% of annual net patient revenue. The AHN Forecasts also include other items not related to reimbursement rates some of which may be optimistic and others that are conservative. These other items result in adding a level of conservatism to the AHN Forecasts which largely offset the previously mentioned $15 million. None of these potential adjustments either individually or in the aggregate is material to the AHN Forecasts. These potential adjustments do not affect our conclusion that the projections included in the Final CAP are reasonable.

Upside and Downside Scenarios

Along with the development of a financial forecast, upside and downside scenarios are typically assessed to provide a broader range of outcomes. AHN management has included an upside and a downside scenario to the forecasts in the Final CAP. If AHN achieves the upside scenario, it is clear that it can achieve the Plan Objectives. It is Grant Thornton's opinion that management has sufficient levers in its control to respond to the downside scenario and still achieve the Plan Objectives.

The upside scenario estimates incremental operating gains of $54 million in 2016 and $97 million in 2017, respectively, resulting in $151 million more cash by the end of 2017 than what is reflected in the AHN Forecasts. This additional cash would allow AHN to make additional investments that could further improve the IDFS. If AHN achieves the upside scenario, it is evident that it can achieve the Plan Objectives.

The downside scenario estimates incremental operating losses of $38 million in 2016 and $50 million in 2017, resulting in an $88 million less cash at the end of 2017 than what is reflected in the AHN Forecasts.

The impact of actions that could be taken by AHN management under the downside scenario were not incorporated into the assessment. The various actions include reducing capital expenditures, selling non-core assets, and reducing cost structure. It is Grant Thornton's opinion that management has sufficient levers in its control to respond to the downside scenario and still achieve the Plan Objectives; provided, however management has regulatory authority to implement such decisions. Further, it is important to note that neither the upside or downside scenarios call for provider-based billing, which would significantly increase AHN's financial performance in either scenario.

Findings: Assessment of Reasonableness

Our opinion on the reasonableness of the financial forecast is based on our understanding of the current regulatory and competitive landscape, the continuation of the current IDFS strategy, management's ability to achieve stated targets, and comparative industry benchmarks. We noted assumptions which in our opinion were conservative as well as assumptions that, in our opinion, appear to be aggressive. We then sensitized the forecast based on the identified conservative and aggressive assumptions for a range of reasonable outcomes. These ranges or variances were then

assessed for their potential impact as a whole and compared to the forecasts, including the downside and upside scenarios for reasonableness as it relates to the forecasted cash balance and capital expenditures. It is our opinion that the downside and upside scenarios provide a reasonable range to the baseline and forecasted financials.

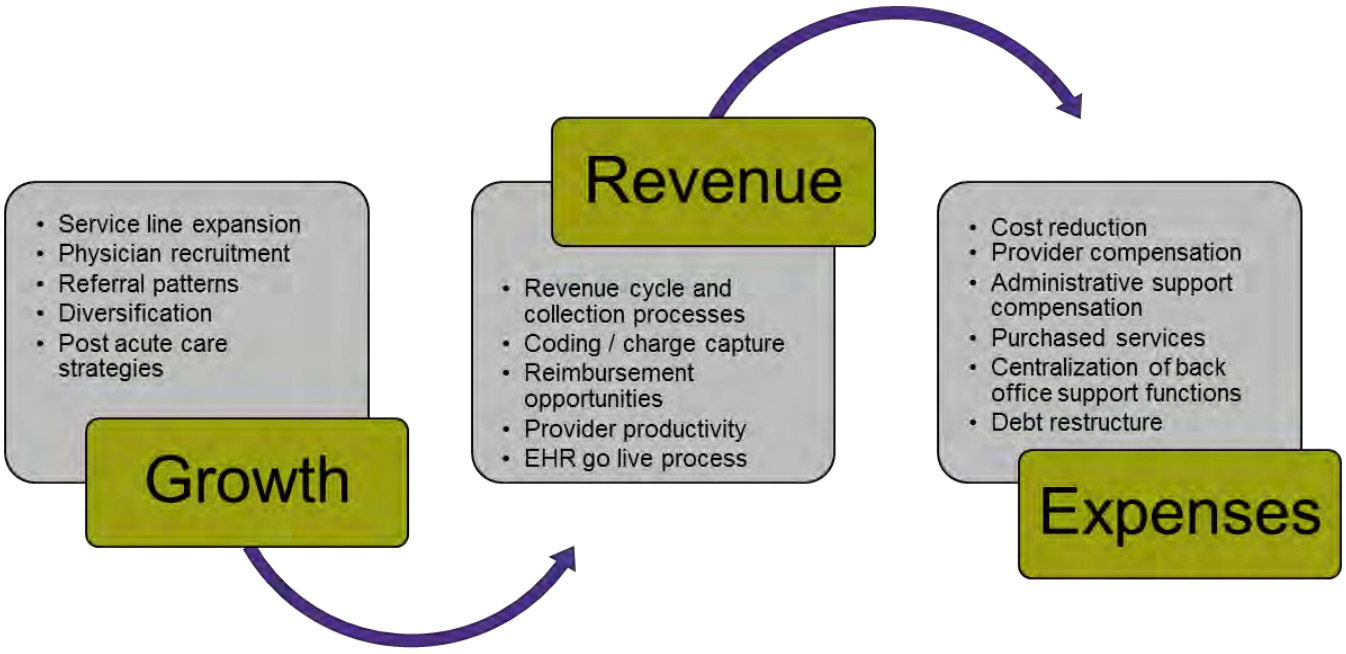
There are multiple levers that the AHN management can move as they drive the health system towards increasing operating margins at the same time as maintaining cash levels to make necessary investments for the future. These levers are best indicated by the assumptions in the forecasted financial statements and the Final CAP. Based upon our assessment, AHN management are moving the right levers to maintain this delicate balance. Our overall finding is that the Final CAP appears reasonable.

ASSESSMENT OF SUFFICIENCY

Introduction

POINT OF VIEW

An approach to turning around a health system is to perform performance improvement assessments in areas with traditional positive return on investment and then to implement action plans in those selected areas which are expected to generate significant improvements quickly with rigorous monitoring to meet targets and sustain results. The following flow chart depicts the typical areas of performance improvement for a healthcare system:



For-profit health systems often reduce head count and operational expense to the bare minimum level at the same

time as maximizing revenue through a combination of focusing on profitable service offerings and revenue cycle/charge capture/reimbursement/pricing opportunities while minimizing outlays for technology and plant investments.

While still having a strong focus on the above initiatives, not-for-profit health system typically focus on their missions and the benefit of the health system to the community.

It is necessary to choose which performance improvement initiatives are undertaken at the same time while addressing other strategic priorities (e.g., recruiting physicians, building out healthcare services and programs for the community, building centers of excellence, performing academic research, employee retention, etc.).

AHN Improvement Initiatives

During our assessment of the Final CAP, we analyzed strategic plans, tactical plans, AHN goals, initiatives, subsequent management reports, and interviewed AHN and Highmark Health management. There are numerous management goals and objectives which directly and indirectly support and advance the Plan Objectives.

The Final CAP and AHN Improvement Initiatives capture the most significant changes and improvements. Management expects these initiatives to result in the forecasted financials which we have reviewed and assessed elsewhere in this Report.

Included in the AHN Forecasts starting in 2015 and continuing throughout 2017 are financial improvements associated with key initiatives that have been started and led by the AHN management that continue through 2017. These initiatives result in both revenue improvements and expense reduction and based upon our performance improvement point of view as outlined above are the right initiatives for the AHN management to be focused on and are sufficient to achieve the Plan Objectives. The sufficiency of these initiatives and the link to the Plan Objectives are summarized in the following table and paragraphs:

Provider-Based Status Opportunity

In August 2002, CMS issued its final provider-based status rule (42 CFR 414.65). Under this methodology, provider-based physicians receive a reduced professional fee based on a reduction in the practice expense component (i.e., site-of-service differential) and an additional hospital facility fee. Payments in a provider-based setting are often greater than payments for the same services rendered in a freestanding clinic. Hospital based physician practices across the country applied for the status. Two bills are issued (one for the payment to the physician and one for the payment to the hospital), therefore provider-based billing may be confusing to patients as they will receive two bills and will be responsible for two forms of co-payment. Highmark philosophically disagrees with the provider-based status rule and has closed the loophole for Highmark provider-based status claims by not reimbursing the hospital facility fee. AHN currently bills medical oncology services at WPH and radiation oncology services at AGH as provider-based however does not bill provider-based facility fee for many other applicable services. It should be noted that AHN does not receive from Highmark oncology provider-based payments.

AHN has chosen not to implement provider-based billing status for all possible services even though this would increase revenue, income and operating cash flow. AHN analyzed physician volume that represents the incremental amount to AHN if they chose to bill as provider-based status for all services and identified an incremental opportunity of $150 - $170 million. AHN has not included this incremental provider-based status opportunity in the AHN Forecasts, however, this amount represents an opportunity the AHN management can take advantage of in the future if they so choose.

This is perhaps the best example of the IDFS maximizing benefits to patients and policyholders. Again, while not currently in the AHN Forecasts, Highmark Health and AHN reserve that right to change their position in the future based upon operational requirements, legal outcomes or regulatory changes.

Capital Expenditures

In order to achieve the Plan Objectives, AHN has proposed a significant level of capital expenditures in the forecast period in addition to investments already made since the Highmark affiliation agreement. We believe capex spend to be a critical component to achieving the Plan Objectives in the Final CAP. AHN has made significant critical capital investments since the affiliation. Grant Thornton selected a few key capex projects from a broad perspective to make site visits. In the visits, Grant Thornton sampled a few key projects to see first-hand that were representative of the broad base forecasted spend. For example, we wanted to get a mix of projects that were (1) finished, in-process or not started; (2) patient-facing vs. non-patient facing (infrastructure); (3) outpatient vs. inpatient; (4) industry-leading vs correction of deferred maintenance; and finally (5) whether they were in a trauma tertiary care hospital setting or community hospital setting.

AHN intends to use the Financial Commitment solely to fund capital expenditures. The $175 million comprises only a portion of the total forecasted capital expenditures in the forecast period. Further, expenditures related to the Financial Commitment are almost entirely for projects slated for 2015 and 2016. Total forecasted capex spend in the forecast period is $507 million.

As with any business, AHN has many capital projects which it may undertake if it generates additional funds from operations.

Management informed us that the capex spend will be continually evaluated based on available cash flow and funding. There are both additional investments that could be made in the event operations or funding yield cash above forecasted levels as well as projects that could be delayed to preserve cash to forecasted levels.

In Grant Thornton's opinion, it would be necessary for AHN to invest in capex at a level which exceeds depreciation expense in order for capex to be sufficient enough to reasonably expect to achieve the Plan Objectives. Even in management's downside scenario, we believe it is highly likely that sufficient capex will be spent to outpace depreciation. In addition, consideration should be given to the $178 million in EPIC spend that is not included in AHN financials because it is booked at the Highmark Health level, as well as the ability of management to let cash balances decline or obtain external funding. This would provide further support to increase the downside scenario capex level should the Plan Objectives require additional spend.

CAPITAL INVESTMENTS – PEER ANALYSIS

Between 2007 and 2015, at least nine healthcare provider systems have issued healthcare revenue bonds to finance acquisition, construction, renovation, and the equipping of various healthcare facilities including emergency

departments and outpatient expansions. AHN's projected capital expenditures reflect normal industry-wide capital investments and practices. Please refer to Appendix D for a summary of selected healthcare capital investments in Pennsylvania.

Risks

The Commonwealth of Pennsylvania is home to three integrated healthcare finance and delivery systems: Geisinger Health System ("Geisinger"), University of Pittsburgh Medical Center ("UPMC"), and AHN. Geisinger established its health insurance plan in 1985 and has operated it for approximately three decades. UPMC formally launched UPMC Health Plan in 1997. The former West Penn Allegheny Health System became an integrated delivery and financing system under the moniker of AHN beginning in 2013 when it affiliated with Highmark.

Affiliate Loss Relative to Primary Entity Cash and Investment Assets

$ in millions

Year	Primary Entity	Affiliate	Affiliate Loss	Primary Entity Cash and Equivalents	Primary Entity Investment Assets
1997	UPMC	UPMC Health Plan	$(13.3)	$101.9	$1,280.6
1998	UPMC	UPMC Health Plan	(16.3)	44.4	1,392.0
2013	Highmark	AHN	(135.3)	1,274.5	5,690.2
2014A	Highmark	AHN	(78.8)	1,108.6	5,347.1

Affiliate Loss as a Percent of Cash and Investment Assets

Affiliate Loss as a Percent of Primary Entity Cash and Equivalents	UPMC	Highmark
Year 1	13.1%	10.6%
Year 2	36.7%	7.1%

Affiliate Loss as a Percent of Primary Entity Investment Assets	UPMC	Highmark
Year 1	1.0%	2.4%
Year 2	1.2%	1.5%

Due to the limited availability of data, only the financial performance of UPMC/UPMC Health Plan and AHN/Highmark can be compared using the first two years of combined operations for the new entities. UPMC

Health Plan recognized losses of $13.3 million and $16.3 million in 1997 (year 1) and 1998 (year 2), respectively.[22] This loss was equivalent to 13.1% and 36.7% of cash and cash equivalents over the same period.[23] Relative to total investment assets, this loss was equivalent to 1.0% and 1.2% in 1997 and 1998, respectively. AHN recognized losses of $135.3 million in 2013[24] and $78.8 million in 2014. This loss was equivalent to 10.6% and 7.1% of cash and cash equivalents over the same period. Relative to total investment assets, this loss was equivalent to 2.4% and 1.5% in 2013 and 2014, respectively.[25] Based on this analysis, it appears that both efforts entail a similar risk profile when comparing the initial losses relative to the cash and investments of the primary entities.

In addition to risks inhered in executing the Final CAP, the execution risk previously discussed (which are consistent with the execution risk for virtually every health system), there is another risk to achieving the Plan Objectives. As health plans and provider integration becomes more prevalent across the country we expect to continue to see the sophistication and integration of regulatory agencies to keep pace. Ensuring adequate oversight while keeping a neutral and consistent approach to all IDFS is going to continue to be a focal point for Center for Medicare & Medicaid Services, State Medicaid Agencies, Departments of Health, Departments of Insurance and the National Association of Insurance Commissioners. Each is focused on this aspect of the market and is expected to continue to refine their regulatory approach towards integrated delivery models. We see the evolution towards a unified regulatory approach to IDFS in Pennsylvania as a key step in ensuring that Pennsylvanians maintain access to pro-competitive, market based, and high quality delivery systems. To the extent there is a disparity in the regulatory approach to an IDFS based upon the status of the primary entity (i.e. insurance vs. provider), we see this as having a potentially adverse impact on the entity subject to the higher level of scrutiny.

Based on our understanding of the Pennsylvania market and even the Pittsburgh market as previously discussed, AHN appears to be at a competitive disadvantage relative to the level of regulatory oversight to which it is exposed. Compared to other IDFSs and providers in Pennsylvania, it is our understanding Highmark and AHN are subjected to a higher level of scrutiny than their competitors. The oversight may cause delays in strategic actions that are not present for AHN's competitors. For instance, the process of approving capital funding for AHN is much more rigorous and time consuming than that which is typically seen for other IDFSs with their roots in the provider space. These delays can place Highmark Health and AHN at risk relative to the timing. Further, considerations are placed on AHN and Highmark for such matters as community benefit and impact on community hospitals which may not be regulatory concerns for the provider and IDFS community. Finally, the public access to strategic, operational and tactical plans may further exacerbate the challenging, competitive environment in which AHN operates. Not having a consistent regulatory approach to all IDFSs would seem that this places additional risk on AHN and Highmark Health.

Findings: Assessment of Sufficiency

There are multiple levers that the AHN management can move as they manage the health system to reach the Plan Objectives. These levers are best indicated by the assumptions in the forecasted financial statements.

Based upon our review of the Preliminary CAP and the Final CAP and the forecasted financial statements, AHN management is performing the right operational activities to meet the triple aim of the Plan Objectives at the same time as making the appropriate investments in new technologies and plant to keep the health system competitive.

[22] "Is UPMC Health Plan for sale or here to stay?" Bill Toland, Pittsburgh Post-Gazette. August 28, 2011.
[23] UPMC Health System Revenue Refunding Bonds Series 1999B Official Statement. April 1, 1999.
[24] Allegheny Health Network Annual Report, 2013.
[25] Highmark Health Audited Financials, 2014.

Our assessment of sufficiency of each of the components of the Final CAP and these operational activities is included in the detail report sections above. Our overall finding is that the Final CAP is sufficient to meet the Plan Objectives.

POLICYHOLDER COSTS AND BENEFITS

Policyholder Costs and Benefits

In accordance with requirements established by the PID, Highmark Health has prepared a report titled "IDN Savings Report for 2014" that addresses value from a policyholder perspective. While the IDN Savings Report is retrospective and the PID has requested Grant Thornton, in its role as an independent external financial expert, to provide its opinion on the CAP's benefits of policyholders on a prospective basis, Grant Thornton believes the IDN Savings Report establishes an essential foundation of methodology, perspective, and benchmarks for conducting the prospective analysis. Milliman has opined as to the reasonableness of the methodologies employed by Highmark Health to develop the IDN Savings Report. While Grant Thornton has analyzed the IDN Savings Report and the underlying documents, fact base and assumptions related to it to obtain sufficient foundational knowledge to conduct our prospective analysis, Grant Thornton is not providing an opinion as to the sufficiency of the IDN Savings Report.

The overall Highmark Health strategy requires that the enterprise operate to maximize the benefits of the IDFS which may be counter to the financial interest, but not necessarily the mission, of its entire provider network – including, but not limited to, AHN. Utilization review, reducing inpatient admissions, shortening the length of hospital stays, moving treatment to lower cost settings, managing population health, reducing reimbursement rates, etc. are core goals and tactics of health plans. These activities and strategies may work counter to traditional provider incentives. Accordingly, balancing the interests of the health plan and the provider system is difficult, and this balance is a cultural and business challenge of every converged IDFS. To date, Highmark Health has had to balance the needs of AHN and Highmark and has chosen to do what is in the best interest of the patients – who are Highmark policyholders and policyholders of other payors (i.e., Medicaid, Medicare and other commercial carriers), at times, to the short-term financial detriment of AHN.

Because of the documented savings already achieved and the aim to sustain and carry forward the successful strategies that have contributed $588 million in value through 2014, the benefit to Highmark policyholders is clear. AHN is now better able to continue to progress towards financial sustainability. This will allow Highmark to continue limiting the growth of premium costs for its policyholders in the region and further its intent of advancing the triple aim in Pennsylvania.

ASSESSMENT OF VALUE

Value

The June 19 Approval Letter calls for "an opinion as to the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investment in AHN. In our opinion, the value of AHN to both Highmark and Highmark Health relates primarily to the role that AHN plays in allowing Highmark Health to function as an IDFS. The creation of the IDFS has allowed Highmark Health to provide the residents of Southwestern Pennsylvania, including Highmark's policyholders, choice, competition and access.

VALUE TO HIGHMARK

The book value of AHN as of July 31, 2015, is $181.0 million. As shown in the financial projections, AHN plans to increase book value by $77.1 million through the projection period, to a value of $258.1 million by December 31, 2017. The expected improvement of AHN's financial position, including the various initiatives in the Final CAP appear reasonable.

VALUATION TESTING METHODOLOGY

The testing of Highmark Health's stipulated value is based on the following accepted valuation methods:

- Market Approach – uses direct comparisons to other enterprises to estimate Fair Market Value. The market approach bases the Fair Market Value measurement on what other similar enterprises or comparable transactions indicate value to be. Two commonly used methods of the market approach include the Guideline Public Company Method ("GCM") and the Precedent Transactions Method ("PTM"). Use of the GCM involves identifying and selecting publicly traded enterprises with financial and operating characteristics similar to the subject company being valued. Once publicly traded enterprises have been identified and selected, valuation multiples can be computed, adjusted for comparability, and applied to the subject company to arrive at an indication of value. The PTM involves a determination of valuation multiples from sales of business enterprises with similar financial and operating characteristics as the subject company and applying those multiples to the subject company to arrive at an indication of value.

In addition to the above, and to the extent a business's capital stock is actively and publicly traded on a recognized exchange, one may also consider the share price of such capital stock and the overall market capitalization value implied by the publicly traded value of such shares.

- Income Approach – sometimes referred to as the Discounted Cash Flow ("DCF") method explicitly recognizes that the current value of an investment is premised on the expected receipt of future economic benefits such as periodic income, or sale proceeds. In valuing a business enterprise, indications of value are developed by discounting future net cash flows available for distribution to their present worth at a rate that reflects both the current return requirements of the market and the risk inherent in the specific investment.

  The DCF method consists of estimating annual future cash flows and individually discounting them back to present value. If the cash flows continue beyond the foreseeable future, an estimate is made for the residual value of the business, which is then capitalized and discounted to the present value. The summation of the annual cash flows plus the residual value after capitalization and discounting indicates the current value of the business enterprise.

VALUATION, STUDIES, AND ANALYSES

Grant Thornton conducted studies, analyses, and due diligence we deemed necessary.

CONCLUSION – VALUE AT JULY 31, 2015

Based upon the documents reviewed, discussions with Highmark Health and AHN management and our performed procedures, it is our opinion that the value of Highmark's investment in AHN as presented to the PID in the Highmark Health consolidating balance sheet as of July 31, 2015, falls within a reasonable range of value and, therefore, is deemed to be reasonable.

Value – December 31, 2016 and December 31, 2017

Management's comprehensive PFI includes both a forecast balance sheet and cash flow statement. The forecast balance sheet reflects changes in the asset and liability accounts, as well as the impact of any positive or negative earnings on the net asset value. Grant Thornton reviewed the forecast balance sheets as a part of our overall review of management's forecast submitted to the PID. Given the reasonableness of the PFI, the net asset value of $282.9 million and $258.1 million as of December 31, 2016 and December 31, 2017, respectively presents a reasonable estimate of investment value from a book value perspective. We note that this value does not reflect the impact of any changes in the capital or financial markets.

In addition to the reasonable accounting treatment and book value of Highmark's investment in AHN, there is extensive strategic value in the IDFS strategy that Highmark and AHN both receive. This strategic value is both quantifiable (as in the IDN Savings Report) and non-quantifiable in terms of other components of the triple aim.

National Trends

Highmark's vertical integration strategy is consistent with trends observed nationally, in Pennsylvania and within the Pittsburgh market. Several organizations have operated successfully as integrated financing and delivery systems, including Kaiser Permanente, Dean Clinic, and Geisinger. UPMC has pursued a similar strategy by developing an insurance arm to further develop its market position in and around Pittsburgh. Among national examples of recent provider acquisitions by health insurers, United Health Group has purchased numerous physicians practices to develop portable care models to extend to other markets.

Downstream Value

Highmark's investment in AHN has generated and will continue to generate value to Highmark, as demonstrated in the financial forecasts for AHN. From a strategic perspective, Highmark will continue to benefit from being affiliated with a low cost, high quality health system. AHN offers a less costly counterweight and comparable quality alternative to relying on UPMC's higher cost provider network. As stated in other accepted Highmark filings, UPMC would otherwise operate as the only provider in certain sub-markets within and around Pittsburgh. The strategic value of AHN allows for Highmark's improved competitive position within these sub-markets while allowing for retention and accrual of members in the near term, as opposed to potentially losing members in a scenario with UPMC serving as the primary provider system in the market.

From an operational perspective, investments that improve AHN's operating performance will logically improve Highmark's competitive, operational, and cost position. An improved cost structure will enhance Highmark's competitive position. Highmark has submitted an analysis of the savings generated through December 2014 in the IDN Savings Report (the "IDN Savings Report") that quantifies the savings that has accrued to Highmark and its policyholders since the formation of AHN in 2013. Actions taken in furtherance of the IDFS strategy have accumulated up to $588 million in benefit to Highmark through December 31, 2014, as presented in the IDN Savings Report Highmark presented to the PID on May 1, 2015. Milliman has opined to the methodology used in this analysis.

Savings

The savings described in the IDN Savings Report accrue to Highmark in the form of lower claims expense. On a forward looking basis, the actions described in the Final CAP will maintain and increase the value described in the IDN Savings report. The investments described in the Final CAP will expand capacity at AHN facilities to accept patient volumes currently receiving care at UPMC upon expiration of the continuity of care provisions in the Consent Decrees at the end of 2016. These actions will also continue to support competitive rates in the market by providing a high-quality alternative to UPMC.

The enhanced competition among providers will likely drive and maintain competitive rates across all providers in Highmark's service area. Investments in clinical facilities and service lines, standardization of supplies and protocols for care, as well as electronic health record implementation will continue to support and potentially increase savings that have accrued to Highmark under the healthier population/right treatment category. Finally, investing in capacity and access to support lower cost facilities and services along the continuum of care, with a focus on community-based care where members are concentrated, will continue to support the savings achieved under the approach of right setting of care. IDFS Savings categories for which the Final CAP will have minimal or no impact have been marked as not applicable.

In summary, Highmark's investment in AHN is reasonable. Further, Highmark's investment in AHN will maintain or increase the value of the investment from multiple perspectives: in the form of increased book value of AHN, through Highmark's enhanced strategic position and competitive profile, which will enable Highmark to compete effectively in retaining and attracting policyholders, and by lowering the cost of medical claims. The investment in AHN will continue to provide access in Southwestern Pennsylvania to high quality AHN providers and provide value to its policyholders through moderated cost growth of premiums.

Findings: Assessment of Reasonableness

In summary, it is our opinion the value assigned to Highmark's investment in AHN is reasonable. Further, Highmark's investment in AHN will maintain or increase the value of the investment from multiple perspectives: in the form of increased book value of AHN, through Highmark's enhanced strategic position and competitive profile, which will enable Highmark to compete effectively in retaining and attracting policyholders, and by lowering the cost of medical claims. Highmark's investment in AHN will continue to provide access in Southwestern Pennsylvania to high quality AHN providers and provide value to its policyholders through moderated growth of premiums.

APPENDICES

A. Consolidated Statement of Operations

$ in millions	2014A	2015F	2016F	2017F	CAGR (2014A - 2017F)
Operating Revenues					
Inpatient Gross Revenue	$3,458.0	$3,560.4	$3,667.8	$3,754.4	
Outpatient Gross Revenue	3,314.0	3,621.8	3,908.0	4,160.5	
Professional Fee Gross Revenue	1,087.4	1,209.8	1,274.1	1,316.1	
Total Gross Revenues	**$7,859.3**	**$8,391.9**	**$8,850.0**	**$9,231.0**	***5.5%***
Contractual Allowances	$(5,482.0)	$(5,885.5)	$(6,219.5)	$(6,470.8)	
Bad Debt	(86.6)	(83.1)	(87.1)	(90.4)	
Total Net Patient Revenues	**$2,290.7**	**$2,423.3**	**$2,543.4**	**$2,669.8**	***5.2%***
% Annual Change		***5.8%***	***5.0%***	***5.0%***	
Other Operating Revenues	$161.5	$184.8	$186.3	$160.8	
Net Assets Released From Restrictions	10.9	4.7	4.7	4.7	
Total Revenues & Gains	**$2,463.1**	**$2,612.8**	**$2,734.5**	**$2,835.3**	***4.8%***
Operating Expenses					
Salaries	$1,167.3	$1,242.1	$1,303.0	$1,351.8	*5.0%*
Benefits	202.3	218.1	229.2	238.5	*5.6%*
Professional Fees & Purchased Services	272.1	279.7	266.9	266.2	*-0.7%*
Patient Care Supplies	446.0	467.2	499.3	527.2	*5.7%*
Non Patient Care Supplies	26.8	33.8	34.0	33.0	*7.2%*
Insurance	38.4	33.8	34.1	34.6	*-3.4%*
Other Operating Expenses	233.7	256.7	260.6	252.8	*2.6%*
Depreciation and Amortization	106.0	125.5	136.6	139.4	*9.6%*
Restructuring/Integration	7.2	3.7	(0.0)	(0.0)	*NM*
Total Operating Expenses	**$2,499.9**	**$2,660.8**	**$2,763.8**	**$2,843.4**	***4.4%***
Operating Income (Loss)	**$(36.8)**	**$(48.0)**	**$(29.3)**	**$(8.2)**	
Operating Margin	*(1.5%)*	*(1.8%)*	*(1.1%)*	*(0.3%)*	
Interest Expense	$(42.0)	$(31.3)	$(30.9)	$(30.5)	
Investment Income	59.5	19.7	20.8	21.6	
Gifts and Donations	0.8	1.1	1.0	1.0	
Gain (loss) in JV Investment & Loss on Refinancing	10.0	4.4	(7.5)	(11.8)	
Income Taxes	1.9	3.1	3.3	3.3	
All Other Non-Operating	6.9	4.6	(0.5)	(0.5)	
Net Income (Loss)	**$0.3**	**$(46.3)**	**$(43.1)**	**$(25.0)**	
Net Income Margin	*0.0%*	*(1.8%)*	*(1.6%)*	*(0.9%)*	

NM = Not meaningful

2014 Consolidated Statement of Operations results contain reclassifications to conform to AHN internal financial statements. The forecast model reviewed may have immaterial reporting differences.

B. Consolidated Balance Sheet

$ in millions

	2014A	2015F	2016F	2017F
Assets				
Current assets				
Cash and cash equivalents	$133.6	$102.3	$94.0	$96.3
Short-term investments	102.7	21.5	22.7	22.7
Current portion of assets whose use is limited	12.6	12.4	12.4	12.4
Patient accounts receivable, net	237.8	258.7	244.8	247.3
Other receivables	80.7	53.0	54.1	54.8
Inventory, net	45.4	47.7	48.7	49.4
Prepaid expenses and other current assets	33.2	45.1	45.1	45.0
Total current assets	**$646.0**	**$540.7**	**$521.7**	**$527.9**
Unrestricted assets - board designated	$205.7	$165.6	$159.6	$153.6
Temporarily restricted assets	18.8	19.4	19.5	19.6
Permanently restricted assets	264.2	268.5	268.6	268.8
Investments	145.5	249.6	257.4	182.4
Investments in affiliates	57.4	62.0	62.0	62.0
Property and equipment, net	997.2	1,071.8	1,090.1	1,090.0
Goodwill and other intangible assets, net	102.2	118.4	118.4	118.4
Other assets	114.4	111.7	113.7	111.7
Total assets	**$2,551.4**	**$2,607.8**	**$2,611.1**	**$2,534.4**
Liabilities and Net Assets				
Current liabilities				
Accrued salaries and benefits	$95.3	$98.8	$98.8	$99.3
Accounts payable and accrued expenses	207.6	219.6	222.1	224.6
Current portion of other liabilities	39.0	38.8	38.8	38.8
Total current liabilities	**$341.9**	**$357.2**	**$359.7**	**$362.7**
Long-term debt	$1,440.4	$1,427.0	$1,420.1	$1,414.6
Benefit plan liabilities	426.3	379.8	333.9	286.9
Other long-term liabilities	222.1	214.5	214.5	212.0
Total liabilities	**$2,430.7**	**$2,378.5**	**$2,328.2**	**$2,276.3**
Net assets				
Unrestricted net (deficit) assets	$(162.3)	$(58.6)	$(5.2)	$(30.2)
Temporarily restricted net assets	18.8	19.4	19.5	19.6
Permanently restricted net assets	264.2	268.5	268.6	268.8
Total net assets	**$120.7**	**$229.3**	**$282.9**	**$258.1**
Total liabilities and net assets	**$2,551.4**	**$2,607.8**	**$2,611.1**	**$2,534.4**

2014 Consolidated Balance Sheet results contain reclassifications to conform to AHN internal financial statements.

C. Interviews

Between August 13 and September 18, 2015, Grant Thornton interviewed 22 key stakeholders in connection with preparing this report. In addition, beginning Thursday, August 20th, Grant Thornton facilitated bi-weekly status report meetings with appropriate parties and/or individuals.

Interview List			
Name		**Entity**	**Title**
Elizabeth	Allen	AHN	Chief Financial Officer & Treasurer
Dave	Berry	Highmark Health	Vice President, Enterprise Actuarial Modeling & Forecasting
William	Cashion	Highmark Health	Senior Vice President and Chief Actuary
Janine	Colinear	AHN	Senior Vice President, Finance
James	Dumpman	AHN	Project Manager
Dr. Tony	Farah	AHN / AC	Chief Medical Officer / President
Dr. William	Goldfarb	AHN	Senior Vice President
Joseph	Guyaux	Highmark Health	Board Chairman
Karen	Hanlon	Highmark Health	Chief Financial Officer
Nancy	Hill	AHN	Director, Finance
David	Holmberg	Highmark Health	President & Chief Executive Officer
Brian	Holzer	Diversified Business	Senior Vice President
Kevin	Kusic	AHN	Director of Finance Analytics
Patricia	Liebman	AHN	Chief Operating Officer
Timothy	Loch	AC	Chief Financial Officer
Julie	Mannion	AC	Director of Finance
John	Paul	AHN	Chief Executive Officer
Heather	Price	Highmark Health	Vice President, Enterprise Finance Strategy & Support Services
Steven	Shaffer	Diversified Business	Vice President, Finance
John	Smith	AHN	Director of Financial Planning
Tammy	Suchanek	AHN	Program Manager
Robert	Tobin	AGH	Vice President of Operations

D. Capital Investments Summary

Selected Pennsylvania Health System Capital Investments Summary			
$ in millions			
Health System	**Issue Year**	**Bond Issue Value**	**Capital Investment Summary**
University of Pennsylvania Health System	2015	$357.6	Payment or reimbursement of bond costs and expenses
Aria Health System (Frankford Health System)	2014	75.0	Finance acquisition, construction, renovation, and equipping of various healthcare facilities including new emergency department
University of Pittsburgh Medical Center	2013	125.0	Finance acquisition, construction, renovation, and equipping of various healthcare facilities
Temple University Health System	2012	311.1	Finance various capital projects and improvements Payment or reimbursement of bond costs and expenses
University of Pennsylvania Health System	2012	137.0	Finance ambulatory expansions, facility enhancements, and other capital expenditures
The Children's Hospital of Philadelphia	2011	100.0	Construction of new ambulatory care center, parking garage, and other capital and equipment purchases Payment or reimbursement of bond costs and expenses
The Children's Hospital of Philadelphia	2011	260.8	Construction of new ambulatory care center, parking garage, and other improvements for ambulatory, capital projects, and equipment purchases Payment or reimbursement of bond issuance costs and expenses
Heritage Valley Health System	2011	66.5	Payment or reimbursement of bond costs and expenses
Excela Health	2010	60.2	Payment or reimbursement of bond costs and expenses
Jefferson Health System	2010	347.9	Finance various capital projects and improvements Payment or reimbursement of bond costs and expenses
West Penn Allegheny Health System	2007	752.4	Finance acquisition, construction, renovation, and equipping of various healthcare facilities including new emergency department Payment or reimbursement of bond costs and expenses

E. Biographies

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Scott B. Davis

Partner

Partner, Advisory

Scott B. Davis is a partner who focuses on businesses and institutions in transition.

Experience

Scott has more than 30 years of consulting and interim management experience assisting underperforming organizations in the areas of strategic change, restructuring, performance improvement, business planning, cash flow forecasting, litigation and forensics.

His experience includes developing and implementing strategic business plans, establishing budgeting and forecasting tools, improving cash management and liquidity, negotiating refinancing and plans of reorganization, revenue enhancement, cost reduction, identifying and disposing non-core business segments, and negotiating acquisitions and dispositions, turnaround, workout and restructuring.

He has also provided forensic and litigation assistance and has served as an expert on a wide variety of matters.

Industry experience

Although Scott has experience in a wide variety of industries, he has focused the last several years on underperforming health care providers and colleges.

Selected case experience

- Casa Grande Regional Medical Center
- Forum Health Care
- Highmark Inc.
- Hospital Partners of America
- Saint Vincent Catholic Medical Centers of New York
- Wadley Regional Medical Center
- West Penn Allegheny Health System

Publications and speaking engagements

- *Health Care Insolvency* – American Bankruptcy Institute Northeast Regional Conference, July 2015.
- *Predicting the Next Storm* – Turnaround Management Association – 2015 Southeast Regional Conference and Capital Mall, May 2015.
- *Hemorrhaging Hospitals: Labor Issues in the Healthcare Insolvency E.R.* – American Bankruptcy Institute Annual Spring Meeting, April 2015.
- *Healthcare Issues* – American Bankruptcy Institute Stetson-Paskay Annual Seminar, March 2015.

- Lexis Practical Guidance on "Understanding Financial Statements", "13-Week Cash Flow Forecasting", "Role of Best Interests of Creditors Test", Financial reporting During Chapter 11", and "Valuation in Section 363 Sales", 2013, 2014, 2015.
- *Advising the Distressed Healthcare Business* – North Carolina Bar Association Annual Conference, November 2013.
- *Restructuring Health Care Providers under Obamacare* - Turnaround Management Association, November 2013.
- *Trends in Healthcare Affiliations – Is Vertical Integration a Trend for the Future?* – McGuire Woods/Grant Thornton Southeast Healthcare Provider Conference, September 24, 2013.
- *Continuing care retirement communities in distress: Considerations for restructuring and workouts* – co-author, *Health CareRx*, Fall 2012.
- *Managing Saint Vincent Catholic Medical Centers' second bankruptcy: Balancing complexity, compassion and cooperation* – Grant Thornton LLP Case Study, September 2012.
- *Current Developments in CCRC Restructuring and Workouts*, ABI Journal, Intensive Care column, June 2012.
- *Understanding Financial Statements for Lawyers* – ABI Spring Meeting 2011.
- *Healthcare Providers under Pressure: Make the Most of Challenging Times*, December 2010, *New Perspectives*, Accounting Matters.

Professional qualifications and memberships

- American Bankruptcy Institute (ABI) and ABI Healthcare Committee, member
- Turnaround Management Association, member
- Association of Insolvency and Restructuring Advisors, member
- American Institute of Certified Public Accountants, member
- Certified Insolvency and Restructuring Advisor (CIRA)
- Certified Public Accountant (CPA) – Connecticut and North Carolina (27675)

Community activities

American Red Cross of the Western Carolinas Region – Board Member
CareRing NC – Board Member

Education

Bachelor of Science, University of North Carolina at Chapel Hill, *Morehead Scholar*

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David Tyler

Principal

Principal, Healthcare Advisory

David is a Principal in the Healthcare Advisory Services practice of Grant Thornton. David leads the national health plan practice, the SE provider practice and supports our Public Sector healthcare practice. He is based in Atlanta, Georgia.

Experience

David has over twenty years of experience primarily in the Healthcare and Managed Care Industry. His primary areas of expertise include provider strategy, revenue cycle, managed care, payment models, finance, M&A, strategic/business planning, payer operations, managed Medicaid and MA/PD. David has:

- Performed various health plan and Medicaid engagements including: operational, strategic and attorney/client privileged engagements for local, regional and national payers.
- Areas include: claims operations, compliance, quality programs, enrollment/disenrollment, network development, provider contract load, appeals/grievance, case install, M&A, health information exchange, FWA, BI, ACO and internal audits/SSEA16 reports.
- Served multiple academic medical centers, for and nonprofit systems, children's, safety net and community hospitals in the areas of revenue cycle, finance, strategy, operations, M&A, IT, ICD-10, managed care, payment model redesign and ACO development.
- Performed various operational and financial projects for commercial, Medicare, MAPD/PBM and Medicaid health plans including affiliate company pricing analyses, operational improvements, costing projects and BI analytics/assessments.
- Performed multiple health IT projects with expertise in claims system, EMR, BI, Cost accounting, EPM, MMIS/DSS and health information exchange (HIE) development.
- Served as CEO of a financial services technology company leading multiple rounds of private equity financing.
- Served as interim CEO of an employer sponsored, consumer driven healthcare company.
- Expert witness qualified in written, deposition and trial testimony.
- Served in a similar capacity with the health advisory practice at Ernst & Young.

Presentations and publications

David speaks frequently on healthcare and has published articles on healthcare and managed care.

Community involvement

Board of Directors of Youth Villages, Inc. a national behavioral health provider recognized by the White House as a leading "high impact, results oriented" nonprofit.

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Appendix D – Glossary of Terms

AHN	**Allegheny Health Network**
Approval Letter	**June 19, 2015 letter from the Department approving the Financial Commitment (as defined in the Approval Letter) by Highmark to AHN**
Corrective Action Plan (CAP)	**Corrective Action Plan as described in the Approval Letter**
Department	**Pennsylvania Insurance Department**
Highmark	**Highmark Inc.**
IDFS	**Integrated delivery and financing system**
Order	**April 29, 2013 Approving Determination and Order No. ID-RC-13-06 approving a change of control of Highmark and other domestic insurers**
WPAHS	**West Penn Allegheny Health System, Inc.**