

BEFORE THE ATTORNEY GENERAL OF THE STATE OF COLORADO 1300 Broadway, Denver, CO 80203	
In re: Master Plan of Conversion filed by Total Community Options, Inc., d/b/a InnovAge, and its Subsidiaries	
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OBJECTIONS AND COMMENTS TO THE MASTER PLAN OF CONVERSION FILED BY TOTAL COMMUNITY OPTIONS, INC., D/B/A/ INNOVAGE AND ITS SUBSIDIARIES, BY THE COLORADO CROSS DISABILITY COALITION, JULIE REISKIN ON BEHALF OF PAMELA CARTER, AND THE COLORADO CENTER ON LAW AND POLICY	

Pursuant to §25.5-5-412, C.R.S., the Colorado Cross Disability Coalition (CCDC), Julie Reiskin on behalf of Pamela Carter, and the Colorado Center on Law and Policy (CCLP) (together “Objectors”), present their objections and comments to the Master Plan of Conversion (hereinafter referred to as the “Plan of Conversion”) filed on October 30, 2015, and updated by the filing of 2015 Financial Statements on Nov. 6, 2015, by Total Community Options, Inc., d/b/a/ InnovAge (hereinafter referred to as “InnovAge”) and its subsidiaries (hereinafter collectively referred to as the “Converting Entities”).

Objectors:

CCDC is a nonprofit Colorado corporation whose members are persons with disabilities and their non-disabled allies. Among CCDC’s members are persons over the age of fifty-five with disabilities who are eligible for Medicare and Medicaid Long Term Care, from whom InnovAge’s client population is drawn.

Pamela Carter is a 67-year-old resident of Colorado who is eligible for and currently receives health care and long term care services through Medicare and Colorado Medicaid. Julie Reiskin is Ms. Carter’s personal representative.

CCLP is a nonprofit Colorado corporation. Its mission is to advocate in legal, legislative and administrative proceedings on behalf of vulnerable, low-income Coloradans. Among the Coloradans CCLP represents are elderly and frail persons eligible for Medicare and Medicaid Long Term Care, from whom InnovAge’s client population is drawn. CCLP has substantial expertise in programs for Medicaid and Medicare eligible persons and was involved in lobbying before the Colorado General Assembly with law makers and interested parties concerning the provisions of Senate Bill 15-137, which in conjunction with the Attorney General’s common law powers and principles of charitable trust law, govern the proposed conversion of the Converting Entities.

Proceedings:

In May 2015, the Centers for Medicare and Medicaid Services (CMS), pursuant to Congressional authorization and following the conclusion of a demonstration program, authorized the Medicare and Medicaid programs to contract with for-profit Programs of All Inclusive Care for the Elderly (“PACE”) providers. Colorado Senate Bill 15-137, passed during the 2015 Colorado legislative session, authorized Colorado PACE programs to operate as for-profit entities, or to convert to for-profit entities, pending federal authorization. Senate Bill 15-137 included certain provisions that governed the conversion process and expressly acknowledged that the Attorney General retains her common law authority in PACE conversion proceedings as follows: “Nothing in this section shall be construed to affect the common law authority of the attorney general.” §25.5-5-412(14)(a)(II)(c), C.R.S.

InnovAge operates a PACE program and filed a Plan of Conversion with the Colorado Attorney General on October 30th, 2015. Under the Plan of Conversion, the Converting Entities propose to convert to Colorado for-profit companies as part of a conversion transaction (the “Transaction”) with Welsh, Carson, Anderson & Stowe XII, L.P. (“Welsh”) and to distribute the proceeds of

the transaction to the Total Community Options Foundation d/b/a/ InnovAge Foundation (“Foundation”). CCLP objected to the Plan of Conversion as incomplete and the Plan of Conversion was amended on November 6, 2015, to include the Converting Entities’ Fiscal Year 2015 audited financial statements.

CCLP submitted comments and questions to Attorney General Coffman on November 13th and 17th. No response has been made to date to the questions posed. Four Colorado health foundations, three of which were created through prior conversions (hereinafter referred to as “Conversion Foundations”), submitted comments on December 2nd. Members of the public and community organizations focused on increasing access to health care and protecting the interests of Colorado’s disabled, frail and elderly have also submitted comments.

History of PACE

The PACE model of comprehensive, integrated, community based medical and long term care services for the frail elderly originated with the development of On Loc Senior Health Services in San Francisco, California in 1971. PACE was authorized as a national replication project by section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended, and made permanent in the Balanced Budget Act of 1997.

PACE provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits and services. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit.

In order to qualify, PACE applicants generally must be 55 years of age or older, live in the service area of a PACE organization, be eligible for long term care, and be able to reside safely in the community. PACE is a risk based, financially capped program. Once enrolled, the program becomes the sole source of services, including hospital and nursing home care, for Medicare and Medicaid eligible enrollees. §25.5-5-412(8), C.R.S. Participation is voluntary. The federal PACE Innovation Act of 2015, signed into law on November 5th, 2015, expands the reach of PACE by clarifying waiver authority applicable to the program, including authorizing the participation of people with disabilities under the age of 55.

According to the National PACE Association, there are currently 116 PACE programs in thirty-two states, with approximately 35,000 enrollees. InnovAge has operated a PACE program in Colorado for twenty-five years and is the state’s largest PACE provider as well as one of the largest PACE providers in the nation. InnovAge’s PACE sites are located in Denver, Aurora, Pueblo, Lakewood, Loveland, and Thornton, Colorado. InnovAge also operates more recently developed PACE sites in Albuquerque, New Mexico, and San Bernardino, California. According to the Colorado Department of Health Care Policy and Financing, InnovAge serves over 2,600 Colorado Medicare-Medicaid enrolled individuals through PACE. *See CMS website: avail. at*

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Monthly-Enrollment-by-Plan.html?DLSort=1&DLEntries=10&DLPage=1&DLSortDir=descending>. Additionally, in the Colorado 2014-15 Fiscal Year, Innovage received over \$164 million in Medicare and Medicaid premiums. App. 1, Levitt Innovage Valuation Analysis (LIVA), p. 12.

Standard of Review:

The Colorado Attorney General reviews the proposed Transaction pursuant to §25.5-5-412, C.R.S.; §24-31-101(5) C.R.S.; §6-19-104(1) C.R.S. and her common law authority and principles of charitable trust law. Principles of charitable trust law require state Attorneys General to determine that conversions of nonprofit entities to for-profit status are in the public interest as well as in the interest of the communities served by converting nonprofits. *In the Matter of the HealthONE System Membership Interest Purchase Agreement (HealthONE Decision)*, ____ Op. Colo. Att’y Gen. ____, ¶ 2 (2011) (also avail. at: http://www.coloradoattorneygeneral.gov/sites/default/files/press_releases/2011/10/13/report_re_healthone_transaction.pdf); National Association of Attorneys General Model Legislation on Conversion of Nonprofit Health Care Entities to For-Profit Status (NAAG Model Legislation), Resolution at Whereas Clause 3.

In 1998, in response to a wave of healthcare conversions nationwide, the National Association of Attorneys General (NAAG) adopted Model Legislation on Conversion of Nonprofit Health Care Entities to For-Profit Status. Although the 1998 Model Legislation is silent as to its application to PACE programs, that lack can be traced to PACE being then restricted to nonprofit providers. Only in 2001 was notice given for the solicitation of proposals for for-profit demonstration projects, and conversions were not then contemplated. Medicare and Medicaid Programs; Notice for the Solicitation of Proposals for the Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE), 66 Fed. Reg. 155 (Aug. 10, 2001). Additionally the magnitude of this transaction justifies the application of protections outlined in the NAAG Model Legislation.

The Model Legislation and Commentary emphasize the special responsibility of Attorneys General as protectors of charitable assets on behalf of the beneficiaries of charitable health care entities, stating:

[T]he assets involved in these transactions are charitable assets involving public charities for which the public has granted tax-exemptions to build the value of the entity over time. Because these transactions involve healthcare entities and raise critical issues of healthcare availability and accessibility, the standards contained in the model act are appropriate and warranted.

NAAG Model Legislation, Notes to the Model Act at 9.01

Emphasizing that “under general common law principles Attorneys General have traditionally served as protectors of charitable assets on behalf of the beneficiaries of charitable health care entities”, NAAG Model Legislation, Resolution at Whereas Clause 3, the Model Act and Commentary offer substantial guidance on the principles that ought to guide a review of any proposed healthcare conversion, including the following eleven key elements:

1. Whether the nonprofit healthcare entity will receive full and fair market value for its charitable or social welfare assets;
2. Whether the fair market value of the nonprofit healthcare entity’s assets to be transferred has been diminished by the actions of the parties so that the fair market value of the assets will not be transferred to one or more foundations as a result of the proposed transaction.
3. Whether the proceeds of the proposed nonprofit healthcare conversion transaction will be used consistent with the trust under which the assets are held by the nonprofit healthcare entity and whether the proceeds will be controlled as funds independently of the acquiring or related entities;
4. Whether the proposed nonprofit healthcare conversion transaction will result in a breach of fiduciary duty, as determined by the Attorney General, including conflicts of interest related to payments or benefits to officers, directors, board members, executives, and experts employed or retained by the parties;
5. Whether the governing body of the nonprofit healthcare entity exercised due diligence in deciding to dispose of nonprofit healthcare entity’s assets, selecting the acquiring entity, and negotiating the terms and conditions of the disposition;
6. Whether the nonprofit healthcare conversion transaction will result in private inurement to any person;
7. Whether healthcare providers will be offered the opportunity to invest or own an interest in the acquiring entity or a related party, and whether procedures or safeguards are in place to avoid conflict of interest in patient referrals;
8. Whether the terms of any management or services contract negotiated in conjunction with the proposed nonprofit healthcare conversion transaction are reasonable;
9. Whether any foundation established to hold the proceeds of the sale will be broadly based in the community and be representative of the affected community, taking into consideration the structure and governance of such foundation; and,
10. Whether the Attorney General has been provided with sufficient information and data by the nonprofit healthcare entity to evaluate adequately the proposed nonprofit healthcare conversion transaction or the effects thereof on the public, provided the Attorney General has notified the nonprofit healthcare entity or the acquiring entity of any inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy;

11. Any other criteria the Attorney General considers necessary to determine whether the nonprofit healthcare entity will receive **full and fair market value** for its assets to be transferred...

NAAG Model Legislation, Model Act at 5.01 (emphasis added).

Colorado Conversions

Colorado now has three decades of experience with healthcare conversions. Careful oversight of those conversions has resulted in the distribution of billions of dollars in conversion proceeds to multiple conversion foundations. The Conversion Foundations, in turn, have dedicated those resources to improving the health of our state's most vulnerable citizens.

Since 1985, Colorado has seen the sale of Presbyterian/St. Luke's Hospitals (1985, sale price \$170 million used to form The Colorado Trust); the sale of Rose Medical Center (1995, sale price \$170 million used to form the Rose Community Foundation); the formation of the HealthONE joint venture between HCA and several nonprofit hospitals (1995, \$174 million used to form the predecessor of The Colorado Health Foundation); and the sale of Blue Cross Blue Shield of Colorado (1999, sale price \$155 million used to form the Caring for Colorado Foundation). Additionally, in 2011, The Colorado Health Foundation sold its interest in the HealthONE joint venture to HCA, a national for-profit hospital company, for a total increase in assets to The Colorado Health Foundation of more than \$1.4 billion dollars.

The Blue Cross conversion was governed by statute, §10-16-324, C.R.S., and overseen by the Colorado Commissioner of Insurance. The hospital conversions were reviewed under common law principles governing charitable trusts and the Attorney General's common law powers. After the hospital conversions were concluded, the General Assembly enacted a Colorado Hospital Conversion statute, §6-19-101, et seq., C.R.S., Attorney General Suthers determined that, although the Hospital Conversion statute did not apply to the 2011 HealthONE transaction, he had ample authority to review the proposed transaction under his common law powers.

In a Letter Opinion in the 2011 HealthONE matter, the Office of the Colorado Attorney General outlined the Attorney General's common law authority as follows:

The Attorney General retains common law authority over charitable assets. The Attorney General's organic act specifically acknowledges the Attorney General's common law authority over 'all trusts established for charitable, educational, religious, or benevolent purposes'. §24-31-101(5), C.R.S. The Act also states that it should not 'be construed as limiting the Attorney General's common law powers'. §6-19-104(1), C.R.S. Accordingly the Attorney General retains his common law power over nonprofit entities....

Letter from Geoffrey N. Blue, Deputy Attorney General, to Troy Eid, Esq., Greenberg Traurig LLP (Sep. 8, 2011) (avail. at: http://www.coloradoattorneygeneral.gov/sites/default/files/press_releases/2011/10/13/090811_letter_troy_eid_re_transaction.pdf).

Attorney General Suthers explicitly relied on six elements of Section 4 of the Hospital Conversion Act, which governs nonprofit to for-profit conversions, to guide his review and decision in the HealthOne matter. Those elements were:

- a. The Transaction must be in the public interest;
- b. The Transaction must result in continuing access to health care services for the affected communities;
- c. No officer or director of the [nonprofit proposing the transaction] shall have any conflict of interest regarding the Transaction;
- e. The [selling party] must receive fair market value for the sale
- h. The [recipient of the Proceeds] must maintain procedures to avoid conflicts of interest by its officers and directors; and
- i. The [recipient of the Proceeds] must maintain [the] historic mission ...[of the not for-profit whose business is being sold].

HealthONE Decision, ¶ 2, (paragraph numbering mirrors the original, which intentionally mirrored the Hospital Conversion Statute, §6-19-101, et seq., C.R.S.).

Objectors believe the principles and elements outlined in the HealthONE matter establish the basis for the Attorney General's review of the Plan of Conversion presented by the Converting Entities in this proceeding.

Summary of Position:

The Plan of Conversion fails to show that its approval and adoption is in the public interest, and therefore it must be rejected. As grounds therefor:

1. The Plan of Conversion does not show that it is in the public interest for the Converting Entities to convert from nonprofit to for-profit status or that their conversion will result in continuing access to health care and long-term care services for the population served by the Converting Entities.
2. The Plan of Conversion does not show that the entity to receive the proceeds of the transaction and its officers, directors, or employees have no conflict of interest that which would affect the independence of the Foundation or benefit the successor for-profit entity.
3. The Plan of Conversion does not show that no officer, director or employee will receive any compensation or other benefit as a result of the sale and conversion of the Converting Entities.
4. The Plan of Conversion does not show that the proposed recipient of the proceeds of the conversion will operate independently of the Converting Entities.
5. The price and valuation submitted in the Plan of Conversion do not represent the fair market value of the Converting Entities. An independent expert found the value of the Converting Entities to be at least \$303 million plus additional amounts, a figure which is at least \$117 million greater than the VMG valuation submitted in the Plan of Conversion. App. 1, LIVA, p. 25.

6. The Plan of Conversion does not show that the proposed recipient of the Transaction proceeds will economically and appropriately serve frail elderly and disabled Coloradans.

The remainder of these comments outlines material deficiencies in the Plan of Conversion and then outlines Objectors' substantive objections.

Material deficiencies of the Plan of Conversion

The Plan as submitted is not complete because it does not contain the following material information:

1. Information sufficient to demonstrate that the InnovAge Board of Directors carefully considered the pros and cons of conversion.
2. Information sufficient to demonstrate that the InnovAge Board of Directors took steps to "test the market" or to determine a range of market values which would have allowed it to evaluate any offer it solicited or received.
3. Information sufficient to determine the basis for the value of \$180,309,100 referenced on the second page of Exhibit D of the Plan of Conversion and the rejection of the value of \$211,814,000 in the VMG valuation on the last page of Exhibit C of the Plan of Conversion.
4. Information sufficient to determine the fair market value of real estate owned by any of the Converting Entities or in which they have an interest, such as appraisals and any internal estimate of value from 2010 to the date of filing.
5. Information sufficient to determine whether or not any key employee, officer or director of any of the Converting Entities or the Foundation is receiving any compensation or benefit of any kind from any of the Converting Entities or Welsh, related directly or indirectly to the transaction, including but not limited to any compensation or benefit associated with the transaction following the conclusion of the transaction.
6. Information sufficient to evaluate any business plans for expansion, and the extent to which, if any, expansion prospects have been taken into account in the valuation presented.
7. Information sufficient to determine the income and expenses for the Converting Entities for the period July 1, 2015 through October 31, 2015.
8. Information sufficient to determine why the Foundation had a negative net worth on June 30, 2015 and any steps the Foundation has taken since that date to eliminate that deficit.
9. Information sufficient to determine the qualifications of any proposed Foundation director.
10. Information sufficient to determine whether the five members of the proposed Foundation board that are drawn from the current InnovAge Board of Directors will continue to serve on the for-profit InnovAge Board of Directors.
11. Information sufficient to determine the economic benefit to InnovAge of being relieved from expenses associated with the Johnson Adult Day Center (JADP) and its effect on the Converting Entities' value to a purchaser.

12. The amounts paid or to be paid to key employees of the Converting Entities under InnovAge's Deferred Compensation Plan.
13. Information sufficient to determine the potential profitability of InnovAge Lowry at this time and in the reasonably foreseeable future and the level(s) of compensation of key employees to the extent they are employees who previously served InnovAge Lowry before the proposed transaction.
14. Information sufficient to determine that it is equally or more cost efficient to distribute the conversion proceeds to the Foundation as opposed to one or more existing health nonprofits, foundations, or for-profits.
15. Information sufficient to determine the mission of the Foundation as proposed.
16. A copy of the review InnovAge claims to have performed of other potential recipients of the proceeds, and the analysis it performed to determine the proceeds should go to the Foundation.
17. Information to determine why InnovAge chose the persons it did, rather than community based persons with a diversity of backgrounds, including representatives of the frail elderly and disabled community, to be the directors of the Foundation after the transaction.
18. Information as to whether the proposed Foundation will make grants or offer any support to recipients in any state but Colorado and to what extent.
19. The Transaction Service Agreements referred to in the filed Plan of Conversion.
20. Information sufficient to determine the amount of any expense incurred in the operations of the Converting Entities from 2013 through the conversion closing date which are attributable to conversion planning and preparation. These expenses would include extraordinary expenses, not ordinary business expenses, such as compensation to conversion experts, including but not limited to outside legal, lobbying, accounting and valuation experts as well as internal work performed.
21. Information sufficient to determine whether InnovAge has evaluated whether or not patient care may suffer as a result of a conversion transaction and whether it has taken any steps to deter or evaluate such potential harm.
22. Any proposed bylaws, mission statement or amendments to the Articles of Incorporation of the Foundation.
23. The minutes of the Board of Directors and the executive committee of InnovAge and of the Foundation for the years 2010 through the date of filing a complete Plan of Conversion.
24. Information sufficient to determine whether the approval of the proposed transaction is in the public interest and the interest of the frail elderly and disabled people of Colorado.
25. Whether Welsh or its investors may receive a tax benefit, now or in the future, by acquiring Converting Entities and the plans for distribution of that tax benefit.
26. Answers to any matters not listed herein which are included in our inquiries in the Colorado Center on Law and Policy's letter to the Attorney General of Nov. 17, 2015.

Objectors' substantive objections to the Plan of Conversion

The Plan of Conversion does not show that it is in the public interest for InnovAge to convert to a for-profit entity or that its conversion will not result in any degradation of health care services to the affected communities.

InnovAge has the burden of showing that this conversion is in the interest of Colorado's frail elderly and disabled population. Here, the Attorney General reviewing this transaction must find, prior to approval, that the transaction is in the public interest and will not result in any degradation of services to the affected communities.

In order to fulfill such a requirement, converting health services entities have been required to 1) show that additional capital is necessary to allow them to continue serving the needs of the community; and, 2) make several commitments regarding their continued operations. The types of commitments required in the hospital conversion context are illustrative of the requirements imposed by Attorneys General under their common law powers and include, among other things, assurances that:

- Communities traditionally served by the entity will continue to receive high quality care; and
- Converting entities will submit to ten years of monitoring to ensure that patients continue to receive high quality care and to require appropriate corrective action if they are not.

InnovAge's June 30, 2015 Balance Sheet shows that InnovAge had tens of millions of dollars in cash, liquid investments and Board designated funds as of that date, which could be used for expansion of services in Colorado. Nowhere in its Plan of Conversion does InnovAge explain in any detail why such funds would not or could not be employed to serve its goal of growth, especially in Colorado. While Welsh may be interested in "accelerating ... growth in the development and operation of PACE programs," Plan of Conversion, Exhibit D, InnovAge has not shown that accelerated growth is necessary to provide quality services to frail elderly and disabled Coloradans served or to be served by the PACE program.

Nor does the Plan of Conversion specify any planned capital investments that will improve InnovAge's ability to serve Colorado's frail elderly and disabled population. It is unclear how additional capital will broaden InnovAge's "relationship with government and commercial healthcare insurance organizations, as well as other health services constituents," Plan of Conversion, Exhibit D, and how that will benefit the Coloradans served or to be served.

Nor does the Plan of Conversion make any provision for monitoring InnovAge's operations post conversion. For the public interest to be served there must be no degradation in the quality of care if a for-profit entity succeeds InnovAge. *See Laurie Sobel, Not in the Public Interest: Insurance Commissioners in Washington and Alaska Reject Premiera Blue Cross' Proposal, Costing Too Much, Offering Too Little*, Consumers Union (Nov. 29, 2007). The public's interest in the provision of health and related services that keep frail, elderly and disabled Coloradans in the community and out of nursing homes is substantial. In particular, the public has an interest in the accessibility and quality of those services and in the safety of our elderly citizens. Thus,

making provisions to monitor the impact that this transaction has on the provision of services to the frail and elderly population served by InnovAge is central to the Attorney General's duty to ensure that this transaction is in the public interest.

The valuation submitted in the Plan of Conversion is incomplete and substantially understates the fair market value of the Converting Entities.

The Valuation submitted in the Plan of Conversion is incomplete and substantially understates the fair market value of InnovAge. The Plan of Conversion presents a valuation by VMG Health (VMG), which states the fair market value of InnovAge to be approximately \$186 million (\$180.3 million plus approximately \$6 million in stock in InnovAge going forward). App. 1, LIVA, Dec. 4, 2015 (LIVA), p. 23. However, the VMG report is out of date and inadequate for several reasons, including but not limited to the following:

1. It fails to take into account the uniqueness of InnovAge in the current market for companies serving the Medicaid-Medicare eligible population. App. 1, LIVA, p.17.
2. The InnovAge data relied upon in the VMG Report are at least 21 months old (as of Feb. 28, 2014) and the other metrics are now at least 18 months out of date. App. 1, LIVA, p. 15.
3. The VMG Report does NOT rely on MARKET data to determine fair MARKET value. App. 1, LIVA, p. 16. Instead, it relies upon an income approach which is not suited to a company like InnovAge in a fast-growing, dynamic market. App. 1, LIVA, pp. 16-17.
4. To the extent the VMG Report refers to market data, it refers to market data relating to public companies as of April 29, 2014, which is substantially out of date in a dynamic market. App. 1, LIVA, p. 16.
5. It fails to provide current fair market value of real estate owned by the Converting Entities, which should be established by current appraisals. App.1, LIVA, p.23.
6. The VMG Report or other Plan of Conversion materials fail to provide the financial information requested in paragraphs 2, 3 ,4, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19 , 24, 25, 26 and 27 of CCLP's November 17, 2015 Letter to the Attorney General requesting that such information be provided.

The principles of charitable trust law and conversions require that the fair market value of the company remains dedicated to the elderly and frail community being served. *See* NAAG Model Legislation discussion above. The VMG report fails to substantiate the fair market value of the Converting Entities. Therefore, the Plan of Conversion must be rejected, or if the Plan of Conversion is found sufficient in other respects, a different and adequate valuation must be used.

The Levitt InnovAge Valuation Analysis (LIVA) is up to date, and more complete. It describes and analyzes extensively the market for "dual eligibles" (persons eligible for both Medicaid and Medicare). It analyzes what has been happening in the public market with respect to companies serving this population and it analyzes other unique factors which result in heightened value to InnovAge. App. 1, LIVA, pp. 5-8.

Additionally, in a standard form of financial valuation, the LIVA provides for an Earnings Before Interest, Taxes, Depreciation and Amortization (EBIDTA) analysis; often called a “cash - flow” analysis. App. 1, LIVA, p. 9. The analysis shows that the multiple of the trailing twelve months EBIDTA used in public market transactions in the recent past range from 9 to 19. App. __, LIVA, pp. 22. The analysis arrives at a normalized annualized EBITDA for InnovAge for fiscal year 2015 of \$25.7 million. App.1, LIVA, pp, 11-15. It concludes that a multiple of 12 to 14 times normalized annualized EBITDA is appropriate. App. 1, LIVA, p. 22.

As to valuation, the Levitt Valuation Analysis concludes:

Based on this research and analysis, it is my professional opinion that the proposed consideration of \$186.4 million...substantially understates the fair market value of the organization in the current competitive managed care market.

Specifically, my opinion is that the fair market Value of InnovAge (Converting Entities) as of June 30, 2015, is in the range of \$303 million to \$354 million plus the fair market value of owned real estate (which should be based on a recent market appraisal).

At closing additional adjustments to fair market value would need to be made for changes from June 30, 2015 for debt outstanding, the excess cash calculation, conversion-related expenses incorporated into the InnovAge financial results (an increase to EBIDTA) and any changes in trailing twelve months EBITDA.

App., 1, LIVA, p. 25.

Based on the Levitt valuation, the Attorney General should find that the fair market value of InnovAge is a number within the range of \$305 and \$354 million, plus the fair market value of InnovAge’s real estate to be determined upon current appraisals, which InnovAge must provide. The final finding of fair market value (and approval of any conversion) must await such appraisals, an estimate of closing adjustments, and other appraisals and adjustments that may be appropriate. If not previously made public, such appraisals and adjustments should be made public or described in any ruling approving the Plan of Conversion.

In addition, neither InnovAge nor Welsh have provided any justification for the placement of \$15,842,130 of the proposed purchase price into escrow for four years. *See* Plan of Conversion, Exhibit 4, p. 12. The recipient of the proceeds will have adequate funds to remedy any post-closing deficiency. Any escrow would only diminish the value of the purchase price and should result in a finding that fair market value is not being obtained. The Attorney General should eliminate that condition of purchase.

Next, the Plan of Conversion proposes that the costs of the conversion be deducted from the fair market value Purchase Price. Providing a public benefit under the *cy pres* doctrine means that the full value is transferred to the public, and not reduced prior to transfer. Under the doctrine of *cy pres*, meaning “as near as possible,” charitable funds must be used according to the original

purposes for which they are held, unless it is illegal, impracticable, or impossible to do so. They should not be used to facilitate or subsidize a private business transaction.

Finally, Objectors state that to the extent, if any, that Welsh or its investors may receive a tax benefit by acquiring the Converting Entities, the Attorney General should require that the economic value of any such benefit be transferred to the recipient of the proceeds realized by the conversion. Such a benefit, if available, occurs not because any work or effort on the part of the Buyer or its investors, but rather because of the nonprofit status of the Converting Entities, and belongs to the public. It should be considered an additional incident of the transaction and conveyed to the recipient of the proceeds.

The Plan of Conversion fails to provide assurance that the charitable assets held by InnovAge will continue to be dedicated to a charitable purpose that benefits Colorado's frail and elderly population.

As a Colorado nonprofit, InnovAge is a public benefit corporation and, as such, holds its assets in "charitable trust." The revenues and other assets that constitute a charitable trust are held for charitable purposes and belong to the public or to the charitable beneficiaries the trust was organized to serve. Thus, if a nonprofit dissolves or converts to a for-profit, the assets held in charitable trust must be distributed so they may continue to be dedicated, pursuant to the *cy pres* doctrine, to purposes as near as possible to their historical purpose. As the guardian of charitable trusts in Colorado, the Attorney General must ensure that the assets held by the Converting Entities, will continue, post conversion, to be dedicated to a charitable purpose that benefits Colorado's frail elderly and disabled population.

In this regard, the Plan of Conversion is deficient for several reasons.

First, it does not provide adequate assurances that the charitable assets held by InnovAge will continue to be dedicated to a charitable purpose. Assets are dedicated to a charitable purpose if they are held by an entity that "operates primarily for the benefit of the community" and provides "a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues." IHC Health Plans v. Commissioner, 325 F.3d 1188, 1199 (10th Cir. 2003); Bob Jones Univ. v. United States, 461 U.S. 574, 591 (1983). A public benefit organization under current law is one that does work that would otherwise "have to be undertaken at public expense." United Presbyterian Assoc., 167 Colo. 485 at 496 (Colo. 1968).

Far from ensuring that the Foundation will operate "primarily for the benefit of the community" to "supplement or advance the work of public institutions," the Plan of Conversion is vague and, where it provides some detail, seems to indicate that the Foundation will benefit InnovAge, the for-profit, rather than Colorado's frail and elderly community generally. The Plan of Conversion describes the Foundation's beneficiaries going forward as "the under-served aging population historically *served by InnovAge*." Plan of Conversion, Exhibit B, p. 8 (emphasis added). Later the Plan of Conversion provides that the Foundation, going forward, will provide "funding for continued support of the frail elderly community *served by the Company*." Plan of Conversion, Exhibit D, p. 11 (emphasis added).

That focus on InnovAge's clientele raises questions about whether InnovAge's plan for the proceeds is intended to enhance the business of the future private company rather than the interests of frail elderly and disabled Coloradans. Using charitable assets to enhance the operation of a converted for-profit business violates charitable trust principles and does not serve the public interest.

That lack of clarity around the Foundation's purpose itself violates Colorado's PACE conversion statute, which requires that the plan provide a "detailed explanation of the plans for distribution of the proceeds." §25.5-5-412(14)(a)(I)(B), C.R.S. The "detailed explanation" required by the Colorado PACE statute, should include a clear purpose with a delineated target population, including health, age, and geographic characteristics, and a plan for structured community involvement that would lead to creation of a mission statement.

The Plan of Conversion's proposal to distribute the conversion proceeds to its own Foundation also creates a greater opportunity for private benefit at the expense of the public. The NAAG Model Legislation reflects those concerns by directing Attorneys General to consider whether conversion proceeds "will be controlled as funds independently of the acquiring or related entities." NAAG Model Legislation, Model Act at 5.01(3). Additionally, scholars have noted that "the potential for divided loyalties . . . [is greater] where members of the former nonprofit . . . form the new foundation's board and, in joint ventures, where the foundation shares the hospital's profits and some of the foundation's trustees sit on the boards of both organizations." Stephen Isaacs, *Health care conversion foundations: a status report*, 16 Health Affairs 6, 228-36 (1997).

Julie Silas for Consumers Union also states, based on a review of health and non-health conversions in several states prior to 2000, that where members of the board that arranged the conversion continued on the new foundation board, "the overlap led to conflicts of interest and the new foundation being used to further the business interests of the for-profit corporation." Julie Silas, *Good as Gold: Preserving Community Resources in Nonprofit Conversions*, Consumers Union, June 2000, p. 28 (avail. at: <http://consumersunion.org/pdf/Gold.pdf>). She says "[a]dvocates should demand . . . foundation independence from both the former nonprofit and the new for-profit" as well as "a community process for determining the mission, governance, and structure of the new foundation" and mechanisms that will ensure ongoing community involvement. *Id.*, 31-2 (emphasis in original).

She describes a student loan market conversion where the new foundation board was composed entirely of former nonprofit board members, and the foundation effectively acted as a marketer, funneling business to that for-profit company. *Id.*, p. 29-30. In contrast, the conversion of Blue Cross and Blue Shield of Missouri involved a settlement in which parties agreed to both full independence of board members and "an outside community advisory committee to nominate all new board members for the foundation." *Id.*, p. 28.

While the Plan of Conversion states that Amended Articles and Bylaws will reflect severance from InnovAge, the current structure of the Foundation and several elements of the Plan of Conversion undercut that assertion. Currently, the Foundation is closely intertwined with

InnovAge, and its sole designated purpose is to support InnovAge's PACE program. The Foundation is physically headquartered with other InnovAge-related entities, including Total Longterm Care, InnovAge Greater Colorado PACE, and Seniors, Inc.

In addition, the Plan of Conversion proposes a nine member board for the Foundation, five of whom are drawn from the current InnovAge Board of Directors, including the current Chair of the Board, Janice Torrez, and four of whom are drawn from the current Foundation Board. *See* InnovAge's website avail. at: <http://myinnovage.org/InnovAgeFoundation/InnovageLeadership.aspx>. The fiduciary duty of all nine board members has been to support InnovAge PACE, regardless of the board on which they sat.

There is no information provided as to whether any of the proposed board members for the Foundation will maintain their seats on the Board of the successor InnovAge for-profit. However, the Plan of Conversion does indicate that the five individuals that currently serve on the InnovAge Board and that will serve on the Foundation Board going forward will also serve on the Boards of the for-profit subsidiaries going forward. Plan of Conversion, ¶ 1(a); for listing of current board members *see* InnovAge's website avail. at <http://myinnovage.org/InnovAgeFoundation/InnovageLeadership.aspx>.

Second, the lack of independence of the Foundation creates a greater potential for private inurement. Without an independent board, it will be difficult to guard against circumstances where a particular individual or limited number of individuals benefit directly, or "reap commercial benefits from the operation of the instrumentality, though they do not do so by direct acquisition or payment over to them of its earnings." *Harding Hospital v. United States*, 505 F.2d 1068, 1072 (6th Cir. 1974) (quoting 6 Mertens, Law of Income Taxation, § 34.13, at 63-4).

The NAAG Model Legislation directs Attorneys General to scrutinize conversion transactions to "[e]nsure that no officer, director, employee, spouse or family member, or private party receives inurement from the transaction." NAAG Model Legislation, Commentary to the Model Act at II(D). The prohibition against inurement is a matter of common law but tax exemption cases should be considered in the analysis because of their common law basis. NAAG Model Legislation, Memorandum from Christine Milliken re the Model Act at 5.01(6). Such cases support the proposition that greater scrutiny is justified "where the facts indicate transactions arguably not on arm's length terms." *Orange Co. Agricultural Society, Inc. v. Commissioner*, 893 F.2d 529, 534 (2d. Cir. 1990). The relationship between the Converting and Receiving Entities is not at arm's length, and further transactions are planned. Specifically, the Plan of Conversion includes a proposal that "The Company and each of the Foundation and JADP will enter into transition services agreements upon the Conversion." Plan of Conversion, Exhibit D, p. 11-12. These agreements have not been provided in the Plan of Conversion.

Third, there are not adequate assurances that the Foundation, as structured in the Plan of Conversion, will effectively and efficiently administer the charitable assets in a way that benefits the public. Nowhere in its filing does InnovAge describe the qualifications or experience of any proposed officer or proposed director of the recipient of the proceeds. Serving on the Board of a

medium to large foundation requires very different skills and experience than serving on the board of a small foundation that has been intertwined operationally with a parent company.

Thomas David has an extensive history with conversion foundations that began in the 1990s and extends to the present. He attests to the problems that ensued where conversion foundation boards were composed of members with ties to the converting entity. Those members were short on skills essential to governing a substantial foundation, and conflicts of interest presented obstacles to adherence to the public charitable purpose. App. 2, Affidavit and Curriculum Vitae of Thomas David (David Aff.).

Based on financial information provided within the Conversion Plan, the Foundation may well lack those skills. The Foundation held assets of \$1,672,106 in June 2012, but by June 2015, it had a deficit of \$825,737. Plan of Conversion, Exhibit F. Without the benefit of further information, this may indicate mismanagement of resources or a deliberate drawdown for reasons that should properly be disclosed. Even if no mismanagement occurred, the existing Foundation certainly has no demonstrated expertise in investment and management of substantial foundation funds.

The current InnovAge Foundation also has no demonstrated expertise in soliciting, evaluating, and administering grants on the scale anticipated, and would have to newly create those capacities. Although creating such an infrastructure is costly and time-consuming, effectively reducing the benefit that the community will receive, the Conversion Plan makes no mention of what would be substantial “start-up” costs for the Foundation, and concludes without any supporting data or arguments that “distributing the Conversion proceeds to the Foundation would have a substantial impact in a highly focused manner.” Plan of Conversion, Exhibit B, p. 8.

If InnovAge has identified benefits to providing the conversion proceeds to a smaller, less experienced foundation, rather than a larger existing foundation with existing mechanisms for and expertise in investment and grant-making activities, those benefits should have been disclosed. In the absence of such information, the Plan must be rejected or the Attorney General must determine that the Proceeds of the Transaction should not go to the proposed Foundation, but to others equipped to efficiently and economically undertake their proper administration in the interest of the community to be served.

Fourth, we cannot stress enough the importance of the decision making process around the charitable foundation receiving conversion proceeds. Reflecting that concern, the NAAG Comments to the Model Legislation state:

The establishment of the new charitable foundation is a critical outcome of the [conversion] transaction. However, because of the pressure of time and the attention paid to issues of valuation, this aspect often does not get the attention it deserves during the review process.

Of considerable importance is the obtaining of public comment on the new foundation and the healthcare needs that foundation should address.

NAAG Model Legislation, Comments to the Model Act at 5.01(9). Additionally, the Commentary states:

Crafting of the articles of agreement, the bylaws and the mission statements, as well as the selection of the initial governing board of the new foundation; and public comment on these issues should be invited at the public hearing and in written comments. The establishment of a new healthcare foundation can be a major event in the history of charitable foundations in a state, and issues of affordability, accessibility, charitable mission, and duplication of existing healthcare services are legitimate topics for public comment.

NAAG Model Legislation, Commentary to the Model Act at II(E).

In the Plan of Conversion, the lack of a proposal for a public process is glaring. Engagement of a diverse segment of community stakeholders, in the view of David Miller, CEO of The Denver Foundation, is essential. As he states in his affidavit, members of the aging community and underrepresented populations should have a significant role in shaping the Foundation's work, should be involved in the selection of the Board of Directors, and should themselves be represented on the board. App. 3, Affidavit and Curriculum Vitae of David Miller (Miller Aff.).

That view is seconded by Thomas David in his affidavit of December 3, 2015 where he opines that, if InnovAge fails to establish a process to "include and seek advice" from the community, it is far more likely that the receiving Foundation will fall short of providing a public benefit. App. 2, David Aff. Mr. Miller refers to the Caring for Colorado Foundation's establishment as "a publicly accountable process." Mr. David, likewise, calls it a good example of meaningful community engagement. Mr. David also points out that a public process may very well result in a different sort of venture for the funds, such as a fellowship or training fund for medical or social work staff, an operating foundation that provides direct long term care, or even funding for community infrastructure changes, rather than a traditional foundation.

Moreover, on behalf of three of Colorado's largest and most established health foundations and its largest community foundation, CEOs Sheila Bugdanowitz (Rose Community Foundation), Ned Calonge (The Colorado Trust), Karen McNeil-Miller (Colorado Health Foundation) and David Miller (The Denver Foundation) requested in their submission of December 2, 2015, that the Attorney General "require the board of the resulting foundation to fully represent the community it serves" and ensure that "those with the most at stake" "have representation and voice in the governance of the resulting foundation." Foundations' Letter to Attorney General Cynthia Coffman, dated December 2, 2015.

The Public Interest requires a Monitoring Plan to ensure access to care and services of the population served following Conversion

The public interest requires a monitoring plan. There should be a post conversion monitoring plan to ensure: (1) that the level and quality of services provided to the InnovAge PACE population by the for-profit entity is not degraded and, (2) the nonprofit recipient of the proceeds of the Conversion acts independently and in the public interest.

Hospital conversion monitoring generally focuses on protecting the community from the potential negative impacts of a change in ownership as hospitals are a major, and often the sole source, of hospital and emergency care in a community. In the 2011 Colorado HealthONE transaction then Attorney General Suthers, citing his common law authority pursuant to § 2-4-211, C.R.S and §24-31-101(5), C.R.S., conditioned his approval of the transaction on HealthONE's adoption of several covenants and required ten years of annual reporting from the for-profit company to show compliance. The covenants included provisions related to HealthONE's participation in Medicare and Medicaid, its community benefit program and its indigent care policy. HealthONE also agreed to invite the Attorney General to the annual meeting of its Board of Directors where the report was presented. *HealthONE Decision*, ¶¶ 5,6.

With respect to The Colorado Health Foundation, Attorney General Suthers required 10 years of annual reporting to include: conflicts of interest reports for all Board, key staff, and investment managers, such reports to include individual certifications of compliance; an investment report including performance and investment policy compliance; a complete listing of all grants made by the Foundation and HealthONE, including a summary of health-related mission compliance and grants that materially impact communities outside of Colorado; and, all IRS 990 filings, including governance checklists. *Id.* at ¶ 5.

NAAG Model Legislation and Comments include the following language:

Once the transaction is completed, the role which the Attorney General has in the development of the new foundation diminishes significantly. However, it is worth considering monitoring the grant-making activity of the resultant foundation. For example, the Attorney General may wish by rule to establish a policy to review the initial round of grant-making to ensure that grants fall within the appropriate range of charitable purposes. Further, the Attorney General may wish to establish a policy to appoint an ex officio board representative to serve for one term and report the board's activity to the Attorney General.

NAAG Model Legislation, Notes to the Model Act at 5.01(9).

Objectors submit that ongoing monitoring of the converted entity in the case of a PACE conversion is critical to ensure that the population suffers no degradation in care. While a PACE conversion is somewhat different from a hospital conversion, in that PACE programs do not serve the community at large, the principle is the same: there should be no degradation of services to the community served as a result of a conversion transaction. PACE participants by definition require long-term care. Once enrolled, they depend on PACE to meet all of their medical and long term care needs, as well as provide other critical supports and services, including transportation. It is hard to imagine a population more in need of protection.

Objectors submit that an ombudsman should be established to ensure there is no degradation of services to PACE participants following a conversion. While the for-profit InnovAge will be subject to state and federal oversight as a PACE program, that monitoring does not include the

kind of independent, proactive, onsite review and intervention that is typical of an ombuds program. For example, the Colorado Long Term Care Ombudsman and the regional Area Agency on Aging Ombuds programs have the power to go on site to nursing homes and speak directly with clients as well as to intervene on their behalf. *See* <https://sites.google.com/a/state.co.us/cdhs-cai-aas/state-unit-on-aging/long-term-care-ombudsman>.

Both the Colorado State and Regional Ombudsmen are independent, third party advocates and have no other agenda, interest or conflict. They are charged with advocating on behalf of long-term care facility residents and are the only entities whose responsibility is to advocate for the rights of the resident and their families. Nursing homes are more highly regulated by CMS and Colorado Medicaid than PACE programs, and even so, it is commonly accepted that an independent third party advocate or ombudsman is essential for the protection and care of residents.

In fact, other dual eligible persons in Colorado now have an ombudsman. The State of Colorado believed that an Ombudsman was a critical component of the Dual Demonstration Project, which serves Medicaid and Medicare eligible individuals through enhanced care coordination. (PACE participants are not part of this Demonstration.) Colorado applied for and received federal funds to establish an ombuds program for Demonstration enrollees. That program is located at Disability Law Colorado and began serving Demonstration enrollees earlier this year. *See* <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>.

An appropriate monitoring plan should be the product of consultation by the Attorney General's office with an expert who has expertise in the needs of the frail elderly and disabled, and who has solicited information from the community about needs and concerns that could be addressed through monitoring. The PACE conversion statute contains a provision enabling the Attorney General to hire experts to assist in the conversion, with costs to be borne by the entity filing the plan of conversion. § 25.5-5-412(14)(a)(II), C.R.S. The buyer should ultimately cover the cost of the consultant on monitoring.

Finally, the InnovAge conversion is the first PACE conversion in the country, and there are, as yet, no regulations or policies in place to guide the Centers for Medicare and Medicaid Services or Colorado Medicaid with respect to treatment of a converting or converted entity. While there are heightened federal and state monitoring obligations for a new PACE program, whether InnovAge is subject to those heightened obligations is unknown, and ultimately may depend on the form of the transfer of ownership to Welsh.

The Plan of Conversion should be rejected for the reasons stated above. If the Plan of Conversion is ultimately cured and approved, the Attorney General should condition approval upon express guarantees from Welsh and an Adequate Monitoring Plan that includes, at a minimum:

- Annual oversight by the Attorney General for ten years of the independence and charitable purpose of the recipient of the transaction proceeds including: monitoring of conflicts of interest among officers, directors and key staff; oversight of mission compliance and grant making activities; review of 990s including governance checklists; and review of the percentage of funds distributed outside the State of Colorado.
- Ongoing monitoring of the level and quality of services provided to clients by the InnovAge PACE or successor program including establishment of an independent ombudsman to serve for at least 10 years to be funded by the for-profit PACE entity, with quarterly public reporting of complaints.
- Independence of the ombudsman from InnovAge or any successor PACE program.
- Authority of the ombudsman to proactively contact InnovAge or its successor's PACE clients and their families and representatives and to advocate on their behalf to address and resolve grievances and complaints as well as provide educational information about the PACE program and the availability of the Ombudsman.

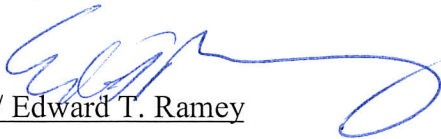
Conclusion

Objectors have pointed out the material deficiencies and other shortcomings of the Plan. InnovAge has failed to carry its burden to show that the proposed conversion:

1. Will result in continuing access to health care and long term care services for the population served at the current level of quality or above in the post-conversion period;
2. Will assure that the fair market value of the Converting Entities, in excess of \$308 million, plus the value of Converting Entities' real estate, will be obtained;
3. Will assure that the InnovAge Foundation, if it receives the proceeds of the transaction, will not act to benefit the Converting Entities, and will act, in all respects, independently of the successor for profit entity, with a diverse board of directors, which includes representative of the community being served;
4. Will assure that no key employee, officer or director of Converting Entities will receive compensation in any form for participating in any respect in the proposed transactions;
5. Will assure that the recipient of the transaction proceeds will economically and efficiently serve disabled, frail and elderly Coloradans.

For each and all of these reasons, the Plan must be rejected by the Attorney General, or approval be conditioned on material changes in the Plan which will result in these objectives (and other shortcomings pointed out in these Objections and Comments) clearly being met by the Plan.

Respectfully submitted,


s/ Edward T. Ramey

s/ Elisabeth Arenales

s/Bethany Pray

s/Edwin S. Kahn

CERTIFICATE OF SERVICE

A true and correct copy of the foregoing was delivered by United States Mail and electronic mail (on December 10, 2015) to:

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APPENDIX 1

10
SCANNED

Innovage Valuation Analysis

Prepared by:
Samuel W. Levitt, ScD, CFA
December 4, 2015

Executive Summary

This report evaluates the fair market value of Total Community Options (doing business as Innovage) and the cash and equity consideration proposed in its Master Plan of Conversion (dated October 30, 2015)¹.

The evaluation considers the Innovage Program of All-Inclusive Care for the Elderly (PACE) business model in the context of relevant market conditions, including:

- **Policy initiatives**, at the Federal and state levels, to encourage the most effective delivery of health care and long-term care services and supports to the frail elderly and disabled populations. In particular, there are a number of ongoing initiatives to facilitate more efficient and seamless interaction between the benefits offered through the Medicare and Medicaid programs; and
- **Market dynamics** generated by numerous private organizations responding to these policy initiatives.

In order to determine the fair market value of Innovage, this report also includes:

- An analysis of the audited financial statements provided by Innovage for the fiscal years ending June 30 2015 (Fiscal Year 2015), June 30 2014 (Fiscal Year 2014), and June 30 2013 (Fiscal Year 2013);
- A review of the VMG Health "Final Report" (dated July 22, 2014), which provides its Fair Market Value analysis of Innovage;
- Research on the larger Medicare-Medicaid Dual-Eligible market, which included analyzing the valuation of publicly-available data regarding managed care organizations (MCOs) providing services similar to Innovage, and reviewing recent publicly-disclosed market transactions involving organizations providing similar services.

Based on this research and analysis, it is my professional opinion that the proposed consideration of \$186.4 million² -- comprised of \$180.3 million in cash plus a 5% equity interest in the new entity, valued at \$6.1 million -- substantially understates the current fair market value of the organization in the current competitive managed care market.

This analysis shows that the fair market value of Innovage as of June 30, 2015 is in the range of \$303 million to \$354 million plus the fair market value of owned real estate.

At closing adjustments should be made for any changes in debt outstanding and working capital since June 30, 2015 as well as any changes in current earnings.

¹ The Master Plan of Conversion and related materials can be found on the Colorado Attorney General's website at: <https://www.coloradoattorneygeneral.gov/node/2185>.

² As per Exhibit D of the Master Plan of Conversion: The total is proposed to be paid to the Total Community Options Foundation, subject to adjustment to account for net working capital and closing cash amounts, and subject to adjustments for Company expenses. In addition, the Plan proposes that \$15.8 million of the total should be held in escrow for four years, subject to any indemnification or adjustment obligations of the Company.

Policy and Market Context

Demographics, fiscal realities, the health reform law, and federal policies have contributed to a rapid growth in the market for third-party, managed care programs for managing the health care and long-term care services and supports needs of individuals dually-eligible for Medicare and Medicaid benefits.

The policy-related factors driving the demand for more effective and efficient coordination of the health care and long-term care services and supports financed by Medicare and Medicaid can be summarized as follows:

- **Demographics:** The U.S. population is aging and life expectancies have increased, leading to a growing cohort of adults over 65 years old.
- **Federal and State Budget Pressures:** In addition to the pressure on social programs (Medicare and Medicaid) created by an aging population, as health care inflation continues its historical trend, exceeding economic growth and non-health care inflation, Medicare and Medicaid expenses are increasingly straining government budgets. In addition to a desire to improve the quality of care and service delivery in Medicare and Medicaid, there is a need to address the rate of growth in expenditures.
- **Managed Care Organizations are Seen as Part of the Solution:** Of the total Medicare eligibles of 54 million, over 30% are in private managed care plans (known as Medicare Advantage, or MA Plans), and at least 50% of Medicaid beneficiaries are in private managed care programs. As managed care approaches become more common, they are more commonly being extended to disabled and frail populations, and to long term care services and supports.³ Individuals in these populations have more intense medical and other needs and are frequently eligible for *both* Medicare and Medicaid. However, coordination between the two programs has been, and remains, challenging.
- **The Patient Protection and Affordable Care Act of 2010 (PPACA):** The health reform law included several related provisions, including Section 2602, which established a "Medicare-Medicaid Coordination Office" (MMCO) within the Centers for Medicare and Medicaid Services (CMS). This office has been sponsoring initiatives, most notably the Dual Demonstration program, to create innovative solutions that more effectively coordinate services offered by the Medicare and Medicaid programs (for the 10 million beneficiaries dually eligible), generally using a managed care framework.⁴ But the office has also been reviewing and advocating for changes in other programs serving the dual-eligible population, including Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) and PACE programs.

³ See: <http://kff.org/report-section/medicare-advantage-and-traditional-medicare-is-the-balance-tipping-issue-brief/> and <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8364.pdf>

⁴ See: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

Given the policy environment as described above, the various third party programs for dually-eligible Medicare-Medicaid beneficiaries have expanded rapidly since the enactment of PPACA and are expected to continue to expand:

- The dual-eligible demonstration programs (a key part of the “financial alignment initiatives” being pursued by the MMCO⁵) now cover over 380,000 individuals in 10 states.⁶ According to the Kaiser Family Foundation, as many as 2 million dual-eligible members may eventually be included in the demonstration programs.⁷
- A subcategory of Medicare Advantage plans, called Dual Eligible Special Needs Plans (D-SNPs) now cover over 1.7 million beneficiaries. And a smaller subcategory called Institutional Special Needs Plans (I-SNPs) cover about 53,000 beneficiaries that are either in nursing homes or requiring that level of care. (I-SNPs are not technically a dual-eligible program, but they cover, by definition, a frail elderly population.)
- In total, there are about 2.2 million individuals in various managed Medicare-Medicaid (and similar) programs, including the Program of All-Inclusive Care for the Elderly (PACE), Dual-Eligible SNPs (D-SNPs), Institutional Special Needs Plans (I-SNPs) and the dual-eligible demonstrations – see included tables.
- In 2013, CMS estimated the total Medicare-Medicaid dually-eligible population to be over 10 million, making up about 20% of total Medicare enrollees.⁸ Within this population, CMS says that data shows that over 40% have a “Medicare qualifying disability,” which implies a more intensive need for health care and/or long-term care services and support.

The expansion of third party managed care programs to dual-eligible populations follows the expansion of – and now near-ubiquity of -- managed care approaches to commercial and employer-based health insurance programs, as well as the expansion of managed care approaches to the (standalone) Medicare-eligible and Medicaid-eligible populations:

As with the earlier (and continuing) expansions of managed care approaches to the standalone Medicare (e.g. Medicare Advantage) and Medicaid (especially the “Temporary Assistance for Needy Families,” or TANF) populations, there are potential quality of care and financial benefits driving these changes.

⁵ See: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/AlignmentInitiativeUpdate.pdf>

⁶ See attached summary tables based on October 2015 enrollment data from the Centers for Medicare and Medicaid Services: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Monthly-Enrollment-by-Plan.html>.

⁷ See: <http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/>.

⁸ See: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

Plans with Largest Medicare-Medicaid Membership

Membership as of October, 2015 (CMS Data)

Parent	D-SNP	I-SNP	Dual Demo	PACE	Subtotal: D-SNP, I-SNP, Dual Demo, and PACE	Other MA	Total
UnitedHealth Group, Inc.	350,918	42,537	20,098	0	413,553	2,479,577	2,893,130
Humana Inc.	173,448	0	16,842	0	190,290	2,548,556	2,738,846
WellCare Health Plans, Inc.	141,201	0	339	0	141,540	214,671	356,211
CIGNA	98,004	1,007	9,931	0	108,942	392,883	501,825
Anthem Inc.	61,622	3,427	40,369	0	105,418	417,774	523,192
InnovaCare Inc.	102,225	0	0	0	102,225	104,240	206,465
Molina Healthcare, Inc.,	39,684	0	55,556	0	95,240	467	95,697
Kaiser Foundation Health Plan, Inc.	83,784	0	0	0	83,784	1,252,747	1,336,531
Medical Card System, Inc.	82,322	0	0	0	82,322	93,847	176,169
Healthfirst, Inc.	69,974	325	2,840	0	73,139	57,161	130,300
Aetna Inc.	27,924	0	27,600	0	55,524	1,221,688	1,277,212
Triple-S Management Corporation	53,491	0	0	0	53,491	70,776	124,267
Gateway Health Plan, LP	46,429	0	0	0	46,429	10,751	57,180
Health Net, Inc.	22,623	0	23,717	0	46,340	248,239	294,579
Centene Corporation	5,836	164	28,263	0	34,263	1,255	35,518
INLAND EMPIRE HEALTH PLAN	1,110	0	22,348	0	23,458	0	23,458
The New York State Catholic Health Plan, Inc.	21,884	0	600	0	22,484	20,565	43,049
UPMC Health System	19,724	155	0	506	20,385	126,010	146,395
UAB Health System	19,479	0	0	0	19,479	28,105	45,584
Southwest Catholic Health Network	19,243	0	0	0	19,243	0	19,243
Commonwealth Care Alliance, Inc.	6,700	0	10,642	0	17,342	0	17,342
Care1st Health Plan	7,258	0	9,040	0	16,298	50,210	66,508
Visiting Nurse Service of New York	13,099	0	3,014	0	16,113	4,597	20,710
Orange County Health Authority	12,609	0	2,926	67	15,602	0	15,602
CareSource Management Group Co.	0	0	15,485	0	15,485	0	15,485
All other	251,578	5,052	94,285	32,643	383,558	4,896,050	5,279,608
	1,732,169	52,667	383,895	33,216	2,201,947	14,238,159	16,440,106

D-SNP: Dual-eligible Special Needs Plan.

I-SNP: Institutional Special Needs Plan – not technically a dual-eligible plan, but serves members requiring a nursing home level of care.

Dual-Eligible Demonstration: Three-year pilot program authorized by health reform legislation.

PACE: Program of All Inclusive Care for the Elderly.

Other MA: Other Medicare Advantage plans (private Medicare plans) – aside from the above special programs.

Medicare-Medicaid Coordination Office (MMCO) and Recent Changes

Since its creation following the enactment of the health reform law, the MMCO has generated a variety of proposals, including, most notably, the “financial alignment initiatives,” which have led to the expanding dual-eligible demonstrations.

However, in addition to the financial alignment initiatives, the MMCO has also made recommendations and adjustments to the PACE program and to Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs).⁹

Largest PACE Organizations						
<i>Membership as of October, 2015 (CMS Data)</i>						
Parent	PACE	D-SNP	I-SNP	Dual Demo	Other Medicare Advantage	Total Medicare Advantage
CentorLight Health System, Inc.	2,817	0	1,043	346	0	4,206
Total Community Options, Inc.	2,673	0	0	0	0	2,673
Providence Health & Services	1,565	0	0	0	47,959	49,524
Altamed Health Services Corporation	1,402	0	0	0	0	1,402
On Lok, Inc.	1,269	0	0	0	0	1,269
Trinity Health	1,238	0	0	0	50,516	51,754
Fallon Community Health Plan	933	4,372	0	0	13,447	18,752
Element Care, Inc.	883	0	0	0	0	883
Blountville Senior Health Services	832	0	0	0	0	832
Rochester General Health System	642	0	0	0	0	642
Center For Elders Independence	610	0	0	0	0	610
Community Care, Inc.	605	545	0	0	0	1,160
Lutheran SeniorLife	603	0	0	0	0	603
Riverside Healthcare Association	549	0	0	0	0	549
Living Independence for the Elderly	526	0	0	0	0	526
UPMC Health System	506	19,724	155	0	126,010	146,395
All Other	15,563	1,707,528	51,469	383,549	14,000,227	16,158,336
Total	33,216	1,732,169	52,667	383,895	14,238,159	16,440,106

D-SNP: Dual-eligible Special Needs Plan
I-SNP: Institutional Special Needs Plan -- not technically a dual-eligible plan, but serves members requiring a nursing home level of care.
Dual-Eligible Demonstration: Three-year pilot program authorized by health reform legislation.
PACE: Program of All Inclusive Care for the Elderly.
Other MA: Other Medicare Advantage plans (private Medicare plans) -- aside from the above special programs.

In the last six months, in part through the efforts of the MMCO, there have two notable policy changes relating to the PACE program that are especially noteworthy and relevant to the Innovage conversion:

- As of May 2015, organizations sponsoring PACE programs can now be for-profit entities¹⁰; and

⁹ Related to Dual-Eligible Special Needs Plans see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/AlignmentInitiativeUpdate.pdf> and <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Minnesota.html>.

¹⁰ Previously PACE programs were required to be not-for-profit organizations. See: <https://innovation.cms.gov/Files/reports/RTC> For-

- In early November, 2015 a law was enacted extending CMS' waiver authority related to the PACE program¹¹, which MMCO had been seeking¹², and which is expected to lead to a pilot to extend the PACE model to disabled adults between the ages of 21 and 55.

Implications of The Policy and Market Context for the Valuation of Innovage

In my opinion, the sum total of the changes to date -- along with ongoing attention from policymakers, legislators, and the MMCO -- will make the PACE programs more visible and will more firmly place them within the larger (and expanding) dual-eligible framework, along with the D-SNPs and the dual-eligible demonstrations.

This, in turn, will make the programs' organizational experience and expertise more valuable in the market. Put another way, **given the potential benefits and the potential risks involved in the expansion of innovative integrated Medicare-Medicaid programs, managed care organizations and investors are seeking to develop and acquire related expertise.** This is driving the demand for -- and thus the valuation of -- specific organizations and assets with demonstrated capabilities.

Clearly, Innovage is one such organization with the related experience and the specific expertise. It is the second largest standalone PACE program in the country, with operations in three states, including California. And it is the first not-for-profit to seek to convert to for-profit status with the backing of a financial sponsor.

Profit PACE Report to Congress 051915 Clean.pdf, Page 6: "We cannot conclude that any of the BBA statements are true. As such, under sections 1894(a)(3)(B) and 1934(a)(3)(B) of the Act, after the date this report is submitted to Congress, the requirement that a PACE organization be a not-for-profit entity will not apply."

¹¹ Since enactment, PACE programs have been limited to participants who were at least 55 years old, and who met other requirements. New law granting the Department of Health and Human Services the flexibility to grant waivers regarding this requirement:
<https://www.congress.gov/bill/114th-congress/senate-bill/1362>.

¹² See: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2014_RTC.pdf.

Valuation: Review, Analysis, and Opinion

This section of the report discusses Innovage's historical financial performance, reviews and discusses the Fair Market Value report provided by VMG Health, and then steps through and applies a market-based valuation approach to arrive at a contrasting fair market value for Innovage.

To be more specific:

- Immediately below is a review and analysis of the financial data provided by Innovage, based on three years of audited financial statements.
- Following that is a detailed analysis of Innovage's earnings and earnings profile over time, in order to further evaluate its financial position, its likely earnings trajectory, and to begin to develop a baseline earnings range for the most recent fiscal year.
- The earnings analysis is used to generate Innovage's normalized fiscal 2015 earnings, focusing on Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA).
- Next is a review of the Fair Market Value analysis report provided by VMG Health, which forms the basis for the \$186.4 million in proposed consideration offered for Innovage.
- This report then steps through research and analysis on the managed care market. This review focuses in on the Medicare-Medicaid Dual Eligible population in private managed care organizations, and then on acquisition transactions focused on the Medicare-Medicaid Dual Eligible population. These organizations and transactions are then used to generate market multiple valuation benchmarks for the valuation of Innovage in the current environment.
- The final section of the report applies the valuation benchmarks to the normalized Innovage EBITDA to calculate the fair market value of Innovage.

Innovage Financial Statement Analysis

Innovage provided three fiscal year-end financial statements along with its plan of conversion -- for fiscal years ending 6/30/2015 (fiscal year 2015), 6/30/2014 (fiscal year 2014), and 6/30/2013 (fiscal year 2013). These statements provide financial information for four fiscal years, including the fiscal year ending 6/30/2012, which was included on the fiscal 2013 statement.

The Innovage financial statements provide information through June 30, 2015, and so this analysis -- and my opinion -- is necessarily as of that date:

To summarize Innovage's financial position:

- **Innovage has a solid balance sheet and capital structure:** Its debt, debt coverage and capital structure ratios are all reasonable. The organization's interest coverage ratio is especially strong, and the debt service coverage ratio has also been strong. Innovage made a large principal payment in FY2015, which lowered the debt service coverage ratio for the year -- in isolation, not a positive metric, but, of course, the principal payment also lowered overall debt, which is a net positive. Innovage had \$145.5 million in unrestricted net assets at the end of fiscal year 2015 (6/30/15), an increase of \$21.6 million from the end of fiscal year 2014. The size of the unrestricted net assets, and the 56% growth in unrestricted net assets over the three-year period (since June 30, 2012) -- a 16% compound annual growth rate -- shows that the organization is on firm footing.

Innovage					
<i>Fiscal Years ending June 30</i>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<i>average</i>
Capital Structure					
Times Interest Earned	8.73	8.21	7.58	6.71	7.81
Debt Service Coverage Ratio	8.57	7.61	7.28	1.97	6.36
Debt/Net Assets	40.5%	35.1%	36.4%	27.4%	34.9%
Debt to Total Capitalization	28.8%	26.0%	26.7%	21.5%	25.8%
Debt/Total Assets	24.5%	22.6%	22.6%	17.8%	21.9%
Net Assets/Total Assets	60.4%	64.4%	62.1%	64.8%	62.9%

- **Innovage's liquidity metrics are also strong:** In particular, it has maintained a strong cash position, with \$97.2 million in cash and cash equivalents, short-term investments, and board-designated funds at June 30, 2015. Its current ratio is good, and its current ratio including board-designated funds is very favorable.¹³ Other favorable metrics are days in accounts receivable (relatively lower) and average payment period (relatively higher), both of which imply consistent attention to working capital management and contribute to the favorable overall liquidity and cash position.

Innovage					
<i>Fiscal Years ending June 30</i>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<i>average</i>
Liquidity ratios					
Current ratio	2.58	2.33	1.95	2.18	2.26
Current ratio Incl. Board-Designated funds	3.19	3.18	2.58	2.86	2.95
Quick ratio	2.47	2.23	1.88	2.07	2.16
Acid test ratio	2.00	1.87	1.34	1.83	1.76
Days in Accounts Receivable	25.52	17.12	38.41	17.44	24.62
Days cash on hand	150.18	135.61	151.70	193.62	157.78
Average Payment Period	67.51	49.83	77.37	77.30	65.50

- **Innovage has been solidly profitable over the four-year period:** Operating margins were in the 7.4% to 8.0% range over the period, with an average of 7.7%. Earnings Before Interest Taxes, Depreciation and Amortization (EBITDA) margins were in the 10.7% to 12.1% range over the period, and averaged 11.4%. These are very strong results, are consistent over time –

¹³ Board designated funds are included as the restriction is “self-imposed” by the organization and these funds are considered available to the board under FAS117:
http://www.fasb.org/jsp/FASB/Document__C/DocumentPage?cid=1218220128861&acceptedDisclaimer=true

and compare very favorably to public companies. This alone makes Innovage an attractive target for acquisition.

Innovage					
Fiscal Years ending June 30	2012	2013	2014	2015	average
Profitability					
EBITDA Margin	10.7%	11.4%	12.1%	11.5%	11.4%
Operating Margin	7.5%	8.0%	8.0%	7.4%	7.7%
Total Margin	7.3%	8.0%	8.0%	6.9%	7.6%
Return on Total Assets	8.0%	8.6%	7.5%	6.3%	7.6%
Return on Net Assets	13.2%	13.4%	12.1%	9.7%	12.1%

- **Innovage has had strong revenue and earnings growth:** Revenues grew 19.8% from Fiscal 2012 through Fiscal 2015, for a 6.2% compound annual growth rate, with Capitation Revenue, Innovage's core revenue source, up 27.1%, for an 8.3% compound annual growth rate. Meanwhile, EBITDA grew 28.5% over the same period, for an 8.7% compound annual growth rate.

Innovage Income Statement View: Operating Income and EBITDA -- Total				
	FY2012	FY2013	FY2014	FY2015
Revenues				
Total Capitation Revenue	\$153,904,819	\$163,886,711	\$179,371,424	\$195,673,049
Total FFS Revenue	\$4,770,451	\$3,240,346	\$2,583,917	\$2,958,268
Grants, Investment Inc & Other	\$11,760,623	\$14,356,029	\$6,737,618	\$5,584,073
Total Unrestricted Revenues	\$170,435,893	\$181,483,086	\$188,692,959	\$204,215,390
Total Expenses	\$157,570,235	\$166,918,742	\$173,575,137	\$189,177,045
Operating Income	\$12,865,658	\$14,564,344	\$15,117,822	\$15,038,345
Operating Margin	7.5%	8.0%	8.0%	7.4%
Adjustments				
Depreciation & Amortization	\$3,730,417	\$4,045,368	\$5,321,313	\$5,876,544
Interest Expense	\$1,611,362	\$2,019,034	\$2,298,468	\$2,481,369
EBITDA	\$18,207,437	\$20,628,746	\$22,737,603	\$23,396,258
EBITDA Margin	10.7%	11.4%	12.1%	11.5%

The financial statement analysis shows that Innovage has been, and is still (through 6/30/2015), in a strong financial position -- with strong margins, strong earnings growth, more than enough liquidity, and capital flexibility. The organization appears to have no material short term earnings, liquidity or capital problems.

Thus, Innovage is entering the conversion process from a position of financial strength.

Earnings Analysis

As stated above and shown in the above table, Innovage has been solidly profitable over the FY2012 to FY2015 period, with operating margins (operating income divided by revenues) in the 7.4% to 8.0% range, and EBITDA margins (EBITDA divided by revenues) in the 10.7% to 12.1% range.

Focusing on the PACE program, for which there is three fiscal years of data (see table below), the operating margin is even stronger, ranging from 8.8% to 10.3%, as is the EBITDA margin, ranging from 11.9% to 13.3%. The PACE program is more profitable than the overall business - which means that the remaining business (about 3% of total revenues in FY2014 and FY2015) has been losing money.

Innovage Income Statement View: PACE Program Only			
	<u>FY2013</u>	<u>FY2014</u>	<u>FY2015</u>
Revenues			
Total Capitation Revenue	\$163,886,711	\$179,371,424	\$195,673,049
Total FFS Revenue	\$0	\$0	\$0
<u>Grants, Investment Inc & Other</u>	<u>\$3,057,223</u>	<u>\$4,618,120</u>	<u>\$2,297,839</u>
Total Unrestricted Revenues	\$166,943,934	\$183,989,544	\$197,970,888
 Total Expenses	 \$149,821,871	 \$167,577,238	 \$180,621,187
 <u>Operating Income</u>	 <u>\$17,122,063</u>	 <u>\$16,412,306</u>	 <u>\$17,349,701</u>
<u>Operating Margin</u>	<u>10.3%</u>	<u>8.9%</u>	<u>8.8%</u>
 Adjustments			
Depreciation & Amortization	\$3,394,102	\$4,089,317	\$4,138,313
Interest Expense	\$1,716,360	\$1,095,458	\$1,988,914
 EBITDA	 \$22,232,525	 \$22,497,081	 \$23,476,928
<u>EBITDA Margin</u>	<u>13.3%</u>	<u>12.2%</u>	<u>11.9%</u>

Turning to the individual state programs, as seen in the table below, based on FY2015 data:

- The Colorado PACE program is very profitable, generating an 11.3% operating margin in FY2015, and \$24.6 million in EBITDA, for a 14.7% EBITDA margin.
- In contrast the New Mexico program generated just a 1.2% operating margin in FY2015, and just \$469,139 in EBITDA, for a 1.9% EBITDA margin.
- California, the newest program, operated at a \$1.8 million loss in FY2015, after losing \$4.9 million in FY2014. *(In two fiscal years Innovage has absorbed \$6.6 million in losses to enter a market outside of Colorado. And, despite those incurred losses, over this period it has still generated over \$15 million in operating income annually.)*
- Also, as seen in the attached table, monthly CMS enrollment data was used to estimate Innovage's average Per Member Per Month (PMPM) premium amounts for the three state programs in FY2015 -- \$6,728 in Colorado, \$5,557 in New Mexico, and \$9,067 in California. (NM is 17% lower than CO, and CA is 35% higher than CO.)

Innovage Income Statement View: PACE Program Only, FY2015, By State

	<u>FY2015</u> CO	<u>FY2015</u> NM	<u>FY2015</u> CA	<u>FY2015</u> Total
Revenues				
Total Capitation Revenue	\$164,659,450	\$24,639,226	\$6,374,373	\$195,673,049
Est. Member Months	24,474	4,434	703	29,611
Est. Revenue PMPM	\$6,728	\$5,557	\$9,067	\$6,608
Total FFS Revenue	\$0	\$0	\$0	\$0
Grants, Investment Inc & Other	<u>\$2,117,182</u>	<u>\$180,657</u>	<u>\$0</u>	<u>\$2,297,839</u>
Total Unrestricted Revenues	\$166,776,632	\$24,819,883	\$6,374,373	\$197,970,888
 Total Expenses	 \$147,979,249	 \$24,511,866	 \$8,130,072	 \$180,621,187
 <u>Operating Income</u>	 <u>\$18,797,383</u>	 <u>\$308,017</u>	 <u>(\$1,755,699)</u>	 <u>\$17,349,701</u>
<u>Operating Margin</u>	<u>11.3%</u>	<u>1.2%</u>	<u>-27.5%</u>	<u>-8.8%</u>
 Adjustments				
Depreciation & Amortization	\$3,791,244	\$160,758	\$186,311	\$4,138,313
Interest Expense	\$1,980,187	\$364	\$8,363	\$1,988,914
 EBITDA	 \$24,568,814	 \$469,139	 (\$1,561,025)	 \$23,476,928
<u>EBITDA Margin</u>	<u>14.7%</u>	<u>1.9%</u>	<u>-24.5%</u>	<u>11.9%</u>

The PMPM premium view by state makes clear that:

- At \$5,600 to \$9,100 PACE program PMPM premiums are significantly higher than average Medicare Advantage premium PMPMs (which are typically closer to \$1,000), which is mainly due to the inclusion of long-term care services and supports (covered by Medicaid funding) as well as the underlying frailty of the population covered.
- PACE premiums can vary significantly from state to state – Innovage's estimated FY2015 California PMPM premium was \$9,067, which is 35% above the estimated Colorado PMPM premium of \$6,728.¹⁴

(Innovage's much higher PMPM premium for its California frail elderly population along with the potential opportunity, with an estimated 1.2 million dual-eligibles, including over 800,000 over 65 years¹⁵, makes clear why Innovage has been seeking to be part of the California market – along with a number of other organizations.)

Normalized EBITDA Calculation

Valuation techniques based on multiples of annualized earnings -- including historical earnings as adjusted for one-time benefits or expenses -- are a standard valuation technique. This is the approach that was used to generate a fair market value for Innovage. The next section shows how the financial statement data for fiscal year 2015 was adjusted to arrive at a normalized annual earnings rate.

In particular, Earnings Before Interest Taxes, Depreciation and Amortization (EBITDA) is often employed as a measure of earnings performance. EBITDA is used because it adjusts for the impact of:

- Capital structure (especially the level of debt);
- Taxes (not-for-profit compared to for-profit organizations and the potential varying impact of state and other taxes); and
- Non-cash expenses (depreciation and amortization).

Attached below is a table showing FY2015 EBITDA for Innovage, showing adjustments to generate normalized EBITDA. The calculation starts with the fiscal year 2015 operating earnings as reported on the financial statements and adds back depreciation and amortization and interest expense to calculate EBITDA. After adjusting out losses in California, the Foundation operating losses, and the operating losses related to the inclusion of the Johnson Adult Day Program, normalized EBITDA rises to \$25.7 – before any further adjustments for conversion-related expenses (and recent performance).

¹⁴ While the higher PMPM premium in California implies that expenses in California will also be proportionately higher than expenses in Colorado, it also implies that the potential dollar margin per member will also be proportionately higher.

¹⁵ See:

http://www.dhcs.ca.gov/dataandstats/statistics/Documents/18_Dual_eligible_by_age_by_County_2013.pdf

Innovage Normalized EBITDA Calculation	
	<u>FY2015</u>
Revenues	
Total Capitation Revenue	\$195,873,049
Total FFS Revenue	\$2,958,268
<u>Grants, Investment Inc & Other</u>	<u>\$5,584,073</u>
Total Unrestricted Revenues	\$204,215,390
Total Expenses	\$189,177,045
<u>Operating Income</u>	<u>\$15,038,345</u>
<i>Operating Margin</i>	7.4%
Depreciation & Amortization	\$5,876,544
Interest Expense	\$2,481,369
EBITDA	\$23,396,258
<i>EBITDA Margin</i>	11.5%
Adjustments to Normalize Earnings	
California Impact	\$1,561,025
Foundation Impact	\$632,411
Johnson Adult Day Program	\$117,497
Transaction-related Expenses	TBD
<u>Recent Performance</u>	<u>TBD</u>
EBITDA After Adjustments	\$25,707,191
<i>Adjusted EBITDA Margin</i>	12.6%

A few specific comments on the adjustments used --- and others proposed, but unavailable --- to create the normalized earnings estimate:

- **California Impact:** The California operations incurred losses in FY2015 of \$1.8 million (or \$1.6 million on an EBITDA basis). The loss is adjusted out from normalized EBITDA, as the California expansion reflects an investment in future growth, which detracted from earnings in FY2015 and which will largely inure to the future owners of the Innovage assets. Adjusting for the losses rather than potentially making a larger adjustment by attributing the non-California margins to the California FY2015 revenues is a compromise, intending to acknowledge the experience --- and value --- that Innovage gained as an organization by entering a new, high-growth market.¹⁶

¹⁶ According to the FY2014 financial statements, InnovAge Greater California PACE was formed in May 2013. In FY2014, the California operation generated losses of \$4.9 million (or \$4.8 million on an EBITDA basis).

- **Foundation Impact:** The Innovage Foundation generated operating losses of \$208,848 in FY2015, or \$117,497 on an EBITDA basis. According to the Master Plan of Conversion, the Foundation will be separated from the remainder of Innovage and will receive the cash and other assets transferred as part of the for-profit conversion. Therefore, it seems logical to adjust for the impact of the Foundation as part of the normalized operating EBITDA calculation.
- **Johnson Adult Day Program:** The FY2015 financial statements state that in September, 2015 this program¹⁷ was transferred to the Innovage Foundation. Furthermore, the Master Plan of Conversion stipulates that the Johnson Program will be transferred to the Foundation, and thus will *not* be part of the converted Innovage entity. Its impact on FY2015 EBITDA was a loss of \$117,497.
- **Other adjustments:** In addition, any internal expenses related to the conversion or other one-time items (positive or negative) should also be excluded from the normalized EBITDA for purposes of the valuation, as these expenses are not part of the normal operation of the business.
- **Recent Performance:** Necessarily, these calculations are based on the latest available financial statements, but any final valuation should evaluate and adjust for any material changes in performance since June 30, 2015.

In the absence of further details on conversion-related expenses, the remainder of the report uses \$25.7 million as the normalized annualized EBITDA for Innovage for fiscal 2015.

VMG Health Fair Market Value Analysis and Report

Included in the materials attached to the Master Plan of Conversion is a 72 page "Valuation Overview" report from VMG Health dated July 22, 2014, along with a series of Appendices.

The VMG Health report -- a third party, independent Fair Market Value analysis -- is based on financial data through February 28, 2014 as well as other data from the spring of 2014. While considering other valuation approaches, VMG Health chose to focus its valuation opinion on the Income Approach, which generates an estimated valuation based on discounted projected cash flows.

This report presents a contrasting approach to valuation, but first reviews and discusses the VMG Health report, focusing on these items:

- The most recent financial data from Innovage in the VMG Health report is from 21 months ago (balance sheet and income statement as of 2/28/14). In addition, the market and other metrics included in the report are now at least 18 months out of date.
- The Income Approach utilizes a discounted cash flow methodology that requires a number of inputs, each of which can impact, sometimes quite materially, the final valuation. Moreover, without access to internal information it is challenging to fully evaluate some of the estimates and/or the processes used to generate the potentially-material estimates.

¹⁷ As stated in the FY2015 financial statements, the Johnson Adult Day Program is a non-profit corporation that operates a day center that specializes in providing adult day activities to those with memory or physical impairments.

- The report includes a certain amount of market data, including the valuation of public managed care organizations and then-recent health and insurance transactions, but chose to not rely on the market data in generating or evaluating its final valuation.
- However, the main issue -- and a major defect -- is that the report misses the uniqueness of the Innovage asset in the current context, and thus the significant difference this makes in assessing an appropriate fair market valuation.

The VMG Health report was finalized on July 22, 2014, and, because of that, is based on data that is now significantly out of date:

- **The report was based on interim internal Innovage financial statements as of February 28, 2014.** Trailing twelve month premiums are cited as \$173.1 million, which compares to \$195.7 million in FY2015 (e.g. the twelve months ending 6/30/15), a \$22 million, or 13%, increase. Innovage's premiums have been growing about 9% a year recently, which implies that normalized annual premiums are increasing about at a rate of about \$18 million every year.
- **The risk-free 20-year Treasury rate is from May 15, 2014.** This rate, which is a building block for the discount rate used in the Income Approach, was 3.1% on 5/15/14, whereas recent rates have been closer to 2.6%.¹⁸
- **Included market data for public companies is cited "as of April 29, 2014."** Since then public company managed care company share prices are up materially -- on the order of 50%.
- **The acquisition transactions included are from 2010 through 2012.** Three large-scale managed care acquisitions were announced in July 2015, at relatively high multiples, and in the last three years there were eight smaller scale acquisitions of plans focused on the Medicare-Medicaid managed care business.

The Income Approach is a standard valuation technique, but because it requires a variety of estimates, its results are highly sensitive to the validity of those estimates.¹⁹ Key assumptions are:

- Cash flows, including detailed revenue and expense statements;
- Growth rates for revenues and expenses over a multi-year period;
- Discount rates, which convert the multi-year cash flows into "present values" that can be summarized in a single value in the present period; and
- The terminal value of the business, which is intended to capture the value of the business in perpetuity.

In terms of the VMG Health model underlying its Income Approach valuation:

- **Much of the data in the analysis is substantially outdated** -- including the baseline Innovage financial data and market metrics (such as the 20-year Treasury Rate, a proxy for the risk-free interest rate);

¹⁸ Everything else held constant, a lower discount rate increases the present value of future cash flows in the discounted cash flow methodology used in the Income Approach -- and therefore increases the final valuation.

¹⁹ Gapenski, Louis C. & Pink, George H., "Understanding Healthcare Financial Management, Seventh Edition." Health Administration Press, Chicago, IL, 2015. Page 717.

- **The model's result is sensitive to a number of key estimates -- including growth rates and discount rates; and**
- **The report incorporates assumptions from internal discussions with Innovage management that are hard to independently evaluate.**

The VMG Health report includes some relevant market data and references market multiples in a section on what it refers to as the Market Approach. However, this section:

- Uses data that is also now significantly out of date;
- Focuses on a variety of companies and transactions, some more relevant than others;
- Does not address the uniqueness of the Innovage asset in this market; and
- Is ultimately dismissed in favor of a full reliance on the Income Approach.

As a counterpoint to the VMG Health analysis, this report provides a fair market valuation range based on updated market multiples, attempting to correct for these limitations.

However, as stated above, the largest issue with the VMG Health valuation report is that it does not address the uniqueness of the Innovage asset -- and thus fails to capture Innovage's true value in the current market:

- To address that defect, this report has provided a brief overview of the Dual Eligible private managed care market, and its ongoing and rapid growth driven by demographics and policy changes.
- Innovage is second largest PACE organization, and it is the first to convert to for-profit status (following CMS' May 19, 2015 report to Congress). **Innovage's scale along with its expertise has a particular market value at this time.**
- Innovage's recent entry (May 2013) into the highly-desirable California market is significant²⁰. As cited previously, California is estimated to have 1.2 million dual-eligible individuals, with about 800,000 over 65 years of age. Moreover, as seen above, California PMPM premiums at Innovage appear to be 35% higher than in Colorado, providing a significant earnings opportunity, especially if Innovage can replicate the 10%+ EBITDA margins it has achieved in Colorado.

Market Valuation Analysis: Part I -- Managed Care Market Multiples

Below this report presents research on, and analysis of, current market multiples relevant to assessing an appropriate valuation for Innovage. This is divided into three categories:

- Current public managed care organization (MCO) market values -- including both the largest MCOs and Medicare-Medicaid focused MCOs;
- Implied multiples for pending large MCO acquisitions; and
- Data on Medicare-Medicaid organization transactions over the last three years.

²⁰ CMS membership data files list the contract effective date as March 2014, with the first enrollees showing up in the July 2014 membership file. The files can be found at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrollData/Monthly-Enrollment-by-Plan.html>

Public Managed Care Organization Market Multiples

Share Prices as of 11/27/15; Financial Data reflects twelve-months ending 9/30/15; Membership from CMS October 2015 file

	EV (\$, M)	Medicare non-Dual Enrollees	Medicare Dual Eligible Enrollees	TTM EBITDA (\$, M)	EV / TTM EBITDA	EBITDA Margin	EV / TTM Revenues	Price to TTM Net Income
Public Companies -- Big 3 MCOs								
Aetna	\$44,335.2	1,277,212	55,524	\$5,606.4	7.9	9.3%	0.7	13.7
Anthem	\$50,152.6	417,774	105,418	\$6,655.4	7.5	8.6%	0.7	12.5
United	\$141,365.8	2,479,577	413,553	\$12,908.0	11.0	8.8%	1.0	18.0
average					8.8	8.9%	0.8	14.8
Public Companies -- Medicare-Medicaid MCOs								
Centene	\$8,420.3	1,255	34,263	\$822.0	10.2	3.9%	0.4	20.7
Molina	\$3,971.5	457	95,240	\$508.3	7.8	3.9%	0.3	25.2
WellCare	\$4,525.1	214,671	141,540	\$473.3	9.6	3.4%	0.3	32.6
average					9.2	3.7%	0.3	26.2

TTM: Trailing twelve months, the previous twelve months.

EV: Enterprise value (The overall market value of the company) = (Share Price * Shares) + Debt - Unrestricted Cash.

Current Public Company Market Multiples

Public company market multiples set a baseline for the valuation of Innovage:

- The three largest managed care organizations – Aetna, Anthem and UnitedHealth, which will be the surviving entities after Aetna acquires Humana and after Anthem acquires CIGNA, are trading at 8.8 times trailing twelve months EBITDA, 0.8 times trailing twelve months' revenues and 14.8 times trailing twelve months' net income.
- The three Medicaid-Medicare focused public managed care organizations – Centene, Molina, and WellCare – are trading at 9.2 times trailing twelve months EBITDA, 0.3 times trailing twelve months' revenues, and 26.2 times trailing twelve months' net income.

These metrics imply a baseline of about 9 times trailing twelve months EBITDA.

Implied Multiples for Pending Large MCO Acquisitions

In July (2015) three major MCO acquisitions were announced within weeks:

- First, Centene announced it was acquiring Health Net for \$6.8 billion;
- Then, Aetna announced it was acquiring Humana for \$37 billion; and
- Finally, Anthem announced it was acquiring CIGNA for \$54.2 billion.

The attached table shows the implied EBITDA multiples for these transactions, based on trailing twelve month results through 6/30/15, the end of the quarter immediately preceding the various announcements. The Humana and CIGNA implied multiples on trailing twelve month EBITDA were 12.6 and 12.9 times respectively, while the Health Net implied multiple was 23.4 times. The average of these multiples is 16.3 times, significantly above the approximately 9 times market multiples for the six public MCO companies discussed above.

Public Managed Care Organization Market Multiples -- Large Acquisitions (Pending)

Financial Data reflects twelve-months ending 6/30/15; Member enrollment from CMS October 2015 file

	<u>Stated*</u> <u>Enterprise</u> <u>Value</u> <u>(\$, M)</u>	<u>Medicare</u> <u>non-Dual</u> <u>Enrollees</u>	<u>Medicare</u> <u>Dual Eligible</u> <u>Enrollees</u>	<u>TTM</u> <u>EBITDA</u> <u>(\$, M)</u>	<u>Implied EV /</u> <u>TTM EBITDA</u>	<u>EBITDA</u> <u>Margin</u>	<u>Implied EV /</u> <u>Revenues</u>
Health Net	\$6,800	248,239	46,340	\$290.0	23.4	1.9%	0.4
CIGNA	\$54,200	392,883	108,942	\$4,190.0	12.9	11.4%	1.5
Humana	\$37,000	2,548,556	190,290	\$2,945.0	12.6	5.6%	0.7
average					16.3	6.3%	0.9

TTM: Trailing twelve months, the previous twelve months.

EV: Enterprise value (The overall market value of the company) = (Share Price * Shares) + Debt -- Unrestricted Cash.

* The stated purchase price, including cash, debt assumed and shares transferred is used as the enterprise value -- and is assumed to be the fair market value of the company.

Medicare-Medicaid Organization Transactions

Below are eight transactions involving Medicare-Medicaid focused plans dating back to late 2012. These transactions are most comparable to the Innovage transaction, as these organizations were all purchased due to their expertise in covering dual-eligible beneficiaries.

Below are three tables with different views of the transactions:

- The first table includes information on the states covered by the businesses, the purchaser, the purchase price, and the Medicare and Medicaid membership when the acquisition was announced;
- The second table reviews financial metrics; and
- The third table shows recent dual-eligible membership (as of October 2015).

Acquired Medicare-Medicaid Focused Organizations

Financial Data reflects twelve-months ending closest to announcement date; Obtained from SEC or State Statutory Filings

Entity	State	Purchaser	Purchase Price (\$, M)	Closing Date	TTM Through	Medicare Members	Medicaid Members
Care1st	CA	Blue Shield of CA	\$1,200.0	10/8/15	12/31/14	46,000	473,000
Trillium (Agate)	OR	Centene	\$120.0	9/1/15	6/30/15	4,206	95,495
Fidells SecureCare of MI	MI	Centene	\$57.0	5/1/15	3/31/15	2,923	
AlphaCare NY	NY	Magellan	\$70.7	3/17/15	12/31/14	1,063	1,411
Simply HC	FL	Anthem	\$876.9	2/17/15	12/31/14	27,144	89,022
Windsor		WellCare	\$220.0	1/6/14	9/30/13	37,000	
AmeriGroup		Anthem	\$4,900.0	12/24/12	9/30/12	39,000	2,383,000
Easy Choice Health Plan	CA	WellCare	\$150.1	11/12/12	12/31/12	39,000	
mean			\$949.3			24,542	608,386
median			\$185.1			32,072	95,495

While there are different purchasers and different specific motivations, each plan had one or more contracts covering dual-eligibles at the time of purchase. For example:

- **Care1st:** Care1st is the second largest acquisition, and the one that has closed most recently. It was bought by Blue Shield of California, which, while one of the largest MCOs in that state, had not historically participated in the state's Medicaid program. And, even though it had been participating in Medicare managed care (e.g. Medicare Advantage), it had not participated in the Dual-Eligible Special Needs Plans or other plans for high-acuity Medicare members. That all changed when it announced in December, 2014 that it had reached an agreement to buy Care1st, a for-profit MCO focused on the Medicaid and Dual-Eligible Medicare business, with over 9,000 Dual-Eligible demonstration program members. Earlier this year, during a hearing in front of the Department of Managed Health Care, the Blue Shield's CEO announced that the purchase price was \$1.2 billion, which represents a **19.8 times multiple on 2014 EBITDA**. (He also said that the purchase was "at a fair market price."²¹)
- **AlphaCare:** Magellan, publicly traded company not previously discussed in this report, has been building and buying its way into the dual-eligible managed care market, and has been gradually acquiring ownership of AlphaCare in NY (as of 9/30/15 it owned 82%), which has several contracts covering beneficiaries in dual-eligible special needs plans, dual-eligible demonstration plans, and managed long-term care plans. AlphaCare, like several of the other companies on the list, has continued to lose money, so an EBITDA multiple is not meaningful, but the valuation of about \$71 million represents **1.8 times annual revenues**.

Acquisition Multiples for Medicare-Medicaid Focused Organizations							
<i>Financial Data reflects trailing twelve-months (TTM) ending closest to announcement; Data obtained from SEC or State Statutory Filings</i>							
Entity	TTM Revenues (\$, M)	TTM EBITDA (\$, M)	EBITDA Margin	Price Paid / TTM EBITDA	Price Paid / TTM Revenues	Average Premium PMPM	Price Paid / Member
Care1st	\$1,668.9	\$60.6	3.6%	19.8	0.7	\$286	\$2,289
Trillium (Agate)	\$462.4	\$35.6	2.7%	3.4	0.3	\$376	\$1,204
Fidells SecureCare of MI	\$34.8	(\$0.5)	-1.3%	N/M	1.6	\$1,371	\$19,501
AlphaCare NY	\$39.9	(\$16.3)	-40.9%	N/M	1.8	\$2,435	\$28,590
Simply HC	\$834.6	\$22.9	2.7%	38.3	1.1	\$757	\$7,549
Windsor	\$677.7	(\$18.5)	-2.7%	N/M	0.3	\$499	\$1,202
AmeriGroup	\$8,095.4	\$299.8	3.7%	16.3	0.6	\$284	\$2,023
Easy Choice Health Plan	\$353.2	(\$3.4)	-1.0%	N/M	0.4	\$909	\$3,849
mean	\$1,519.6	\$47.5	-4.1%	19.4	0.9	\$864.64	\$8,276
median	\$565.0	\$11.2	0.9%	18.1	0.7	\$627.78	\$3,069

²¹ See testimony by Blue Shield of California CEO Paul Markovich to the California Department of Managed Health Care at: https://www.blueshieldca.com/bsca/documents/about-blue-shield/newsroom/Blue%20Shield%20CEO_DMHC%20Testimony.PDF

- **Simply Healthcare:** Anthem purchased Simply Healthcare earlier this year for a purchase price of at least \$877 million (based on disclosures in Anthem's SEC filings). This represents a multiple of *38 times trailing twelve month EBITDA and 1.1 times trailing twelve-month revenue*.
- **AmeriGroup:** At end of 2012, Anthem, then known as WellPoint, purchased AmeriGroup, which at the time was publicly traded and the largest standalone Medicare-Medicaid focused MCO. It paid \$4.9 billion, representing *16.3 times trailing twelve month EBITDA*.

Below is additional information on these organizations, reporting their current membership in the Dual Demonstration program, Dual-Eligible Special Needs Plans, and Institutional Special Needs Plans. All offer Dual-Eligible Special Need Plans, with AmeriGroup (Anthem), Care1st (Blue Shield of CA), and Fidelis (Centene) also participating in various Dual-Eligible Demonstration programs.

Medicare-Medicaid Focused Organization Acquisitions					
<i>Current Membership from CMS October 2015 Files</i>					
Entity	Dual Demo Members	Dual SNP Members	I-SNP Members	Other MA	Total MA
Care1st	9,040	5,460		50,210	64,710
Trillium (Agate)		3,533	128	451	4,112
Fidelis SecureCare of MI	4,053	454	164	1,255	5,926
AlphaCare NY	74	489		745	1,308
Simply HC		13,366	362	9,258	22,986
Windsor		19,758		20,848	40,606
AmeriGroup	19,911	37,962		22,625	80,498
Easy Choice Health Plan		11,035		21,505	32,540

*Dual Demo: Dual Eligible demonstration program.
Dual SNP: Medicare Advantage Special Needs Plan for beneficiaries eligible for both Medicare and Medicaid.
I-SNP: Medicare Advantage Institutional Special Needs Plan for beneficiaries in a nursing home or requiring that level of care.*

Valuation Summary

The various market reference groups produce a wide range of valuations -- *with averages from 9 times to 19 times trailing EBITDA*. To summarize:

- Based on the above valuation data, nine times trailing twelve month EBITDA is a baseline valuation; and
- There have been transactions with significantly higher multiples, based on demand for specific capabilities, access to specific state/regional markets (or a contract), and/or a critical mass of membership.

Valuation Summary: Market Multiples

	EV/ Trailing EBITDA average	Trailing EBITDA Margin average	EV/ Trailing Revenue average
<u>Public Company Valuations</u>			
Largest MCOs: Aetna, Anthem, United	8.8	8.9%	0.8
Medicare-Medicaid MCOs: Centene, Molina, WellCare	9.2	3.7%	0.3
<u>MCO Acquisitions Pending:</u>			
CIGNA, HealthNet, Humana	16.3	6.3%	0.9
<u>Medicare-Medicaid Acquisitions</u>			
	19.4	-4.1%	0.9

In terms of applying the 9 times to 19 times EBITDA valuation range to Innovage, it is my opinion that the relevant factors can be summarized as follows:

- **Factors Favoring a Higher Relative Valuation**
 - Valuable organizational expertise that is in demand right now as key stakeholders are seeking new models for integrated health care and long-term services and supports;
 - Over 25 years of experience, and, as the second largest PACE organization in the country, provides services to nearly 2,700 beneficiaries;
 - Strong financial performance over time, with PACE program EBITDA margins averaging over 12% over the past three years, and capitated revenue growth over 9% over the past two years; and
 - A multi-state presence; including an organization in New Mexico, and a newly established organization in California -- a large and important market and a state that is seeking partners capable of effectively managing frail and disabled populations, dually-eligible for Medicare and Medicaid.
- **Factors Favoring a Lower Relative Valuation**
 - A sponsored conversion, entailing additional management, transaction costs and subject to an enhanced level of regulatory scrutiny;
 - The first large PACE organization operating as a for-profit, which increases the uncertainty and risk; and
 - The likely need for a capital infusion to support a higher growth trajectory.

The net impact of these factors in my opinion suggests that the fair market value is toward the middle of the range -- at 12 to 14 times trailing twelve month EBITDA.

Below is discussion applying this valuation range within a larger transaction framework, including adjustments for debt, working capital and board-designated funds, and real estate assets.

Market Valuation Analysis: Part II -- Implications for the Innovage Transaction

The market multiple approach to valuing Innovage is based on public market valuations -- comparable organizations and comparable transactions. As discussed above, these market-based valuations include publicly traded managed care organizations, recently announced merger and acquisition activity involving relevant publicly traded managed care organizations, and various publicly-disclosed transactions involving comparable organizations. This approach is not only very different from the Income Approach relied upon by VMG Health -- which forms the basis for the financial consideration included in the Master Plan of Conversion -- it also generates a much higher, and more realistic, fair market value.²²

Transaction Framework

The logic in the Master Plan of Conversion used to calculate the proposed total cash and other consideration (e.g. equity) starts with the results of the VMG Health Income Approach valuation and is summarized in "Exhibit C.x1." The calculations in Exhibit C.x1 add up to \$185.4 million, while the below table adds to \$185.2 million -- about \$1 million lower than the amounts in Exhibit D. The goal of the attached table is to succinctly recreate the logic that connects the calculations in the VMG Health valuation to the cash and other consideration offered.²³

VMG Health: Fair Market Value & Transaction Adjustments*

Income Approach Fair Market Value	\$132,421,000
- Debt Assumed	(\$38,148,000)
Net	\$94,273,000
+ Working Capital Adjustment	\$37,320,000
+ Real Estate Adjustment	\$53,650,000
Value of Cash and Other Consideration	\$185,243,000**

* A summary based on the VMG Health report and the last page of Exhibit C.

** This is about \$1.2 million less than the \$186.4 million in total consideration offered.

²² On pages 50 and 52 of the VMG Health report there are tables included in a section discussing the "Market Approach." And those tables, while completed as of the end of April 2014, include calculations and reference points that are analogous to those in this report. The biggest difference, therefore, is that VMG Health's Fair Market Value analysis relied entirely on the results of the Income Approach without any weighting to the results of the Market Approach.

²³ The report omits a single, clear summary table outlining the calculations supporting the \$186.4 million in total consideration. Also the report does not appear to provide the data and methodology used to calculate the real estate adjustment in the Master Plan of Conversion, even though there are summary figures included in Exhibit C.x1. Likewise, missing are the calculations supporting the debt and working capital adjustments. While there are references to a February 28, 2014 balance sheet, the report does not include a consolidated balance sheet as of that day.

The transaction framework in this report follows a similar logic, but starts with trailing twelve months EBITDA, as adjusted -- see attached. Specifically, the fair market valuation as of June 30, 2015:

1. Starts with the normalized trailing twelve month EBITDA calculation (see discussion earlier in this report), which is based on FY2015 as reported in the audited financial statements plus adjustments;
2. Multiplies normalized EBITDA by the twelve to fourteen times market multiple to arrive at a core business enterprise value;
3. Subtracts current debt at 6/30/15 to calculate net valuation;
4. Adjusts for excess working capital and board-designated funds at 6/30/15, using a baseline of two times current liabilities, with any excess amount added to the transaction; and
5. Adds in the appraised fair market value (when determined) of Innovage's real estate.

Real Estate Valuation

Clearly, real estate owned by Innovage is a significant asset that should be valued and included as part of this transaction. However, the Master Plan of Conversion omits: (1) detail on the real estate owned by Innovage and or (2) the basis for the VMG Health report's \$53.65 million adjustment -- aside from a simple table showing "low," "mid" and "high." (The property appraisals supporting those valuations were previously requested.)

The 6/30/15 balance sheet lists total "Property and Equipment, at Cost" of \$114.8 million, along with accumulated depreciation of \$24.5 million. A starting point for the real estate valuation would be "book value," which would be just the real estate assets at cost adjusted for depreciation. But a fair real estate market valuation would need to take into account current commercial real estate market valuations in the Denver market and elsewhere that Innovage has properties.

Market Multiple Fair Market Value Calculations			
	Low	High	Comments
EBITDA Normalized	\$25,700,000	\$25,700,000	FY2015 with adjustments
Market Multiple	12	14	12x to 14x
Core Valuation	\$308,400,000	\$359,800,000	
- Debt Assumed	(\$38,700,000)	(\$38,700,000)	FY2015 Balance Sheet: Long Term Debt
Net of Debt	\$269,700,000	\$321,100,000	
			FY2015 Balance Sheet: (Current Assets + Board-Designated Funds)
+ Excess Cash Adjustment	\$33,286,000	\$33,286,000	Less 2x Current Liabilities
+ Real Estate Valuation	TBD	TBD	Based on Appraisal
Fair Market Value	\$302,986,000+	\$354,386,000+	

Conclusion

This analysis differs in methodology and conclusions from the VMG Health report. Given that a fair market valuation needs to be determined as part of its conversion from a not-for-profit organization to a for-profit corporation, the best approach in my opinion -- and the approach pursued in this report -- is to focus on the underlying business, and how its tangible and intangible assets and expertise would be valued in the current market environment.

This report starts with, and is grounded in, an overview of the policy and market context for Innovage and similar organizations, showing that there is significant market demand for organizations that have experience and expertise managing the health care and long-term care services and supports needs for frail elderly and disabled adults.

Innovage is such an organization, the second largest PACE program, with 25 years of experience coordinating care for a complex, frail elderly population -- and managing to generate impressive earnings margins in so doing. It is now operating in three states, including California, which has a very large dual eligible population that is gradually being shifted into third party managed care programs.

Based on this research and analysis, it is my professional opinion that the proposed consideration of \$186.4 million²⁴ -- comprised of \$180.3 million in cash plus a 5% equity interest in the new entity, valued at \$6.1 million -- substantially understates the fair market value of the organization in the current competitive managed care market.

Specifically, my opinion is that the fair market value of Innovage as of June 30, 2015 is in the range of \$303 million to \$354 million plus the fair market value of owned real estate (which should be based on a recent market appraisal). At closing the debt outstanding and the excess cash calculation should be adjusted against the 6/30/15 amounts included in the above calculation.

Additional adjustments should also be made for conversion-related expenses incorporated into the Innovage financial results (an increase to EBITDA) and any changes in trailing twelve months EBITDA since 6/30/15.


12/4/15

²⁴ As per Exhibit D of the Master Plan of Conversion: The total is proposed to be paid to the Total Community Options Foundation, subject to adjustment to account for net working capital and closing cash amounts, and subject to adjustments for Company expenses. In addition, the Plan proposes that \$15.8 million of the total should be held in escrow for four years, subject to any indemnification or adjustment obligations of the Company.

Author Bio

Samuel W. Levitt, ScD, CFA is a health care industry consultant and financial analyst.

Dr. Levitt consults with health care organizations and analyzes health care companies, utilizing the skills and knowledge gained in his eleven years as an equity analyst focused on the managed care industry and health services companies. His consulting and analysis is also informed by his financial executive experience within managed care organizations and hospitals.

Dr. Levitt's most recent professional roles were at a large national managed care organization, where he was involved with financial planning and reporting for the Medicare and Medicaid businesses, and, before that, held a senior role in Investor Relations, which included involvement with a large acquisition. He also teaches "Financial Transactions and Analysis" to masters and doctoral students at the Harvard Chan School of Public Health.

He has a doctorate in Health Policy and Management from the Harvard Chan School of Public Health and is a CFA Charterholder.

APPENDIX 2

AFFIDAVIT

The State of California)
County of SAN MATEO) S.S.
)

Thomas David, being duly sworn, deposes and says:

1. I am over eighteen years of age and am competent to testify on the matters set forth herein. I make this affidavit on the basis of my personal knowledge.
2. I have worked in the field of organized philanthropy since 1987. Before establishing a consulting practice advising foundations and other public benefit organizations, I was Director of Organizational Learning and Evaluation at the Marguerite Casey Foundation in Seattle. Prior to that position, I was Executive Vice President at the California Wellness Foundation, a healthcare foundation with an initial endowment of \$300 million that resulted from the conversion in 1991 of HMO Healthnet from nonprofit to for-profit. I have also served as Vice President of the S.H. Cowell Foundation and Senior Program Officer at the James Irvine Foundation in San Francisco. I have served on numerous boards, including Grantmakers in Health, Women and Philanthropy, and Northern California Grantmakers.
3. As a consultant, since 2004, I have worked with nonprofit organizations that operate in a range of areas, but primarily those that focus on healthcare. Those organizations include the California HealthCare Foundation, Bill & Melinda Gates Foundation, Kansas Health Foundation, Immigrant Legal Resource Center, the Mid-Iowa Health Foundation, David and Lucile Packard Foundation, the SCAN Foundation, and many others. Within the state of Colorado specifically, I have worked with The Colorado Health Foundation, The Colorado Health Institute, and The Colorado Trust.
4. My publications are numerous. Some examples include "Realizing the Promise of Spring: Foundations Should Consider Changing How They Do Business," Health Affairs blog, April 16, 2012, as well as those available on my website, tdavid.net, some of which were commissioned by Grantmakers in Health and other organizations: "A Defining Moment for Health Philanthropy," March 2010; "Community Engagement," May 2008; "Partnering with Intermediaries," June 2007; "Tom's Tips on Due Diligence," April 1998; "The Challenge of Assessing Policy and Advocacy Activities: Strategies for Prospective Evaluation Approach," October 2005.

5. I have been asked to provide an expert opinion on best practices for the creation or selection of an entity to receive assets from the conversion of a healthcare provider, including recommendations specific to board composition and foundation independence. I have also been asked to provide an expert opinion on foundation mission and the process for determining that mission. Where appropriate, I am providing a reasoned opinion on the arrangements described in the Master Plan of Conversion for Total Community Options, Inc. and its subsidiaries ("Master Plan"), for the proposed Foundation Board and the foundation's mission.

6. In preparation for this affidavit, I have reviewed my prior writings and research, including the publications named here, and reviewed the Introductory document and Exhibits B and D of the Master Plan. My substantial history with healthcare conversions during the 1990s and beyond provides historical context to my observations about foundation structure and mission that are successful, and those that are problematic.

7. Conversion foundations are unlike many other charitable foundations. Other foundations are created by donors who give resources for a specific charitable purpose, whereas conversion foundations are a public trust, dedicated to benefit the public, and their value derives from broad community support, including tax-exemption. Because the public is the beneficiary, it has a significant interest in how assets are used.

8. Early on in the wave of hospital and insurance conversions in the 1990s, foundation boards tended to include those with expertise more appropriate for the running of the pre-conversion entity or similar institutions, and failed to include those with skills more closely tied to foundation work, including public health expertise, investment management skills, and experience in the management of large philanthropic programs. In addition, continuing roles for original board members have led to conflicts of interest, especially where joint ventures are considered between the nonprofit and for-profit, or where the foundation is funded with stock in the for-profit successor. I note that the initial Foundation Board identified in the Master Plan includes five members — a majority — from the converting entity's board members and four from the current InnovAge Foundation Board. The board appears to be self-perpetuating going forward, and the foundation is partially funded by stock in the InnovAge successor. All of these proposals raise concerns.

9. Those early conversion foundation boards also frequently failed to include and seek advice from the community, particularly the community to be served by the Foundation, about community needs. One way to ensure that the wider community is involved in the planning for a new foundation is to establish a planning committee, as was done for establishment of the Carling For Colorado Foundation in 1997. That process established a committee to assist with soliciting community input in board formation, and included those with different backgrounds

and points of view. I recommend a process that similarly ensures that community voices play a primary role in this conversion, though a simplified process could certainly be used. For example, members of the several health-related Colorado foundations could staff a committee to help establish a mission and determine a meaningful process for initial board selection.

10. Making effective and efficient use of the assets made available from a conversion is an important consideration in any conversion. Simply adding those funds to the small, existing InnovAge Foundation would be inefficient and costly, when one considers that distributing the funds to a large foundation or foundations would take advantage of an established sizeable organization with grant-making infrastructure, staff capacity and expertise, as well as well-developed processes and connections. Initial costs to staff up a small foundation, as well as ongoing operational and transaction costs are not trivial. Transfer of the assets to existing entities would markedly reduce foundation costs.

11. If a foundation is selected to receive the proceeds, its autonomy will be critical to its ability to effectively and appropriately steward its resources. A basic principle of board composition for the receiving entity is that it not be controlled by the converting entity. In addition, board members should agree to a strict policy regarding recusal in the event of appearance of a conflict of interest, self-dealing, or any other form of inurement. Unless these principles are inherent in the structure for the proposed Conversion Foundation Board, through Articles of Incorporation or Bylaws, there is a substantial risk that the foundation's autonomy will be jeopardized.

12. There has been significant evolution in the philanthropic world over the last two decades in thinking about best practices for distribution of conversion proceeds ranging, for example, from distribution of conversion proceeds to a new, independent foundation to distribution to an existing community foundation or foundations, to direct distribution of the assets to community organizations that serve the interests of the population previously served by the converting non-profit. While cy pres principles establish that a foundation's charter should be consistent with the historic mission of the converting entity, the guidelines should not be rigid. Colorado has an opportunity to do something really effective and innovative with the assets that will become available through the InnovAge conversion.

13. As examples, a new or even existing foundation modeled on earlier conversion foundations may not be the answer given the rapid expansion of the aging population, the increasing focus on community based care and aging in place, and the immediate and short term needs of Coloradans. One question the community might be solicited to answer is whether community needs are best served through a foundation that disperses approximately 5% of its corpus annually, or through a more immediate, community asset and resource building strategy.

14. As examples, a public process like one of those noted in paragraph 9 above could be used to consider whether the assets might go to a different sort of venture: one-time grants to safety-net providers, earmarked for healthcare to the aging population; a fellowship or training fund for medical and social work staff, including social workers and care coordinators, that could help deal with the chronic staffing shortages in this area; an operating foundation that provides direct long-term care to indigent seniors and that can provide care above and beyond Medicare levels; or a "commons" approach, that would provide funding for infrastructure like parks and sidewalks in lower-income neighborhoods with substantial numbers of older or disabled residents, and could help keep that population active and at home. Creative thinking by those in the community knowledgeable about the gaps in the safety net for older and disabled Coloradans could yield dynamic results.

14. My observations of the existing plan for the conversion proceeds, in light of my experience with foundations in Colorado and elsewhere, is that much more consideration ought to be given to the inefficiencies of a small foundation, to the processes necessary to ensure foundation and board independence, to the need for a broad stakeholder process, and to the many innovative ways to use funding that could maximize benefit to the public far beyond what a traditional foundation can do. Conversions are a public trust, and the public must figure in decision-making beyond what is contemplated here in the Master Plan.

SUBSCRIBED AND SWORN TO)

BEFORE ME, on the)

^{10 43}
3rd day of December, 2015)

Helan Sutherland)

) Thomas G. Davis

NOTARY PUBLIC)

) THOMAS G. DAVIS

My Commissioner expires: July 27, 2017)

Please See

Attached

Document

California Jurat Certificate

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of San Mateo

S.S.

Subscribed and sworn to (or affirmed) before me on this 3rd day of December,
Month

20 15, by Thomas G. David and
Name of Signer (1)

_____, proved to me on the basis of
Name of Signer (2)

satisfactory evidence to be the person(s) who appeared before me.

Helen Sutherland
Signature of Notary Public

Helen Sutherland, comm: 2031794
For other required information (Notary Name, Commission No. etc.)



Seal

OPTIONAL INFORMATION

Although the information in this section is not required by law, it could prevent fraudulent removal and reattachment of this jurat to an unauthorized document and may prove useful to persons relying on the attached document.

Description of Attached Document

The certificate is attached to a document filed for the purpose of

containing 2 pages, and dated 12/03/15

Additional Information

Method of Affiant Identification

Proved to me on the basis of satisfactory evidence:

☐ form(s) of identification ☐ credible witness(es)

Notarial event is detailed in notary journal on:

Page # _____ Entry # _____

Notary contact: _____

Other

☐ Affiant(s) Thumbprint(s) ☐ Describe: _____

Thomas G. David

2140 Prospect Street
Menlo Park, CA 94025
(650) 854-4506
t_david01@yahoo.com
www.tdavid.net

PROFESSIONAL EXPERIENCE

STRATEGIC ADVISOR to foundations and other nonprofits 2004-present

Roles have Included:

- Strategic Planning (Blue Shield of CA Foundation; The SCAN Foundation)
- Program Design and Implementation (Community Clinics Initiative/Tides)
- Evaluation (Women Donors Network; The Colorado Health Institute)
- Organizational Learning (Humanity United; The CA Endowment)
- Meeting Facilitation/Retreats (Compton Foundation; Sierra Health Foundation)

MARGUERITE CASEY FOUNDATION, Seattle, WA 2002-2004

Director of Organizational Learning and Evaluation

Member of the leadership team creating a new national foundation supporting movement building among low-income families.

- Develop and implement an evaluation strategy for the foundation
- Help the foundation realize its potential as a learning organization
- Grantmaking in evaluation, action research and child welfare systems reform

THE CALIFORNIA WELLNESS FOUNDATION, Woodland Hills, CA 1995-2002

Executive Vice President (1997-2002)

Vice President, Programs (1995-1997)

Responsible for development and implementation of the Foundation's grantmaking, evaluation and organizational learning, and in the President's absence, for overall management of the Foundation.

- Oversee an annual grants budget of approximately \$45 million.
- Supervise a program staff of 23 in two locations.
- Commission and coordinate numerous evaluations, including multi-million dollar projects.

S.H. COWELL FOUNDATION, San Francisco, CA 1994-1995

Vice President Grant Programs

Leadership role in the development of funding policies, grant opportunities and identifying best practices in the Foundation's fields of interest, and initiating a comprehensive review of all its programs.

- Oversee an annual grants budget of approximately \$7.5 million.
- Supervise work of both program officers and related support staff.
- Grantmaking in Population and Environment and Public Policy

JAMES IRVINE FOUNDATION, San Francisco, CA 1987-1994

Senior Program Officer (1991-1994)

Program Officer (1987-1991)

Responsible for grantmaking in Health and Youth across the state of California, and for special projects at the direction of the President, including Higher Education and Public Policy.

- Developed the Foundation's grantmaking program in Health (\$4 million annually).
- Designed and initiated a special 5-year, \$5 million grants program in Women's Health.
- Commissioned and supervised the Foundation's first retrospective grants program evaluation.

CHILDREN'S HOSPITAL, LOS ANGELES, Los Angeles, CA

1986-1987

Coordinator of Clinical Research

Initiated a new position within the Division of Adolescent Medicine. Advised medical staff and Fellows on research activities, developed proposals to public and private funding sources, and led a regular seminar on research and evaluation.

- Designed and implemented program evaluation for a state-funded multi-agency collaboration to address the needs of homeless youth in the Hollywood area.
- Served on state and local level task forces focusing on policy issues affecting high-risk youth.

UNIVERSITY OF CALIFORNIA, LOS ANGELES, Los Angeles, CA

1981-1986

Bush Program in Child and Family Policy

Director (1984-1986)

Associate Director (1981-1984)

Developed an interdisciplinary training program for doctoral students and post-doctoral and midcareer Fellows in public policy issues affecting children, youth and families. Supervised individual internships and policy research projects and led a weekly seminar.

- Worked with officials from state and local government and non-profit agencies to develop timely policy analyses and program evaluations.
- Authored policy reports on adolescent pregnancy and runaway and homeless youth.
- Founding member of the Los Angeles Roundtable for Children, and co-author of the first Los Angeles County Children's Budget.

EDUCATION

National Institute on Aging NRSA Postdoctoral Fellow,

Stanford University Medical School, 1979-1981.

Ph.D. Educational Psychology, University of Chicago, 1979

M.A. Architecture & Urban Planning, UCLA, 1972

A.B. Psychology, UCLA, 1970

COMMUNITY SERVICE

Board of Directors, Grantmakers in Health (2008-2014)

Advisory Board, Stanford Medical Youth Science Program

Board of Directors, Northern California Grantmakers (including term as Chair) (1999-2002)

Board of Directors, Women and Philanthropy (member of Executive Committee) (1997-2002)

Advisory Committee, Pacific Institute for Women's Health (1998-2000)

Co-Chair, AIDS Task Force, Northern CA Grantmakers (1992-4)

Co-Chair, Region IX Public Private Task Force on Maternal and Child Health (1992-4)

Board of Directors, CA Child, Youth and Family Coalition (1990-1992)

PERSONAL

Recipient of the 2002 Terrence Keenan Leadership Award from Grantmakers in Health

Senior Fellow, UCLA School of Public Policy and Social Research (1998-1999)

Recipient of the Inaugural Individual "Involving the Public in Health Choices" Award from California Health Decisions, 1999

Recipient of the Distinguished Evaluator Award from the Health Foundation of Greater Cincinnati, 2007.

APPENDIX 3

AFFIDAVIT

The State of Colorado)
) S.S.
County of Denver)

David Miller, being duly sworn, deposes and says:

1. I am over the age of 18 and am competent to testify on the matters set forth herein. I make this affidavit on the basis of my personal knowledge.
2. Since 1996, I have been the Executive Director/President and Chief Executive Officer of The Denver Foundation, the oldest and largest community foundation in the Rocky Mountain region. A Denver native, I graduated from Harvard Law School and worked for ten years in the public sector and seven years in the private sector before joining The Denver Foundation. My public sector work included serving as Executive Director of the Colorado Office of State Planning and Budget and Chief of Staff for former Mayor Federico Peña. Subsequent work as a principal at a strategic communications firm included consulting work for a foundation, and led to my move to The Denver Foundation. At the end of 2015, I will be stepping down from my position at The Denver Foundation to create an Institute for Philanthropy and Social Enterprise at the University of Denver. My long-standing work in and with the nonprofit community has given me a grounding in the structures, governance, and development of nonprofit community foundations.
3. During my tenure at The Denver Foundation, the organization has increased its assets from \$58 million to over \$700 million. At the same time, the Foundation has greatly expanded its grant-making activities, from \$2 million in 1996 to \$67 million in 2014. Careful stewardship of foundation assets contributed significantly to these expansions.
4. These expansions occurred in tandem with concerted efforts to develop and expand our relationships with the Metro Denver community, including people of color and other underrepresented populations. Reaching out to and including diverse members of the community has been an essential element in The Denver Foundation's work for nearly two decades. Our commitment to engaging the community has led to a range of initiatives, including the Strengthening Neighborhoods Program, the Nonprofit Inclusiveness Project, EPIC (Expanding Philanthropy in Communities of Color), and many others. It's impossible to imagine these initiatives without extensive community involvement every step of the way.
5. In preparation for my testimony herein, I have reviewed the introductory document of the Master Plan, entitled "Master Plan of Conversion, Total Community Options, Inc. and Its Subsidiaries," and Exhibits B and D of the Plan. In the interest of full disclosure, I note that one of The Denver Foundation's 1,000+ funds is a fund whose proceeds are designated to support the Johnson Center, an assisted living facility that has been operated by InnoVage in the past.

6. In my professional work, I have become familiar with charitable trust law as well as the governance of several charitable foundations. In my opinion, it is very much the preferred situation for a charitable foundation board to be selected by a process that includes extensive community input, and for community input to play a significant ongoing role in the work of the foundation. In my experience at The Denver Foundation, identifying and bringing in diverse community voices entails considerable time and planning.

7. I am familiar with the process used in 1999-2000 to select the Caring for Colorado Foundation directors. That process involved a community advisory committee and a diversity of nominees, with the finalists selected by the Governor, and assured a publicly accountable process that took into account the views of community representatives. I recommend that a process that similarly accounts for the public interest be employed here.

8. The Master Plan woefully lacks information as to how underrepresented populations will be consulted, represented, and involved in the selection of the board and the ongoing work of the foundation. For example, it is critical, in my opinion, that members of the aging community who have limited financial means be well represented on the governing board. By analogy, The Denver Foundation has included people with homeless experience on our Basic Human Needs Committee, a group that is empowered to give away millions of dollars to help provide basic human needs to people in Metro Denver. Similarly, the needs of aging people of color often vary widely due to cultural considerations. The Master Plan does not address these cultural challenges.

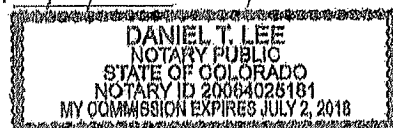
9. After many years both as an observer of foundation work and development and as President and Chief Executive Officer of The Denver Foundation, my opinion is that far more detail is needed in the Master Plan. A transparent process that includes robust community input regarding an appropriate receiving foundation and an community-based board would be much more likely to provide an ongoing benefit to health needs of vulnerable Coloradans.

SUBSCRIBED AND SWORN TO
BEFORE ME, on the
15th day of December, 2015

Daniel T. Lee

NOTARY PUBLIC

My Commission expires: 7/2/2018



David J. Miller

DAVID J. MILLER

David Miller has been the President and CEO of The Denver Foundation since 1996. The Denver Foundation is the oldest and largest community foundation in the Rocky Mountain region. Under David's leadership, the assets of The Denver Foundation have grown from \$50 million to more than \$700 million.

David is a native of Denver and a fifth generation Denverite. He is a graduate of Thomas Jefferson High School in Denver, Harvard College, and Harvard Law School. Since then, he has worked in all three sectors: public, private, and nonprofit.

David spent ten years in Colorado state and local government, serving as Executive Director of the Colorado Office of State Planning and Budgeting and Chief of Staff for Denver Mayor Federico Peña. After that and before coming to The Denver Foundation, he was a principal in Greenberg, Baron, Simon & Miller, a strategic communications consulting firm.