

Lakewood Hospital
Due Diligence Report to the City of Lakewood
August 14, 2015



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Engagement Overview

Engagement Overview

Scope of Engagement

Huron Consulting Services LLC d/b/a Huron Business Advisory (“Huron”), has been engaged by the city of Lakewood, Ohio (the “City”) to provide due diligence and research in connection with a potential transaction involving Lakewood Hospital (the “Hospital”), which is owned by the City and leased to Lakewood Hospital Association (“LHA”). The Cleveland Clinic Foundation (the “Cleveland Clinic”) manages day-to-day operations at the Hospital. The City, LHA and the Cleveland Clinic are contemplating a transaction whereby Lakewood Hospital will be closed and replaced with an outpatient family health center to be owned and operated by the Cleveland Clinic (the “Transaction”).

At the direction of the City, our investigation and analysis were limited to the following four areas:

- A review and presentation of current healthcare trends, especially as they relate to the conversion of acute care hospitals into outpatient centers;
- A review and analysis of the report was prepared by Subsidiary Healthcare;
- An assessment of Lakewood Hospital Association’s standing under the 1996 Definitive Agreement; and
- A review and analysis of Lakewood Hospital’s current financial position.

Huron was not engaged in an investment banking capacity in connection with the Transaction or any other transaction involving Lakewood Hospital. Further, nothing in this document should be considered as investment advice. The decision as to whether to consummate any transaction lies solely with the City and LHA. Our findings or other work product, whether written or verbal, shall not in any way constitute a recommendation as to whether you should or should not consummate any transaction or the terms upon which a transaction should be consummated. The City Council and the Board of Trustees of LHA shall be fully and solely responsible for applying independent business judgment with respect to the services and work product provided by Huron, and to determine further courses of action with respect to any matters addressed in this report. Huron has made efforts to verify the accuracy of the information contained in this report, which relies on data obtained from numerous sources. Huron cannot guarantee the accuracy of the information provided or any analysis based thereon.

Engagement Overview

Sources of Information

In connection with this engagement, we interviewed representatives from the city council, LHA, Cleveland Clinic and Subsidiary Healthcare, as well as community leaders and physicians. We reviewed certain information and documents that were provided to us by the above parties or publicly available sources. Below is a list of principle sources that were used in our analysis:

- Financial statements for Lakewood Hospital for the fiscal years ended December 31, 2012 through 2014 and the six month periods ended June 30, 2014 and 2015;
- Key performance metrics for Lakewood Hospital for the year-to-date period ended November 30, 2013 and the fiscal year ended December 31, 2014;
- Patient day data for the fiscal years ended December 31, 2010 through 2014 and the year-to-date period ended June 30, 2015;
- *2013 Community Health Needs Assessment-Lakewood Hospital*, dated February 24, 2012;
- Amended and Restated Lease Agreement by and between the City of Lakewood, Ohio and Lakewood Hospital Association, dated December 23, 1996;
- Letter of Intent by and among The Cleveland Clinic Foundation, Lakewood Hospital Association and Lakewood Hospital Foundation, Inc., dated January 14, 2015;
- Definitive Agreement by and between The Cleveland Clinic Foundation and Lakewood Hospital Association, dated December 19, 1996;
- Subsidiary Healthcare's *Lakewood Hospital Data Book* (undated);
- Subsidiary Healthcare's *Lakewood Hospital Select Committee Options Analysis Follow-Up Documentation from October 9th Meeting*, revised and dated October 11, 2013;
- Subsidiary Healthcare's *Lakewood Hospital Association Board of Trustees Strategic Options Evaluation Process*, dated January 12, 2015;
- LHA press release entitled *Lakewood Hospital Association, Lakewood Hospital Foundation and Cleveland Clinic Announce Partnership to Transform Healthcare in Lakewood*, dated January 15, 2015;
- Letter to Council from Mayor Michael P. Summers, dated January 14, 2015;

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Sources of Information

- Community Meeting Presentations: *Subsidium Healthcare Lakewood Community Meeting*, dated January 28, 2015; *Subsidium Healthcare Community Meeting Regarding Lakewood Hospital*, dated February 11, 2015; and *Future of Healthcare in LKWD*, dated March 10, 2015;
- “Lakewood City Council Committees of the Whole Considering the Letter of Intent;”
- Subsidium Hospital RFP, *Lakewood Hospital Request for Proposal* (undated);
- Subsidium Healthcare’s Preliminary Memorandum, *Community Hospital Seeks Community Partner* (undated);
- Lakewood Health Center *Overview of Real Estate Elements in the Letter of Intent*, dated March 30, 2015;
- Minutes from the Lakewood Hospital Association Meeting of the Special Committee: 1.13.10 to 2.28.11, 3.6.14 to 1.14.15, 5.20.13 to 2.19.14, and 5.4.11 to 1.28.13;
- *Monahan Response and Correspondence* documents (dates ranging from 2010 to 2014);
- Proposal submitted by Cleveland Clinic entitled “*Healthy Change for a Healthier Lakewood*,” dated April 21, 2014;
- Cleveland Clinic’s *2014 Shared Admin Service Allocation (Lakewood Brief)* Presentation (undated);
- Cleveland Clinic’s *LHA 2014 Admin Services Details and Allocation Methodology* Excel File (undated);
- The Advisory Board Company’s *The New Performance Standard* (undated);
- Allegro Realty Advisors’ *Physical Conditions of Hospital Properties*, July, 2015;
- The MetroHealth System *Lakewood Hospital Proposal* (undated);
- Claritas demographics reports;
- Risk Management Association’s *Financial Ratio Benchmarks 2014 – 2015*;
- Ingenix’s *Almanac of Hospital Financial and Operating Indicators 2014*;
- SEC filings of publicly traded hospital companies, as generated by Capital IQ;
- The American Hospital Association; and

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Sources of Information

- Various other news articles and resources such as Modern Healthcare, Definitive Healthcare, Becker's Healthcare, the Medicare Payment Advisory Commission, the National Rural Health Association, the Henry J. Kaiser Family Foundation, Medicare.gov, American College of Physicians website (acponline.org), Dartmouth Atlas of Health Care: Tracking the Care of Patients with Severe Chronic Illness 2008 Edition, Health Leaders Media website (healthleadersmedia.com), NPR.org, cleveland.com, fiercehealthcare.com, medscape.com, American Journal of Public Health website (ajph.aphapublications.org), Urgent Care Association of America website (ucaoa.org), American College of Emergency Physicians (acep.org), Centers for Medicare & Medicaid Services website (cms.gov), Cleveland Clinic website (clevelandclinic.org), and the City of Lakewood website (onelakewood.com).

Engagement Overview

Definitions

Definitions for several terms that are utilized within this report are provided below:

Inpatient Care

Medicare.gov defines inpatients as “patients who are formally admitted to a hospital with a doctor’s order.”

Outpatient Care

Medicare.gov defines outpatients as “patients who receive emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, when the doctor hasn’t written an order to admit them to a hospital as an inpatient.”

Patient-Centered Medical Home

The American College of Physicians defines patient-centered medical homes as “a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”

Population Health

Population health is defined by the American Journal of Public Health as “the health outcomes of a defined group of people, including the distribution of such outcomes within the group.”

The American Hospital Association further expands this definition by saying, “population health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages: (i) the distribution of specific health statuses and outcomes within a population; (ii) factors that cause the present outcomes distribution; and (iii) interventions that may modify the factors to improve health outcomes. Population health resides at the intersection of three distinct health care mechanisms. Improving population health requires effective initiatives to (i) increase the prevalence of evidence-based preventive health services and preventive health behaviors, (ii) improve care quality and patient safety, and (iii) advance care coordination across the health care continuum.”

Engagement Overview

Definitions

Urgent Care Center

According to the Urgent Care Association of America, urgent care centers are defined as healthcare facilities that “treat minor or acutely rising medical conditions that patients feel require immediate medical attention but that are not medical emergencies.”

Freestanding Emergency Department

The American College of Emergency Physicians defines freestanding emergency departments as “a facility that receives individuals for emergency care and is structurally separate and distinct from a hospital.”

Situational Overview

Situational Overview

Introduction

Lakewood Hospital is a short-term, acute-care general hospital located in Lakewood, Ohio that opened in 1907. The real property and buildings comprising Lakewood Hospital are owned by the City of Lakewood. LHA is required to operate the Hospital pursuant to a lease agreement with the City signed in 1996 and scheduled to expire in December 2026. The Cleveland Clinic is responsible for day-to-day management of Hospital facilities and operations pursuant to the definitive agreement between LHA and the Cleveland Clinic, which was also signed in 1996.

Due to downward trends in utilization and financial performance, LHA engaged Subsidiary Healthcare in late 2012 to review the Hospital's current position within the marketplace and assess the Hospital's strategic options. After going through the evaluation process, LHA elected to pursue a transaction with the Cleveland Clinic.



Attribute	Indication
Address	14519 Detroit Rd., Lakewood, OH
Beds	263
Inpatient Admissions (2014)	8,495
Outpatient Volume (2014)	142,212
Total Revenue (Latest 12 Months)	\$117 million
EBITDA Margin (Latest 12 Months)	4.5% (Operating EBITDA = 2.4%)
^[1] Debt to EBITDA (As of 6/30/2015)	1.8x
Total Cash & Long-Term ("LT") Investments (As of 6/30/2015)	\$54.2 million
Cash & LT Investments to ^[1] Debt (As of 6/30/2015)	555.1%
^[1] Debt includes current portion of LT debt, notes payable, and capital leases.	

Situational Overview

Proposed Transaction

On January 14, 2015, a non-binding Letter of Intent (“LOI”) was entered into by and among the Cleveland Clinic, LHA and Lakewood Hospital Foundation, Inc. The LOI proposes the closing of Lakewood Hospital, the opening of an outpatient family health center with a standalone emergency room, and the formation of a \$32 million community wellness foundation. Other details and key components outlined in the LOI are summarized below.

- The lease agreement between LHA and the City of Lakewood will be terminated and LHA’s hospital operations will dissolve. LHA will operate Lakewood Hospital’s emergency department during the wind-down of inpatient operations and, if reasonably possible, until the emergency department of the new family health center is operational and open.
- Cleveland Clinic will construct, staff, own, operate and manage a new family health center, which will operate from a 62,100 square foot facility located on or near the existing Lakewood Hospital site. Cleveland Clinic will commit capital of approximately \$34 million for the design, construction and equipping of the health center plus “whatever capital is required to maintain the safety and appearance of the [health center] in a manner consistent with other Cleveland Clinic Foundation family health centers.”
- Cleveland Clinic, assuming certain conditions are met, will make payments totaling \$24.4 million to a non-profit tax-exempt entity designated by LHA. Cleveland Clinic will also make 16 annual payments that total, in aggregate, \$8 million starting on the effective date of the new definitive agreement or upon the formation date of the new tax-exempt entity. The purpose of this new tax-exempt entity will be to support community health and wellness activities in the City of Lakewood.
- Cleveland Clinic will pay \$8.2 million in cash to LHA (which will be paid to the City upon execution of the new definitive agreement) for the property located at 850 Columbia Road.

Situational Overview

Demographics^[1]

Lakewood Hospital's service area, as defined by the four surrounding zip codes, contains approximately 153,752 people. The population of this area has decreased 0.48% annually over the past five years and is expected to decrease 0.32% per year over the next five years. In comparison, the U.S. population increased 0.68% annually over the past five years and is forecast to increase 0.69% per year over the next five years. In addition to a declining population, the area has a comparatively low household median income (\$38,282 locally vs. \$53,706 nationally) and a high percentage of population living below the poverty line (19.9% locally vs. 9.1% nationally). Note that a majority of the low income households come from zip code 44102 and the opposite can be said for households in zip code 44116.

Population Statistics					
Population Overview	Lakewood PSA	United States	Estimated Population by Age	Lakewood PSA	United States
2020 Projection	151,336	330,689,365	Age 16 and over	79.87%	79.56%
2015 Estimate	153,752	319,459,991	Age 18 and over	77.36%	76.85%
2010 Census	157,526	308,745,538	Age 21 and over	73.98%	72.53%
2000 Census	173,069	281,421,942	Age 65 and over	13.14%	14.67%
Growth 2015-2020	-1.57%	3.52%	Estimated Household Information	Lakewood PSA	United States
Growth 2010-2015	-2.40%	3.47%	Median Household Income	\$ 38,282	\$ 53,706
Growth 2000-2010	-8.98%	9.71%	% of Families Below Poverty	19.9%	9.1%
			[1] Estimated Unemployment Rate	5.3%	5.1%
CAGR 2015 - 2020	-0.32%	0.69%	Estimated Population by Gender	Lakewood PSA	United States
CAGR 2010 - 2015	-0.48%	0.68%	Male	75,222	157,270,864
CAGR 2000 - 2010	-0.94%	0.93%	Female	78,530	162,189,127
Estimated Median Age	37.60	37.90	Male-to-Female Ratio	0.96	0.97
Estimated Average Age	38.50	38.70			
Footnote:					
[1] Unemployment rate for the Cleveland-Elyria, OH MSA and the United States as of April 2015, per U.S. Bureau of Labor Statistics.					
Source: Claritas 2015 Population Report					

[1] Per Claritas (The Nielsen Company) for zip codes 44102, 44107, 44111, and 44116.

Situational Overview

Competitive Landscape

As will be described in the following pages, Lakewood Hospital operates in a competitive marketplace with competitors including Fairview Hospital, MetroHealth, Lutheran Hospital and St. John Medical Center. All four hospitals are located within approximately ten miles of Lakewood Hospital. Fairview Hospital and MetroHealth are the most comprehensive systems in the market area, collectively operating nearly 1,000 beds and maintaining affiliations with over 800 physicians.

Lutheran Hospital and St. John Medical Center are the smallest of the competitors but have the newest facilities. Lutheran Hospital recently remodeled its emergency room, which has impacted Lakewood's emergency department and associated admissions.

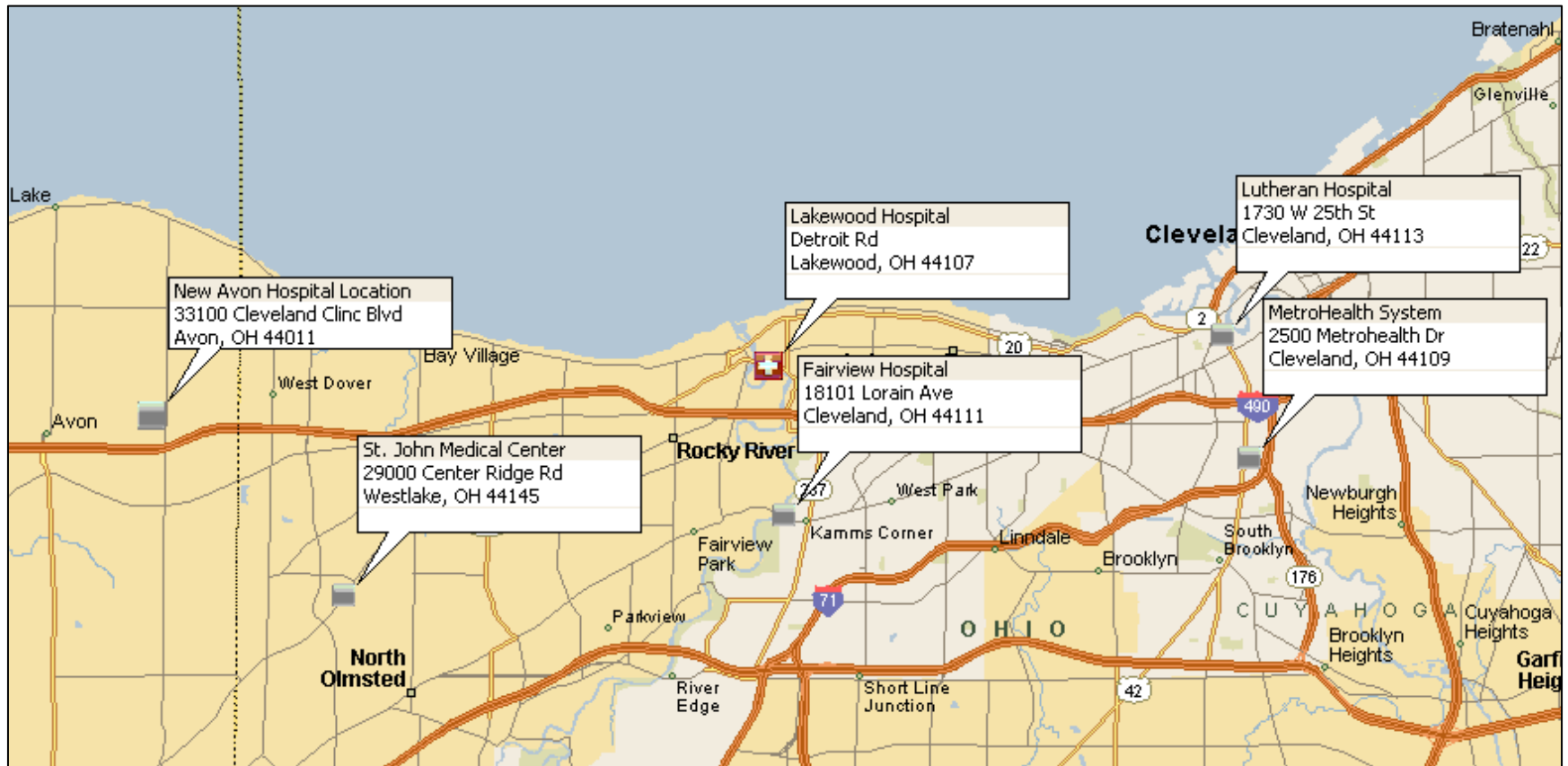
In addition to the above, Cleveland Clinic is constructing a 126 bed hospital in nearby Avon that is expected to open in 2016. This facility may have a significant impact on volume at Lakewood Hospital, as approximately 30% of the hospital's referrals are received from Cleveland Clinic physicians.

The significant number of hospitals within a relatively small area has resulted in a high number of inpatient beds per 1,000 people, indicating an oversupply of hospital beds. Further, it does not appear that Lakewood Hospital offers any services that cannot be obtained at one or more of the nearby competitors.

Situational Overview

Proximity of Competitors

There are four competing hospitals within a 10 mile radius of Lakewood Hospital. An additional competitor, Avon Hospital, is expected to enter the market in 2016. University Hospitals (not shown below) also has a presence in the community with its UH Westlake Health Center, which is 5.7 miles and a 10 minute drive from the Hospital.



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Comparison of Competitors

Hospital	Staffed Beds	Affiliated Physicians	Net Revenue (2013)	Census / Bed Utilization	Distance from Lakewood Hospital	Average Age of Facility	Accreditations
Lakewood Hospital	263	87	\$130 million (\$124 million in 2014)	115 / 52.9%	-	n/a	Level II Trauma Center, Association of American Medical Colleges Member, Council of Teaching Hospitals and Health Systems Member, Palliative Care Program
Fairview Hospital	399	217	\$486 million	242 / 58.8%	3.4 miles (12 min. drive)	13 Years	Integrated Network Cancer Program, American Nurses Credentialing Center Magnet Facility, Level II Trauma Center, Academic Medical Center, Association of American Medical Colleges Member, Council of Teaching Hospitals and Health Systems Member, Palliative Care Program
MetroHealth System	523	616	\$854 million	292 / 56.5%	7.2 miles (15 min. drive)	20 Years	The Joint Commission for Accreditation of Health Care Organizations, National Committee for Quality Assurance, Commission Accreditation of Rehabilitation Facilities, Commission on Cancer, American College of Surgeons' National Accreditation Program for Breast Centers
St. John Medical Center	170	165	\$146 million	102 / 59.9%	10.4 miles (18 min. drive)	10 Years	Community Cancer Program, Level III Trauma Center
Lutheran Hospital	126	61	\$98 million	39 / 32.1%	5.7 miles (12 min. drive)	10 Years	Association of American Medical Colleges Member, Council of Teaching Hospitals and Health Systems Member, Palliative Care Program
Avon Hospital	126 (estimate)	n/a	n/a	n/a	12.4 miles (20 min. drive)	Opens 2016	n/a

Situational Overview

Inpatient Beds in Market

According to data published by the American Hospital Association (“AHA”), the nationwide average for staffed community hospital beds per 1,000 people is 2.6, which below the average of 2.9 for the state of Ohio. Note that community hospitals are defined by AHA as all nonfederal, short-term general and specialty hospitals whose facilities and services are available to the public. In the area defined by zip codes 44102, 44107, 44111 and 44116, which includes Fairview Hospital and Lakewood Hospital, there are 4.3 staffed hospital beds per 1,000 people. If Lakewood Hospital were to close, the number of beds per 1,000 people in the Lakewood market would decline to 2.6 (note that this excludes accessibility to several other nearby hospitals). If the market is expanded to include all five competing hospitals identified earlier, the number of staffed beds per 1,000 people in this area is 5.5 (5.0 if Lakewood Hospital is closed and Avon Hospital is opened). Based on a review of this data, the local market appears to be over-bedded and will remain so even if Lakewood Hospital is closed. However, this assessment does not factor in the inconvenience to Lakewood residents or the potential impact on public health (especially for high-risk conditions such as stroke and cardiac arrest) resulting from increased transit times to other hospitals if Lakewood Hospital is closed.

[1]Beds per 1,000 People

Lakewood PSA ^[2] 4.3	Lakewood PSA (Excluding LH) ^[2] 2.6	Fairview and Avon in Lakewood PSA ^[3] 3.4	Eight Zip Codes ^[4] 5.5	Eight Zip Codes ^[4] (Excluding LH) 4.5	Eight Zip Codes ^[4] (Excluding LH and including Avon Hosp) 5.0
Ohio 2.9	Pennsylvania 3.1	Michigan 2.5	Oregon (National low) 1.7	Washington D.C. (National high) 5.7	United States 2.6

[1] Per American Hospital Association, 2014 report based on 2012 information. Population reports per Claritas.

[2] Lakewood's primary service area includes Fairview Hospital (399 beds) and Lakewood Hospital (263 beds – which is per the community needs assessment). Population count includes zip codes 44102, 44107, 44111, and 44116.

[3] Assumes Avon has 126 hospital beds. Population count includes zip codes 44102, 44107, 44111, and 44116.

[4] Eight zip code statistics, unless otherwise noted, include Lakewood, Fairview, MetroHealth, St. John, and Lutheran Hospital beds and the total population of the following zip codes: 44011, 44107, 44111, 44116, 44102, 44109, 44113, and 44145.

Situational Overview

Impact on Quality of Care Based on Number of Beds in the Market

Several studies have been undertaken to determine the impact of capacity (number of beds) on the quality of care. Based on our review of these studies, it appears there are potential drawbacks for communities that are either over-bedded or under-bedded. As examples:

- According to a 2012 article published in Health Leaders Media, under-bedded populations suffer from lower revenue for hospital operators and poorer quality for patients.
- According to the 2008 edition of the Dartmouth Atlas of Health Care: Tracking the Care of Patients with Severe Chronic Illness, over-bedded populations tend to have relatively high spending (on a per-patient basis) and do not see any appreciable difference in quality.

In regard to the impact on quality resulting from the closure of a hospital, an article published on npr.org and referencing a study published in the journal *Health Affairs* found that there are “no significant changes in how often Medicare beneficiaries were admitted to hospitals, how long they stayed or how much their care cost.” The report further points out that the reasoning for this may be due to the financial health of the remaining hospital(s) (versus the hospital that closed), which would likely result in greater resources and, accordingly, better care. Dr. Ashish Jha, one of the authors of the study, noted, “on average, people are going a little further, but it clearly has no negative effect on their outcomes and on their health.”

Huron has not taken a position on the anticipated impact on quality of care for the residents of Lakewood if the Hospital is closed and replaced with a family health center. Certain areas for the City Council to consider include, among others:

- What are the wait times for each emergency room in the area? Will wait times deteriorate to unacceptable levels if Lakewood Hospital is closed?
- Will emergency responders utilize the emergency room at the family health center or will they take patients to full-service hospitals located outside of Lakewood? If the latter, what is the risk for patients with critical care issues such as stroke and cardiac arrest?
- Will the general health of the community improve as a result of the superior outpatient facilities and services of the family health center?
- What will be the impact on the ability to recruit physicians to the community if there is no hospital in the city?

Situational Overview

Outpatient Surgery Centers

According to the Ambulatory Surgery Center Association (“ASCA”), excluding surgery capabilities at the local hospitals, there are nine Medicare-certified ambulatory surgery centers (“ASCs”) within a reasonable driving distance of Lakewood Hospital. These ASCs, according to Definitive Healthcare, contain 35 operating rooms (“ORs”) and provide both general and specialty surgical services. Also according to Definitive Healthcare, there are approximately 685 operating rooms in the state of Ohio.

ASC	Specialty	Number of ORs	Distance from Lakewood Hospital
North Shore Endoscopy Center	Gastroenterology	3	7.2 miles / 12 min. drive
Premier Physicians Ambulatory Surgery Center	Gastroenterology & General (Minor)	3	8.0 miles / 14 min. drive
North Ohio Endoscopy Center	Gastroenterology	3	10.3 miles / 16 min. drive
Cleveland Eye & Laser Surgery Center, LLC	Ophthalmology	3	7.1 miles / 21 min. drive
Kaiser Foundation Health Plan	Multi-Specialty	5	6.8 miles / 23 min. drive
Vision Surgery Center, LLC	Ophthalmology	1	8.3 miles / 26 min. drive
Surgery Center Pearl	Urology	4	8.1 miles / 27 min. drive
Big Creek Surgery Center	Multi-Specialty	6	9.5 miles / 19 min. drive
Surgery Center	Multi-Specialty	7	9.6 miles / 21 min. drive

11.2 ORs per
100,000 People in
the Nine
Surrounding Zip
Codes^[1], Including
Lakewood’s PSA

5.9 ORs per 100,000
People in the State
of Ohio

[1] Nine zip code statistics include the nine ASCs listed above (35 ORs) and the total population of the following zip codes: 44102, 44107, 44109, 44111, 44113, 44116, 44126, 44130, and 44145. Note that these zip codes include Lakewood’s PSA plus the zip code in which each ASC is located (if it is outside of Lakewood’s PSA).

Situational Overview

Services Offered at Lakewood Hospital/Proposed at Family Health Clinic

The table below summarizes the major service lines currently offered at Lakewood Hospital and those proposed for the family health center (per terms of the Letter of Intent). The services listed in the LOI exclude specialties that may be offered by private practitioners in the Lakewood Professional Building. As is evident, the City will retain many of the service lines and specialties currently offered at Lakewood Hospital and add others not currently offered such as chronic disease, musculoskeletal and pulmonology. However, Lakewood will lose all inpatient services as well as certain service lines such as the cancer center, teen health center and surgeries.

Service Line	Currently Offered at LH	Proposed at FHC	Service Line	Currently Offered at LH	Proposed at FHC
Behavioral Health Services	√	√	Pain Management Center	√	
Cancer Program	√		Pharmacy		√
Chronic Disease Clinics		√	Primary Care/Pediatrics	√	√
Diabetes & Endocrine Center	√	√	Pulmonology Services		√
Digestive Health Center	√	√	Radiology & Lab Services	√	√
Emergency Department	√	√	Rehab/Physician & Occupational Therapy Services	√	√
Heart Center	√	√	Senior Care/Geriatrics Services	√	√
Home Care		√	Surgical Services	√	
Musculoskeletal Care		√	Teen Health Center	√	
Neurological Services	√	√	Vein & Vascular Center	√	
Ophthalmology	√	√	Women's Health	√	√
Orthopedic Services	√				

Situational Overview

Area Physicians

According to Definitive Healthcare, there are 5,375 physicians within the market defined by the cities of Lakewood, Cleveland, Parma, Westlake, Avon, Rocky River and Brooklyn. Of these, 4,364 (81.2%) are part of a network and 1,011 (18.8%) are independent. Premier Physicians (combination of Northeast Ohio Group Practice and Premier Physicians Center) is the largest independent group in the market, with 159 physicians and over 25 specialties. While Premier is within Lakewood Hospital's immediate market, the group has already declined to affiliate with the Hospital. There appear to be relatively few other independent physicians within the Lakewood area.

Group Name	Main Specialty	# of Physicians	% of Total	Network
Cleveland Clinic	Multi-Specialty	2,662	49.5%	Cleveland Clinic Health System
University Hospitals Medical Group	Multi-Specialty	758	14.1%	University Hospitals Health System
MetroHealth Professional Group	Multi-Specialty	565	10.5%	The MetroHealth System
Healthspan Physicians	Multi-Specialty	165	3.1%	Mercy Health
Community Hospitalist	Internal Medicine	139	2.6%	None
Clinic Physician Services Co.	Anesthesiology	100	1.9%	None
Northeast Ohio Group Practice	Multi-Specialty	89	1.7%	None
Ohio Permanente Medical Group	Multi-Specialty	77	1.4%	Mercy Health
Clinic Regional Physicians	Multi-Specialty	72	1.3%	None
Premier Physicians Centers	Multi-Specialty	70	1.3%	None
Cuyahoga Physician Network	Multi-Specialty	46	0.9%	None
Westshore Primary Care	Family Practice	46	0.9%	Sisters Of Charity Health System
St Vincent Charity Medical Group	Multi-Specialty	40	0.7%	Sisters Of Charity Health System
North Ohio Heart	Cardiology	40	0.7%	None
Lakewood Hospital Association	Internal Medicine	22	0.4%	Cleveland Clinic Health System
Community Express Care of Parma Hosp.	General Surgery	20	0.4%	University Hospitals Health System
Drs. Hill & Thomas Co.	Radiology	17	0.3%	None
Orthopaedic Associations	Orthopedic Surgery	14	0.3%	None

Situational Overview

Physician Recruitment

Given Lakewood Hospital's financial position and its status as a stand-alone community hospital, it is unlikely that the Hospital will be able to significantly expand its employed physician base, especially considering the annual loss-per-physician of \$50,000 to \$200,000 that we see as typical throughout the country. Thus, in order to expand physician support for the Hospital it will be necessary to (i) expand usage among existing independent physicians in the market or (ii) recruit independent physicians into the community.

In regard to the latter, recent trends suggest that young physicians and residents are increasingly choosing the path of employment rather than opening a private practice. A recent article published in Fierce Healthcare, which cited a study performed by recruiting firm Merritt Hawkins, states that "senior medical residents rated hospital employment as their top career choice, with just 1% of new doctors saying they wanted their own practice." This is a result of many factors including (i) high student-loan debt that can be alleviated with signing bonuses and income guarantees that are often offered by hospitals, (ii) significant IT investments and skillsets needed to comply with meaningful use requirements and compete in an evolving reimbursement marketplace, and (iii) the general preference among younger physicians to focus on the care of patients instead of running a practice.

Thus, it is unlikely that there will be a large influx of independent physicians into the market in the near future. Alternatively, organizations such as the Ohio Independent Collaborative, a statewide collaborative meant to help reduce costs for independent physician practices, could aid the situation if they are successful in their missions.

[1] Population data is per Claritas. The total physician count in the United States and the state of Ohio is per The Henry J. Kaiser Family Foundation and physician count for the seven surrounding cities is per Definitive Healthcare.

Situational Overview

Community Needs Assessment

As part of our investigation, we reviewed the 2013 Community Needs Assessment prepared by Tripp Umbach. Significant findings of the CNA are summarized below:

- The needs of the Lakewood community include: improving access to primary, preventative and mental health services, improved coordination of affordable healthcare services and outreach, and transportation and other basic community services.
- The community health areas that require the greatest improvement are: Chronic obstructive pulmonary disease (COPD), adult asthma and congestive heart failure.
- The community shows lower rates of high blood pressure and depression, but higher rates of obese citizens, citizens who smoke and citizens with chemical dependency. The Lakewood community has one of the lowest penetrating trauma rates in Cuyahoga county and the state of Ohio. The prevalence of heart and lung disease is lower but liver conditions are higher when compared to the county and the state.
- The citizens of the community identified adequate healthcare facilities and institutions that are easily accessible as needs. They believe healthcare should be affordable and include both preventative and emergency services. They also believe that there are gaps in available services due to a lack of communication and the absence of a formal connection between service providers in the community. When asked what it might take in order to reach their vision of a healthy community, citizens indicated a strong network of organizations and institutions that work together and provide support and services to residents. There is a perceived lack of community development, direction, planning and resources. Further, the infrastructure of the community may not be able to meet resident demands, including the housing stock, old infrastructure and limited handicap accessibility. Lastly, citizens commented that healthcare systems in the area need to provide clinics to the residents: There should be a central location that residents can go to have all their healthcare needs met.
- The community need index indicates there is a high need for community health reform.

Situational Overview

Lakewood Hospital Facility

Built in 1916, Lakewood Hospital contains approximately 499,000 square feet and staffs 263 beds. Below is an overview of significant milestones at the Hospital.

- 1916 – 4-story brick building called the “Detroit Building” is completed
- 1940 – Hospital adds the B wing
- 1951 – Hospital is expanded to include the C and F wings
- 1968 – Hospital is expanded to include the “Marlowe Wing” now called the D and E wings
- 1971 – B and C wings are renovated and the fourth floor of the Marlowe Wing is finished
- 1985 – Hospital expands inward and encloses its courtyard
- 1990 – New birthing center opens
- 2002 – The Hospital’s opens its newly expanded and renovated emergency department
- 2007 – Newly renovated Coronary Care Unit opens



Mr. Frank Aucremanne, the Hospital’s Executive Director of Buildings and Properties, prepared a summary of the facility’s deficiencies and identified improvements that will be needed in order to extend the life of the Hospital. These include:

- The Hospital has many structural issues and deferred maintenance including: the foundation and walls throughout the Lakewood campus, parking garage repairs (\$2 million to \$4 million), 75% of windows exceeding their useful lives, roof replacements (\$1 million), plumbing and sewage main replacements.
- The Hospital requires updates or replacements of various systems including: emergency switchgear exceeding its useful life, Air Enterprise AHUs nearing or exceeding their useful lives, fire tube boiler nearing the end of its useful life, main normal power switchgear relocation, and updates to the in-room heating/cooling systems.

A member of Huron’s healthcare real estate team inspected the facility on August 12, 2015. A summary of his observations are outlined below:

- Patient rooms are small and set up for semi private;
- Transition to private rooms would likely require complete renovation including but not limited to full bathroom reconstruction and new headwalls;

Situational Overview

Lakewood Hospital Facility

- Bathrooms in patient rooms are severely under sized and require major work to meet market standards;
- Bathrooms have complete lack of showers;
- HVAC systems are past their prime but in generally good working order;
- Boilers are adequate for operation but no redundancy is available (i.e. backup boilers are not available in case of failure of main boilers);
- Air handling units are old but functional;
- Water systems include antiquated galvanized pipe;
- Asbestos is prominent in the original 1917 building in flooring, pipe insulation and possibly structural materials;
- Roofing is in need of replacement in four of the older sections of the facility;
- Underground diesel tanks are at the end of their useful lives and may need replacement, though they are up to EPA standards;
- Single pane windows are in existence in certain areas of the older wings, lead caulking is failing;
- Elevators date back to 1930's vintage with certain parts no longer available, indicating an eventual need for complete replacement;
- Low floor-to-ceiling height limits space for mechanical, electrical, plumbing, and IT component installation;
- Building switch gear and transformation equipment date to the 1980s;
- Portions of the building are not set for three phase power and would need full replacement; and
- Parking garage suffers from spalling and cracking concrete.

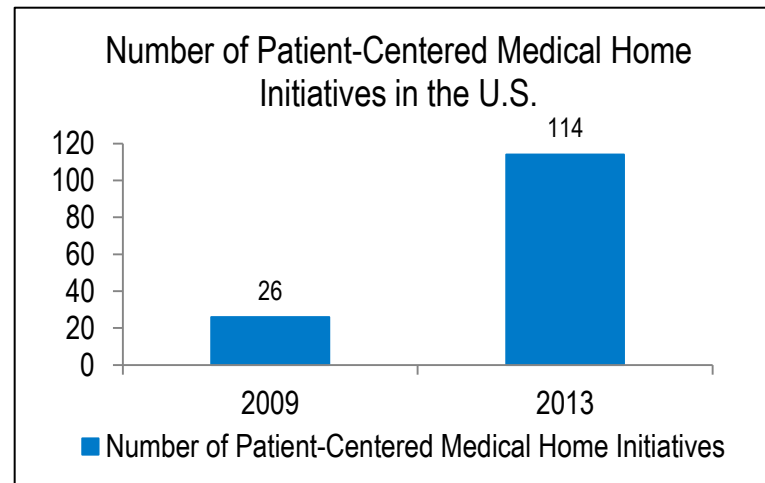
The total renovation costs for the facility have reportedly been estimated at \$91.5 million. While the lease includes customary tenant covenants requiring LHA to maintain the Hospital in good repair and operating condition during the term of the lease, these covenants should not be interpreted as requiring LHA to make material capital investments in the Hospital, to maximize Hospital revenues or to operate the Hospital as a state-of-the-art facility. Consequently, the financial burden of the facility replacement or renovation would likely fall to the City if LHA declines to renew the lease at expiration.

Industry Trends

Industry Trends

Population Health

A significant trend in healthcare relates to mitigating the costs of care by keeping patients healthy and out of hospitals through the use of population health management. The population health management model includes measures to prevent conditions before they result in costly medical procedures (i.e. educating patients about the risks of tobacco use) by advising patients to go to wellness centers or patient-centered medical homes. With these wellness centers and patient-centered medical homes, the population health management model also focuses on reducing the amount of high-cost procedures by identifying conditions before they become more serious – conditions that result in the need for procedures that are typically performed in a hospital setting or result in a hospital visit. Hospital-based procedures carry a higher expense structure which results in the need to charge a higher rate (these costs are passed along to both payors and patients). Conversely, ambulatory procedures, or procedures carried out in an outpatient facility, are typically less expensive, hence the growth in outpatient service centers.



Source: The Commonwealth Fund

Industry Trends

Population Health

Under a population health model, reimbursement typically transitions from fee-for-service to capitation. In a capitation model, lump sum payments are made to cover all of a patient's medical expenses. Capitation payments incentivize providers by allowing them to profit when that sum is greater than the expense incurred to care for the patient and forcing them to take the loss if costs exceed revenue. This creates a scenario where providers are better compensated when they (i) avoid the need to perform costly procedures by keeping their patients healthy, (ii) utilize the best practices of providing care when their patients are sick, and (iii) utilize lower cost facilities to provide care, such as wellness centers and patient-centered medical homes.

Further motivation to transition to a population health model derives from incentives and penalties introduced in the Affordable Care Act. These incentives include, but are not limited to, the programs listed below, per the Centers for Medicare and Medicaid Services ("CMS"):

- **Hospital Readmissions Reduction Program:** This program allows CMS to reduce payments to inpatient hospitals with excess readmissions. This program has presented additional risk to hospitals that hope to continue to operate in this space.
- **Quality Rating System:** This system rates quality health plans based on relative quality and price. Quality rating scores are published on the Health Insurance Marketplaces where individuals and small businesses shop for, select, and enroll in private health plans. Hospitals and health systems must remain attractive through high quality and patient satisfaction scores in an environment of growing competition such as Lakewood.
- **Quality Improvement Strategy:** This program reinforces national healthcare quality as a priority by setting a payment structure that provides increased reimbursement or other incentives to improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities.

Industry Trends

Population Health

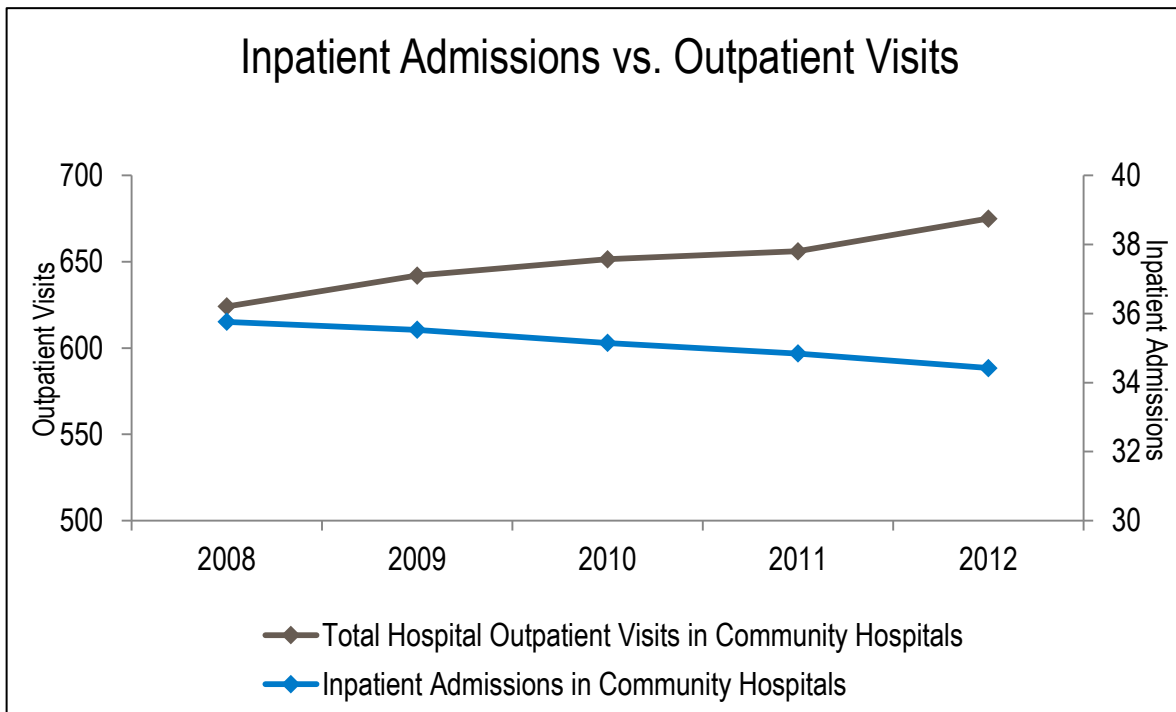
When considering a change to a population health model, systems will consider the following:

Pros	Cons
Forward thinking and commonly referred to as the future of healthcare	Uncharted and unproven territory (risk)
Projected increases in reimbursement (or avoidance of cuts to reimbursement)	Population becomes concerned when local hospitals close and replacement clinics are unable to provide same scope of care
Ultimately results in a healthier population	Difficulty moving away from established fee-for-service model
New Medicare policies make it possible for all parties to save money	Physician reluctance and the belief that it will adversely impact their compensation
Demand is higher for outpatient services as it relates to lower co-pays	Providers often do not understand their total cost of care
Family health centers/care clinics are typically leaner and significantly cheaper	Access to primary care and subspecialty services continues to be a significant challenge
Trends suggest a large scale movement to outpatient facilities is already underway	Information technology necessary to support secure access to patient electronic health records continue to lag in adoption

Industry Trends

Inpatient vs. Outpatient Volumes

National trends indicate a steady increase in the number of outpatient visits, combined with declining inpatient visits. According to the American Hospital Association and as illustrated below, total inpatient admissions at community hospitals fell from 35.8 million in 2008 to 34.4 million in 2012, equivalent to a 0.9% decrease per year. Meanwhile, total outpatient visits rose from 624.1 million to 675.0 million over the same period, an increase of 2.0% per year. Over the long-term, this trend has resulted in many older hospital facilities becoming functionally obsolete, as most hospitals built before 2000 were designed to support a much larger inpatient population and have insufficient capacity for outpatient services.



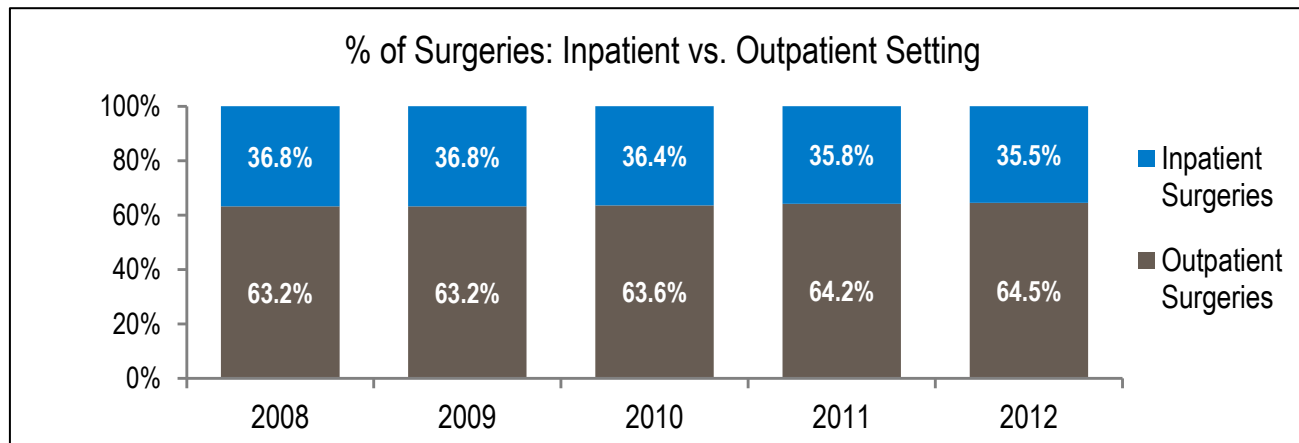
Source: American Hospital Association Annual Survey data, 2014, for community hospitals.

While the overall trend is generally understood, most executives underestimate the potential drop in inpatient utilization. A March 2014 Kurt Salmon survey of U.S. hospitals found that 63% of executives and board members expect an average decrease in inpatient services of 3% over the next five years (measured by admissions per 1,000 population). This reduction is far below the 30% drop indicated by Milliman's Health Cost Guidelines (HCGs) for markets that shift to well-managed rates. Such a reduction will lead to significant excess inpatient physical capacity in many markets.

Industry Trends

Inpatient vs. Outpatient Volumes

Outpatient services are growing for a number of reasons. First, new technology has allowed for a greater number of tests and procedures to be performed in less costly outpatient settings. Surgeries performed in outpatient settings, in particular, have grown significantly. Huron has witnessed this through hundreds of transactions in which we helped health systems acquire ambulatory surgery centers. As mentioned, outpatient facilities typically have lower overhead costs than hospital-based operating rooms. With a lower cost structure, procedures can be offered at lower rates – cost savings that are captured by the health systems and passed along to patients and their insurance carriers.

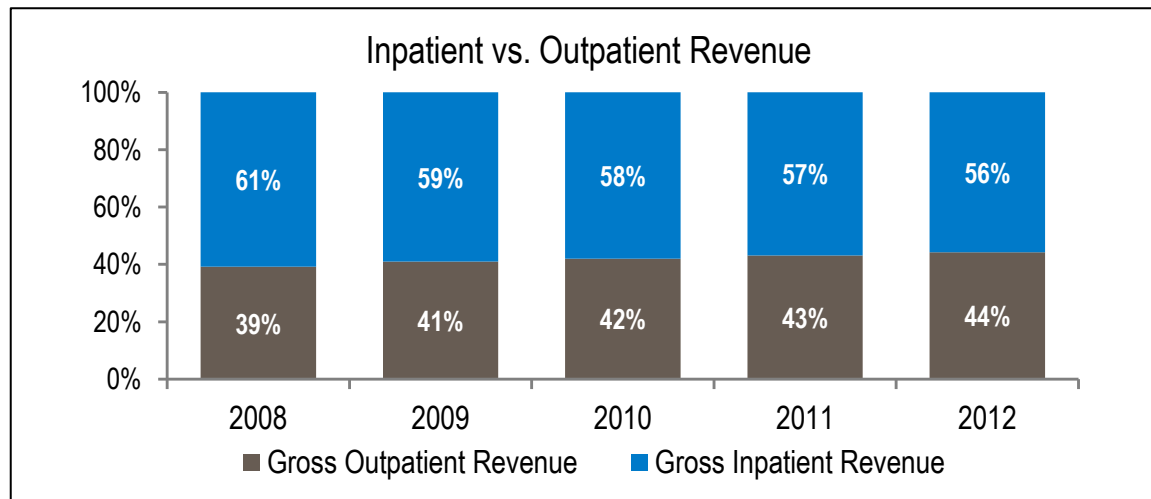


Source: American Hospital Association Annual Survey data, 2014, for community hospitals.

Industry Trends

Inpatient vs. Outpatient Volumes

Another reason for the growth in outpatient services is patient demands and preferences for the settings in which tests and procedures are performed. According to a recent Becker's Healthcare article^[1], over 20% of the insured population now has a high-deductible policy compared to less than 5% roughly ten years ago. These high deductibles have resulted in patients who hold such plans becoming more price conscience. Huron has, again, experienced transactional-based evidence in our work assisting health systems in their acquisitions of urgent care centers. Urgent care centers have significantly lower costs (co-pays) than emergency rooms. Further, while not necessarily a new phenomenon, convenience is desirable – and not just in terms of accessibility. Patients are beginning to realize the advantages of a continuum of care. This has become possible with the advent and implementation of electronic health records systems, patient-centered medical homes, vertically integrated health systems and wellness centers that utilize case managers. Lastly, the growth in chronic disease is outpacing population growth. Since chronic disease cases are typically treated in an outpatient setting, the demand for outpatient capacity is expanding on a per-capita basis.



Source: American Hospital Association Annual Survey data, 2014, for community hospitals.

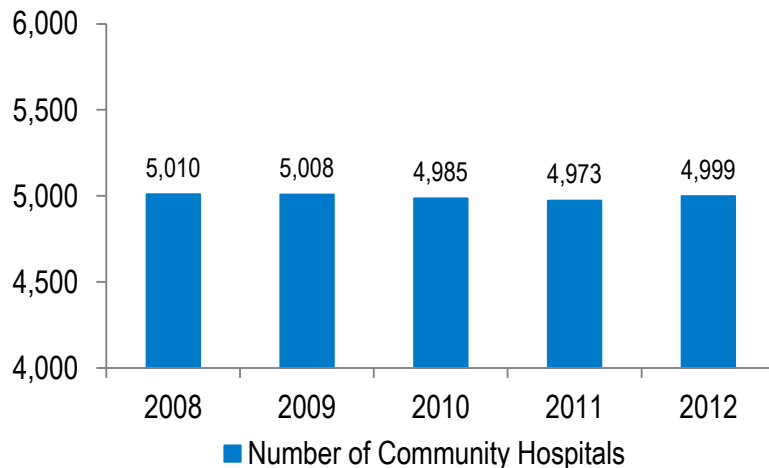
[1] <http://www.beckershospitalreview.com/finance/how-hospitals-can-offset-the-effects-of-high-deductible-health-plans.html>

Industry Trends

Hospital Closures

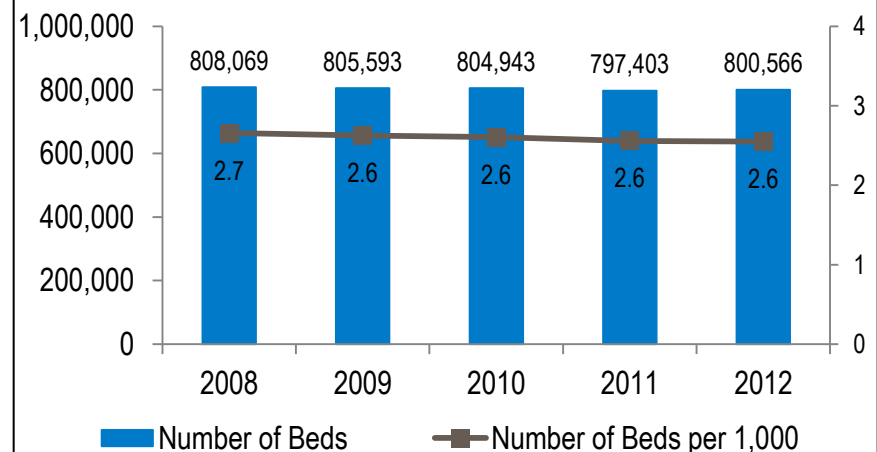
According to the Medicare Payment Advisory Commission, 17 hospitals closed in 2012, five of which converted to outpatient care facilities. This was followed by 25 acute care hospitals closing in 2013 (15 hospitals opened) and 27 hospitals closing in 2014. This accelerating trend is not expected to abate anytime soon, as evidenced by the National Rural Health Association's estimate that 283 rural hospitals are currently in danger of closing (no forecasts for at-risk urban hospitals were identified). The main reasons for these closures include, among others: (i) low occupancy, which results in poor financial performance, (ii) low quality scores, (iii) aging and functionally obsolete facilities, (iv) lack of physician support, (v) technology needs, and (vi) competitive factors. Note that these closures are occurring despite the national trends of population growth and the aging population. Please see the Appendix of this report for additional information on certain relevant hospitals that transitioned from acute care facilities to outpatient centers.

Community Hospitals in the U.S.



Source: American Hospital Association Annual Survey data, 2014, for community hospitals.

Number of Beds and Beds per 1,000 People in U.S. Community Hospitals



Source: American Hospital Association Annual Survey data, 2014, for community hospitals.

Industry Trends

Healthcare Spending Per Capita

The Henry J. Kaiser Family Foundation publishes healthcare expenditure data on a per capita basis, with the most recent report effective as of 2009. As illustrated in the table below, healthcare expenditures per capita for the state of Ohio are above the national average. Note that the level of expenditures per capita generally correlate with the number of beds per capita. For example, note that Washington D.C. represents the national high in both healthcare expenditures per capita and beds per 1,000 people. On the other hand, Utah has the lowest level of spending and has one of the lowest levels of bed capacity.

	Healthcare Expenditures per Capita	Beds per 1,000 People
United States	\$6,815	2.6
Ohio	\$7,076	2.9
Washington D.C.	\$10,349 (National High)	5.7
Utah	\$5,031 (National Low)	1.8

Review of Subsidiary Report

Review of Subsidium Report

Introduction

Subsidium Healthcare was retained by LHA to assist in the evaluation of strategic options for the Hospital. This evaluation, which was contained in several presentations and summarized in an 86-page report, was utilized by LHA to undertake a search for an affiliation partner, which ultimately led to the proposal that is being considered by LHA and the City of Lakewood. Huron was asked to investigate the following in connection with Subsidium's study:

- Do Subsidium's conclusions stand up to scrutiny?
- Did Subsidium, using audited annual financial statements provided by the Cleveland Clinic and market data, accurately predict the financial obsolescence of Lakewood Hospital?
- Did Subsidium consider all potential viable alternatives?
- Were the decision criteria employed by Subsidium comprehensive?
- If other healthcare systems had been invited to respond with a proposal to replace the hospital with a family health center (as opposed to running an inpatient facility), would it have been likely in light of the healthcare marketplace that other entities would have responded with viable alternatives?
- Are there other conclusions Subsidium should have reached instead of or in addition to those presented in its January 2015 report to the hospital trustees?

Our review of the Subsidium report and responses to the above questions are summarized in the following pages.

Review of Subsidium Report

Subsidium's General Concepts

Subsidium concluded that Lakewood Hospital should pursue a strategy of converting the inpatient facility to an outpatient center and investing in community health and wellness. The reasoning provided includes the following:

Outpatient trends: Technology trends are driving a shift from inpatient services to outpatient services. Further, the community health needs of Lakewood are more consistent with comprehensive ambulatory care.

Huron agrees that technological advances are one of the driving forces behind the shift from inpatient services to outpatient services. This and other drivers are outlined on pages 31 and 32 of this report. Further, Huron agrees that the community needs of the City, as outlined in the Community Needs Assessment and including (i) improving access to primary, preventative and mental health services; (ii) improved coordination of affordable healthcare services and outreach; and (iii) transportation and other basic community services, can be largely serviced in an ambulatory or outpatient setting, with the possible exception of (iii) above, for which Huron does not have the information to opine on the impact.

There is a macro trend toward population management and medical homes models.

Huron agrees that there is a trend toward population health management and payment models, as outlined on pages 27 through 29.

There is an excess of inpatient beds in area.

As described on page 17, there appears to be an excess of inpatient beds in the local and regional markets. However, the metrics utilized to support this finding do not factor in the potential inconvenience of Lakewood residents facing longer transit times to reach other hospitals, nor the potential impact on public health resulting from longer ambulance rides (assuming that EMTs divert to other hospitals).

There is no facility in the area that would compare to the proposed outpatient family health center. Further, people expect to seek outpatient care in their immediate area, so there will be less competition from other nearby communities.

Huron agrees that the immediate area has no family health centers that are similar to the proposed center. Further, we have found that newer and well-designed healthcare facilities tend to limit competition from outside entities, especially if the facilities are located in convenient areas and offer a full suite of services. That said, if Lakewood Hospital is closed, nearby hospitals will compete for the City's inpatient business through various outreach programs.

Review of Subsidium Report

Subsidium's General Concepts

At current average panel sizes, Lakewood needs roughly 20-25 PCPs, which are currently available in the market. Lakewood has sufficient other clinical resources necessary to convert to an outpatient family health center.

The number of physicians necessary to adequately staff the proposed family health center will be dependent on the services and specialties offered. Based on our review of the physicians in the market (page 21) and our discussions with various parties, there seems to be an adequate number of primary care physicians serving Lakewood, although certain specialties and subspecialties are in short supply. As the largest employer of physicians in the market, Cleveland Clinic has the ability to staff most any specialty/subspecialty that may be offered at the center, whether on a permanent or rotating basis. Huron agrees that Lakewood likely has sufficient other clinical resources to convert to an outpatient family health center.

The family health center would be a relatively low cost investment.

Huron agrees that ambulatory/outpatient facilities are significantly less costly to construct than acute care hospitals, plus they have lower ongoing operating costs.

The family health center is the best option as far as financial sustainability, potential partner congruency, and execution risk & complexity.

A population the size of Lakewood has the ability to support an acute care hospital if the outmigration of healthcare services is significantly reduced. However, Lakewood Hospital has not been able to stem this outmigration for reasons that may include the age and condition of the facility, the lack of referrals from area physicians (both independents and those employed by competing systems), and others. Financial sustainability as an acute care facility would likely require (i) a refurbishment of the facility including a reduction in the number of beds and an expansion of outpatient services, and (ii) rebuilding the physician network supporting the Hospital. The latter point is speculative given the lack of independent physicians in the market and the high cost of recruiting and employing new physicians. Regarding potential partner congruency, a family health center best suits Cleveland Clinic's market structure given its nearby hospitals. An outpatient center may also be attractive to other systems in the marketplace, primarily as a feeder into their hospitals, though we are unaware of any other systems that have active interest in that option. Lastly, the execution risk is likely lower for an outpatient facility than the restructured acute care facility described above.

Review of Subsidiary Report

Subsidiary's Criteria and Identified Options

Subsidiary considered several criteria in determining viable options for Lakewood. This criteria included: market trends, competitive landscape, medical staff/personnel, facility readiness, market need, community impact, financial sustainability, potential partner congruency and implementation complexity. *Huron believes this to be a reasonable and comprehensive set of criteria.*

Subsidiary considered numerous strategic options for the Hospital. These options are summarized below, segregated between Subsidiary's preferred and non-preferred options, along with Huron commentary. Note that we are comfortable that Subsidiary considered essentially all relevant potential options for Lakewood Hospital.

Subsidiary's Preferred Options	Huron Commentary
Convert to a Family Health Campus	We view this to be a viable option for many of the same reasons as Subsidiary, including current healthcare trends (mainly the shift from inpatient services to outpatient services and future payment models), the excess of inpatient beds in the market, the healthcare needs of the community, and the relatively low cost and complexity of the transition. This option would also serve as a resolution to what we view as the biggest issues facing the Hospital including the threat of new competition for inpatient services, a lack of a strong physician network (outside of Cleveland Clinic), and the aging facility.
Covert to a hybrid family health center with general inpatient beds	We consider this a viable option if there is sufficient capital for facility renovations and physician support. The major risk of this option is considered the difficulty in building the physician network, especially given the likely loss of referrals from Cleveland Clinic physicians once Avon Hospital is open. We believe that finding a partner would be the best opportunity to pursue this option.
Convert to a hybrid family health center with acute rehabilitation beds	This may be a viable option if it is determined that there is a need for rehabilitation beds in the community. A partner with expertise in rehabilitation would likely be needed to pursue this option. We do not view this option as significantly different than a straight conversion to an outpatient center, as the traditional inpatient services currently provided by the Hospital would be removed from the community.

Review of Subsidium Report

Subsidium's Criteria and Identified Options

Subsidium Non-Preferred Options	Huron Commentary
Remain status quo	This may be a viable option if LHA and the City prefer to delay a decision on the Hospital, during which time the City would continue to receive payments under the lease. A potential drawback is that the investment portfolio would likely be depleted over the next few years unless the performance of the Hospital improves significantly. Also, LHA would need to utilize the additional time productively to develop a strategy to address facility issues, develop a supportive physician network, and pursue negotiations with potential partners. If this strategy is unsuccessful, the cost to the community in terms of financial losses and lost services could be significant.
Right size the Hospital by reducing the number of beds	We consider this a viable option if there is sufficient capital for facility renovations and an ability to expand the physician network and capture additional community support for the Hospital. The major risk of this option is considered the difficulty in building the physician network, especially given the likely loss of referrals from Cleveland Clinic physicians once Avon Hospital is open. We believe that finding a partner would be the best opportunity to pursue this option.
Change the service mix to a lower-acuity, chronic care-focused hospital	We agree that this does not appear to be a viable option. Most of the existing inpatient services of the Hospital would be lost under this scenario, plus there would be no improvement in outpatient services.
Convert to a Hospital with Centers of Excellence	We agree that this does not appear to be a viable option, as it would likely prove difficult to build the Centers of Excellence without a large and engaged network of specialist physicians.
Open an orthopedic specialty hospital	This option would likely be profitable if the project received support from a large group of orthopedic physicians, but would likely result in fewer primary care services in the market, which is not considered a favorable trade-off. Most existing inpatient services would be lost under this scenario.
Open a rehabilitation hospital	We view this option similar to the orthopedic hospital option.

Review of Subsidium Report

Subsidium's Criteria and Identified Options

Subsidium Non-Preferred Options	Huron Commentary
Open a psychiatric hospital	We view this option similar to the other specialty hospital options.
Open a long-term acute care/skilled nursing facility	We view this option similar to the other specialty hospital options.
Transition out of health care delivery in Lakewood	We do not view this as a viable alternative.

Review of Subsidium Report

Partner Search

Based on the recommendations developed by Subsidium, LHA elected to search for an affiliation partner. Our understanding of the partner search was based on a review of various documents and discussions with representatives from Subsidium and LHA. Significant milestones in the process reportedly included the following:

- In July 2013, as Subsidium began its engagement of exploring strategic options for LHA, informal discussions were held with several local systems including University Hospitals, Catholic Health Partners, MetroHealth and Premier Physicians. In these preliminary discussions, the potential partners conveyed interest in Lakewood Hospital only as an outpatient facility. This feedback caused Subsidium and LHA to believe that their best option would be to issue a request-for-proposal (RFP) to convert Lakewood Hospital to an outpatient center.
- On January 3, 2014, Subsidium furnished an engagement letter to the Select Committee of the LHA Board, in which Subsidium would work with LHA to develop and administer the RFP process to convert Lakewood Hospital to an outpatient center. During this time, the Select Committee of the LHA Board had several discussions and ultimately decided that it should issue parallel RFPs, with the second one asking for proposals to continue as an inpatient hospital.
- On or about March 17, 2014, Subsidium issued an RFP for parties interested in operating Lakewood Hospital as an outpatient facility to Cleveland Clinic. Cleveland Clinic responded with a proposal for a family health center on or about April 21, 2014.
- Subsidium issued an RFP for parties interested in operating Lakewood Hospital as an inpatient facility to MetroHealth on or about March 21, 2014. MetroHealth submitted a preliminary proposal on or about May 2, 2014. MetroHealth reportedly expected to utilize Lakewood Hospital as an overflow facility while it renovated its own hospital. The organization would not commit to retaining the Hospital as an acute care facility over the long-term.
- The Hospital was also marketed as a going concern to other area health systems including University Hospitals and Catholic Health Partners during March 2014. These organizations reportedly declined interest.
- Given the modest level of interest from local health systems, LHA and Subsidium approached seven national health systems that met the following criteria: (i) the system must have hospitals in the Midwest and (ii) the system must have other similar hospitals in their portfolio (stand-alone community hospitals in metropolitan areas). Four parties signed NDAs and received RFPs, including Community Health Systems, Universal Health Services, Capella Health and IASIS Health. The others (Hospital Corporation of America, Prospect Medical and Ohio Health) all declined interest. Those that received the RFP quickly withdrew from consideration.

Review of Subsidiary Report

Partner Search

- In October 2014, MetroHealth withdrew its proposal.
- In January 2015, LHA signed an LOI with Cleveland Clinic.
- In June 2015, MetroHealth publicly disclosed that they have no further interest in Lakewood Hospital.

While it is Huron's belief that the Hospital was marketed to all logical local health systems and a representative sample of national systems, we have the following concerns regarding the process:

- Subsidiary is not a licensed investment bank (broker-dealer). While the sale of a hospital does not need to be conducted by a licensed investment bank unless it involves the sale of securities, we are of the opinion that investment banks have the best combination of skillset, training and procedures to successfully accomplish complicated hospital sales. Note that Subsidiary informed us that they did not serve in an official brokerage capacity, but instead assisted LHA in the marketing of the asset.
- It is our understanding that a release from Cleveland Clinic regarding potential tortious interference claims was not obtained upon the initial marketing of the Hospital. We would generally not conduct a sales process in such a circumstance without first obtaining a release (or permission) from the company managing or operating the hospital. It is not known if the lack of such a release impacted interest among potential buyers. Subsidiary later obtained verbal permission from Cleveland Clinic that it would not object to such a sale, and the sales literature to the national systems contained language to such effect.
- It is our understanding that certain parties received RFPs to operate the facility as an acute care hospital while others received RFPs for an outpatient facility. While we understand the rationale behind this decision, we do not know if such a process limited buyer interest in either option. It is our belief that Cleveland Clinic and MetroHealth are the most logical candidates for an outpatient center given the proximity of their hospitals to Lakewood Hospital and their large physician networks.
- The Hospital was not marketed to several potential buyers that have a history of acquiring distressed hospitals. These include organizations such as Prime Healthcare, Paladin Healthcare, Blue Mountain Capital Management and Alecto Healthcare Services, among others. Regardless, these organizations would likely have no interest in Lakewood Hospital due to the lack of a physician staff and the inability to build a portfolio of hospitals within the market.

Review of Subsidium Report

Partner Search

- Likewise, the Hospital was not marketed to many faith-based systems that may view the mission of providing healthcare to all patients as more important than the financial performance of the business. Examples include Ascension, CHE/Trinity Health and Catholic Health Initiatives. Once again, we generally recommend including these systems in a marketing effort for a distressed hospital, but we would not anticipate a favorable response unless any of the parties had assets within the marketplace or a strategy to enter the local market.

Overall, it is our belief that the Hospital was marketed to nearly all logical parties and we have no expectations that a different outcome would have resulted if the above concerns were addressed during the sale process. We view a local system as the most likely buyer of Lakewood Hospital. Assuming that option has been exhausted, it will likely be difficult to attract an out-of-market organization due to the Hospital's aging facility, lack of a developed physician network and status as an "orphan" facility.

Review of Subsidium Report

Facts or Assumptions Presented in Subsidium's Report

Subsidium Assumption or Conclusion	Huron Commentary
Lakewood Hospital's financial performance is no longer generating enough income to re-invest in maintenance and capital expenditures. The Hospital is losing money and will drain its balance sheet.	In 2014, the Hospital generated earnings before interest, tax, depreciation and amortization (EBITDA) of \$9.0 million, or 7.2% of net revenue. Through the first six months of 2015, the Hospital was on pace to generate EBITDA of \$0.7 million, or 1.2% of revenue, for the year. The current level of profitability is insufficient to fund maintenance capital expenditures (excluding deferred and project-based capital expenditures). Additionally, in the fiscal 2014 period, the Hospital's depreciation expense far outpaced its capital expenditures, with \$5.7 million in depreciation expense compared to \$2.0 million in capital expenditures. Lastly, based on the forecast developed by Subsidium, the deterioration in profitability at the Hospital is expected to continue over the next five years. Accordingly, we find it probable that the Hospital will need to utilize its cash and investment reserves to fund operating losses and capital requirements.
The Hospital requires \$90+ million for renovations and deferred maintenance on the facility in order for the Hospital to remain viable.	Huron agrees that it is increasingly difficult to compete in the healthcare market without state-of-the-art facilities. As referenced on page 25 of this report, total renovation costs for the facility have been estimated at \$91.5 million.
Cleveland Clinic is unwilling to renew the Definitive Agreement under current terms (at expiration).	While we have seen no official documentation of this decision, we were given a similar message by LHA representatives.
Lakewood is a "valuable market" that generates 25,000 admissions per year.	Huron is unable to verify this statement.

Review of Subsidium Report

Facts or Assumptions Presented in Subsidium's Report

Subsidium Assumption or Conclusion	Huron Commentary
The Lakewood community exhibits above average prevalence rates of obesity, smoking and chemical dependency, as well as higher than average rates for several chronic conditions including COPD, adult asthma, congestive heart failure and diabetes.	This statement has been verified through the Community Needs Assessment.
The market is over-bedded with over 3,000 beds in the Cleveland market, which is double the demand.	Huron agrees that the market appears to be over-bedded. Based on the beds per population level of the United States, the bed capacity in the market is slightly less than double the industry norm. We recognize that certain markets require bed capacity above the national average.
There is a significant presence of physicians in Lakewood.	As noted on pages 21 and 22, there are numerous physicians in the market. We are not able to state that all specialties are adequately represented in the Lakewood market.
Outpatient spending per capita is currently growing at nearly twice the rate of overall health care spending. Healthcare spending increased 8.5% from 2009 to 2011 with outpatient significantly outpacing other cost categories.	Per the source document identified by Subsidium (<i>The Health Care Cost Institute's Health Care Cost and Utilization Report: 2011</i>), "inpatient spending per capita rose 4.8% to \$963. Outpatient spending per capita rose 6.8% to \$1,245."
Hospital revenues are shifting from inpatient to outpatient, per Jones Lang LaSalle.	We agree that inpatient revenue is trending down and outpatient revenue is trending up.
Inpatient bed supply: Subsidium estimated the approximate beds per population levels for several different market areas.	Subsidium's calculations are similar to those of Huron.

Review of Subsidium Report

Facts or Assumptions Presented in Subsidium's Report

Subsidium Assumption or Conclusion	Huron Commentary
Subsidium estimated the average cost to build ambulatory and inpatient centers plus the potential jobs and payroll taxes each option would generate.	Huron reviewed the underlying assumptions utilized by Subsidium and found them to be reasonable.
Subsidium did not have a legal opinion as to whether Cleveland Clinic would have an obligation to fund operating losses (which may impact action to stem losses).	According to Thompson Hine LLP, counsel for the City, pursuant to the terms of the Definitive Agreement and the Lease Agreement, the Cleveland Clinic does not have a general obligation to fund operating losses at Lakewood Hospital. We view Cleveland Clinic's potential liability under the cash-to-debt covenant to be minimal unless Lakewood Hospital's debt level increases significantly (in combination with a decline in the cash and investment portfolio), which must be approved by Cleveland Clinic.
45% of the Hospital's admissions are referred by Premier physicians and 35% of the Hospital's admissions are referred by Cleveland Clinic physicians.	Based on production data received by Huron for fiscal 2014, Premier physicians referred approximately 34% of inpatient cases at the Hospital while Cleveland Clinic physicians referred approximately 30% of the inpatient cases at the Hospital. Note that the table in Subsidium's appendix outlining the number of admissions by admitting group has been redacted.
Subsidium calculated the present value of the lease payments that are due to the City from LHA over the remainder of the lease.	Huron reviewed these calculations and found them to be accurate.

Review of Subsidiary Report

Forecast of Operations

As part of its engagement, Subsidiary prepared a forecast of operations for the hospital, including several different scenarios. The summary nature of Subsidiary's presentation prohibits Huron from examining certain inputs such as volumes, reimbursement, service mix (inpatient vs. outpatient), payor mix and operating expenses. Given this lack of detail, we were unable to replicate the forecast or confirm certain calculations.

The baseline version of the forecast is summarized below, while the underlying assumptions and Huron's commentary are presented on the following pages. As indicated, the Hospital is projected to realize mounting losses due largely to the opening of Avon Hospital in 2016, and deplete its cash reserves by 2018. All of their scenarios showed the cash balance depleted, with most by the year 2019 or before.

Subsidiary prepared its forecast in 2014 so we now have actual results by which to judge the forecast's merits. Subsidiary utilized the budget for fiscal 2014 which projected operating EBITDA of \$4.96 million, which proved to be somewhat conservative as actual operating EBITDA for the period was \$5.94 million. Alternatively, Subsidiary forecast operating EBITDA of \$5.09 million in 2015, which is well above the actual amount generated over the latest twelve month ("LTM") period ended June 30, 2015 of \$2.80 million.

	2012	2013	2014	2015	2016	2017	2018	2019	2020
	Audited	Unaudited	Budget	Projected	Projected	Projected	Projected	Projected	Projected
Free cash flow									
EBIDA	3,479,000	6,430,000	4,955,318	5,090,670	(10,917,480)	(26,923,726)	(26,881,890)	(26,839,028)	(26,795,501)
Less:									
Change in net working capital		(276,240)	(412,800)	(167,300)	(172,057)	(168,962)	(165,954)	(163,028)	(160,178)
Capital expenditures		2,259,000	5,568,000	5,134,000	5,439,321	5,420,382	5,421,557	5,421,484	5,421,488
Free cash flow		4,447,240	(199,882)	123,970	(16,184,745)	(32,175,145)	(32,137,493)	(32,097,484)	(32,056,810)
Cash flow deficit		-	199,882	-	16,184,745	32,175,145	32,137,493	32,097,484	32,056,810
Long term investments									
Rate of return			6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
Beginning balance		45,110,000	50,310,000	50,789,600	51,297,976	38,191,110	8,307,431	n/a	n/a
Change in value		7,739,000	3,018,600	3,047,376	3,077,879	2,291,467	498,446	n/a	n/a
Sales of investments		(2,539,000)	(2,539,000)	(2,539,000)	(16,184,745)	(32,175,145)	(32,137,493)	n/a	n/a
Ending balance		50,310,000	50,789,600	51,297,976	38,191,110	8,307,431	(23,331,615)	n/a	n/a

Review of Subsidium Report

Forecast of Operations

Subsidium Assumption (Base Case)	Huron Commentary
Baseline revenue will decrease 3.0% per year (based on the 2013 rate of change).	We have assumed that this statement means that Subsidium expects total revenue to will decline 3.0% annually as a result of both volume decreases from shifting trends in the healthcare market (from inpatient to outpatient) as well as reimbursement changes – all excluding the impact of Avon Hospital. Based on our work preparing or assessing forecasts for dozens of community hospitals annually, we can confirm that many hospital executives anticipate downward reimbursement pressure and lower inpatient volume, while attempting to stem these negative trends through growth in outpatient volume. Overall, we believe this to be a reasonable assumption but some of the volume losses related to reduced inpatient services could potentially be offset by increases in outpatient services. At best, we would expect baseline revenues to be flat.
Expenses will decrease proportionately to revenue.	This is a speculative assumption given the high fixed costs of the Hospital, although it should be noted that Subsidium caveats this assumption by saying, “expense reductions may not be able to keep pace with revenue reductions.”
Cleveland Clinic will move 80% of its current volume to the new Avon facility. 35% of Hospital admissions come from Cleveland Clinic.	In our opinion, this is a pessimistic assumption given the ability of patients to choose their facility, especially given the convenient location of Lakewood Hospital for many residents of the community. We expect referrals from Cleveland Clinic to decline significantly once Avon Hospital opens, but we anticipate a lower loss percentage. Regardless, according to Subsidium’s more optimistic projection of only losing 50% of referrals, the Hospital will deplete its investment portfolio in 2019 (with all other assumptions held constant).

Review of Subsidiary Report

Forecast of Operations

Subsidiary Assumption (Base Case)	Huron Commentary
Capital expenditures will equal depreciation expense, working capital requirements will equal 8% of revenue, and the investment portfolio will earn a rate of return of 6%.	Huron agrees that these are reasonable assumptions based on our review of market data and our forecasting work with other hospitals. Note that the capital expenditure assumption will tend to cover typical maintenance-level items, but will not cover deferred maintenance or facility refurbishment.

Given the above, we view the Subsidiary forecast as directionally accurate but modestly pessimistic. Our sensitivity analysis (using more optimistic assumptions such as flat baseline revenues and the loss of 50% of Cleveland Clinic referrals) showed the investment portfolio being depleted by the end of the lease period in all cases. It is possible that the losses could be mitigated through expense reductions, performance improvement measures or strategic initiatives, but we view the financial outlook for Lakewood Hospital to be highly speculative if operations continue on a status-quo basis.

Review of the 1996 Definitive Agreement

Review of the 1996 Definitive Agreement

Overview

As part of our investigation, Huron was asked to review the financial obligations of LHA and the Cleveland Clinic under the Amended and Restated Lease Agreement by and between the City of Lakewood and LHA, dated December 23, 1996 (the “Lease Agreement”) and the Definitive Agreement by and between Cleveland Clinic and LHA, dated December 19, 1996 (the “Definitive Agreement”). We have also analyzed the financial terms of the LOI compared to the status quo option (continue leasing the Hospital to LHA through the remainder of the lease). Specific questions we have addressed include:

- What are Cleveland Clinic’s obligations under the cash-to-debt covenant contained within the Definitive Agreement, specifically in view of what should and should not be treated as “cash” and “debt”?
- What are the implications of Cleveland Clinic’s obligations under the cash-to-debt covenant in the Definitive Agreement for the model regarding operating cash flow/deficits in Subsidiary’s analysis?
- Are the annual administrative fees charged by Cleveland Clinic to LHA within the industry-wide standard?

It should be noted that Huron is not a law firm so any views or analysis contained herein should not be considered as legal advice. Throughout our study, we have spoken with legal counsel for the City and relied upon certain interpretations that have been relayed to us.

Review of the 1996 Definitive Agreement

Cash-to-Debt Covenant

According to Section 2.1.1 of the Definitive Agreement, Cleveland Clinic “shall assure that Lakewood Hospital shall have a cash to debt ratio of 1:1 on a fiscal year basis.” This covenant is enforceable to the extent that Cleveland Clinic would be required to “advance sufficient funds to Lakewood Hospital to meet such ratio.”

Cash is defined as, “all cash in any accounts of Lakewood Hospital maintained for any purpose, whether or not such purpose is limited to a specific use [...] Cash shall also include marketable securities. Cash shall also include the proceeds of any disposition of accounts receivable, whether or not such disposition is at the direction of Cleveland Clinic, provided that such proceeds shall only count towards cash for the amount received for accounts receivable that exceed by thirty percent (30%), as measured in days in receivable, the median accounts receivable for Northeast Ohio hospitals, as published by the Greater Cleveland Hospital Association.” As of June 30, 2015, the Hospital had \$4.01 million in cash and \$50.16 million in long-term investments which are mostly comprised of marketable securities. The Hospital also held \$16.23 million in net patient accounts receivable, though we were not provided an aging schedule so we could not calculate the portion of receivables that could be monetized for the purpose of the cash formula. Accordingly, the Hospital had a minimum of \$54.17 million in “cash” on June 30, 2015.

Debt is defined as, “revolving working capital loans, debt incurred as a result of a pledge of accounts receivable, long term debt, and current installments of long term debt [...] Required payments to the City of Lakewood under the Lease Agreement shall be included as debt only if unpaid in the year the payment is due.” As of June 30, 2015, the Hospital had a current portion of long-term debt of \$586,000 and notes payable and capital leases of \$9.17 million; however, based on the 2014 audit, it is Huron’s assumption that the notes payable and capital leases are related strictly to lease payments owed to the City, none of which are overdue. Therefore, the Hospital appears to have a total “debt” balance of \$586,000, which would imply a current cash-to-debt ratio of 92-to-1. Note that trade payables and other accruals are typically not considered “debt” in transaction documents, and therefore were not included in this calculation.

Based on the above review, it does not appear that Cleveland Clinic will have any significant liability under the cash-to-debt covenant unless debt at the Hospital escalates materially or a court finding defines “debt” differently than the version described above. Further, as noted in Section 1.1.1.6 of the Definitive Agreement, LHA cannot incur, assume, or guarantee debt in excess of \$500,000 without a written specification from Cleveland Clinic. Thus, when considering this provision in conjunction with all the provisions regarding approval of the budget, capital expenditures, etc., it seems clear that LHA cannot operate the Hospital in such a way that would result in a triggering of the cash-to-debt ratio covenant without the Cleveland Clinic having agreed that such approach to operating is acceptable and preferable to spending down the cash on hand.

Review of the 1996 Definitive Agreement

Administrative Fees

As part of our assessment of administrative fees paid by Lakewood Hospital to Cleveland Clinic, we interviewed representatives from LHA and Cleveland Clinic, reviewed audited and unaudited financial statements for Lakewood Hospital, reviewed minutes from the LHA Board of Trustees meeting on October 21, 2011, reviewed proprietary and confidential documentation provided by Cleveland Clinic regarding specific fees incurred and the allocation thereof, and analyzed publicly available market data.

The total administrative services expense in the LTM period ended June 30, 2015 was \$23.80 million, representing 20.3% of net revenue and 20.8% of total operating expenses. A further breakdown of the services provided and expenses incurred is provided below.

Expense Description	Service Provided	Total Expense ^[1]	As a % of Net Revenue ^[1]
Shared Services	Finance, IT, Marketing, Supply Chain Management,, Human Resources, Executive Team, Revenue Cycle Management, and Corporate Compliance	\$18.31 million	15.6%
Clinical Services	Anesthesia, House Staff Coverage, etc.	\$4.04 million	3.5%
Administrative Services	Legal, Special Projects, Consulting, Dues & Licenses, Travel, and other Hospital-Specific Issues	\$1.43 million	1.2%

It is our understanding that clinical and administrative service fees are direct costs that are incurred by Cleveland Clinic and allocated to Lakewood Hospital. Further, these costs are passed through without markup. These statements were reiterated in correspondence and written documentation provided to Huron by Cleveland Clinic. If so, and assuming that the underlying staff earns market wages, the process is typical for the industry.

[1] Estimated based on percent of total administrative expense statistics provided by Dr. J. Stephen Jones of Cleveland Clinic. According to Dr. Jones, 77% of total administrative fees are related to shared services, 17% are related to clinical services, and 6% are related to administrative services.

Review of the 1996 Definitive Agreement

Administrative Fees

The shared services allocation to Lakewood Hospital is reportedly determined by pooling the costs of various corporate and administrative services that are utilized by all Cleveland Clinic hospitals, then allocating the total among the facilities on a proportional basis. Once again, Cleveland Clinic reportedly includes no mark-up in the calculation. This process is similar to those utilized by most national health systems. Based on Huron's experience and our review of market data, shared services allocations tend to range from a low of 2.0% to 5.0% of net revenue for pure management agreements, to up to 15% of revenue for comprehensive agreements that include billing. Given the comprehensive services contained within the subject shared services component, it is reasonable to assume that an allocation near the high end of the market range is reasonable. It should be further noted that Cleveland Clinic has claimed that if they did not provide these services, Lakewood Hospital would need to contract for these services. Huron agrees that this approach would likely be more expensive.

Review of the 1996 Definitive Agreement

Financial Implications of Letter of Intent vs. Current Lease Agreement

On January 14, 2015, the Hospital received a non-binding outline of a potential arrangement among Cleveland Clinic, LHA, and Lakewood Hospital Foundation. This LOI proposed to change the model of healthcare delivery to the community from a predominantly inpatient focus to a comprehensive ambulatory-based program of health services, wellness activities and outreach services. The financial implications of this deal are summarized below.

Our financial assessment does not include other potential impacts such as loss of payroll taxes, which may be a consideration for the City but is typically not considered in assessing the merits of a proposed transaction. That said, it is our understanding that each employee that stays with Lakewood Hospital will be offered an employment opportunity under the new definitive agreement. It should also be noted, per the LOI, the City would retain ownership of the land with the exception of a sufficient amount to be conveyed to Cleveland Clinic, at fair market value, “for the construction and operation of the Family Health Center as well as for drive-up access and immediately adjacent selected parking.” As the sale of the land plot is speculative at this point, we have excluded it from our analysis. The City would also retain ownership of the following properties: (i) Lakewood Hospital South Parking Garage, (ii) Lakewood Hospital Professional Building, (iii) Community Health Care Center, (iv) Residential Homes, and (v) Paved Parking Lots. Per the LOI, upon LHA's dissolution, all of LHA's property of every nature and description, and any and all equipment and fixtures at the Hospital, shall be monetized, paid over and/or transferred to Cleveland Clinic.

*(In Millions)**

New Facility (at cost) ^[1]	\$34.0
Current Assets & LT Investment Portfolio ^[2]	79.0
Payment Upon Signing of the new Definitive Agreement ^[3]	12.2
Present Value of Payment Made at Opening of the Family Health Clinic ^[3]	10.1
Cash Payment Related to the 850 Columbia Road Property ^[4]	8.2
Present Value of Wellness Foundation Payments ^[5]	4.3
Current Balance of the Beneficial Interest in Lakewood Hospital Foundation, Inc. ^[6]	33.5
Less: Wind-Down Costs/Liabilities ^[7]	(13.1)
Less: Parking Garage Repair, and Demolition of Facility ^[8]	(15.2)
Total	\$153.0

* See next page for footnotes.

Review of the 1996 Definitive Agreement

Financial Implications of Letter of Intent vs. Current Lease Agreement

Footnotes:

[1] According to the LOI, Cleveland Clinic will make a capital commitment in the amount of \$34.0 million for the design, construction and equipping of the proposed family health center.

[2] We have assumed that the current assets plus long-term investments will be returned to the City and/or utilized for wind-down costs of the Hospital's patient and other operations. The amount shown is the book value per the June 30, 2015 balance sheet.

[3] Cleveland Clinic will make payments equal to \$24.4 million with one-half (\$12.2 million) being paid upon the approval and signing of the new definitive agreement, and the other half being paid upon the opening of the family health center and City approval of a plan to complete the demolition or modification of the remainder of Lakewood Hospital. The second payment was estimated to incur approximately two years after the execution of the new definitive agreement. Note that "all or a substantial portion" of these funds must be aggregated with the funds available from Lakewood Hospital Foundation into a new foundation.

[4] Per the LOI, Cleveland Clinic will pay LHA (which will in turn be paid to the City) \$8.2 million for the property at 850 Columbia Road.

[5] Cleveland Clinic will make a payment of \$500,000 on the effective date of the new definitive agreement and will continue making payments of \$500,000 per year for each of the next 15 years.

[6] The Beneficial Interest in Lakewood Hospital Foundation funds will be retained by the City but must be contributed to the new foundation in aggregate with Cleveland Clinic's contributions. Note that we have included the current balance of the Beneficial Interest in Lakewood Hospital Foundation at its full value, although there is risk to this assumption as we assume that the fund balance is permanently restricted and may require donor approval in order to be available to LHA or the City under the proposed agreement.

[7] It is our understanding that the City will need to pay all outstanding costs to wind down the Hospital's patient and other operations, which we assume to include all current liabilities with the exception of the capital lease payments to the City. Per the June 30, 2015 balance sheet, these liabilities have a balance of approximately \$13.1 million. There are additional wind-down costs that will be incurred and likely will exceed the amount shown on the previous page; however, Huron does not currently have the information necessary to estimate these costs.

[8] The parking garage repairs were estimated by Allegro Realty Advisors at \$5.2 million. The demolition of the Hospital has reportedly been estimated at \$10 million.

Review of the 1996 Definitive Agreement

Financial Implications of Current Lease Agreement vs. Letter of Intent

We examined the financial impact of staying in the lease throughout the remaining term and have provided a summary of our analysis below. As illustrated, the net value of this option is well below that of the proposed LOI.

Pursuant to Section 12.2 of the Lease Agreement, should the lease expire or be terminated, “after payment of all its obligations, [LHA] shall transfer all of its then assets to the City or to another nonprofit-corporation organized for the purpose of operating the Hospital.” The value of these assets is dependent on if (and when) the lease is terminated, but they will likely be significantly diminished by 2026 as a result of the general depreciation of fixed assets, the use of cash and investments to fund ongoing operations and capital expenditures, the anticipated low level of working capital, and the aged facility. It is assumed that, if the Hospital is not operating as a going-concern, the Interest in Lakewood Hospital Foundation funds will be returned to the donors.

Footnotes:

[1] The present value of lease payments was calculated using the payment schedule per the lease agreement and a cost of capital of 10%.

[2] The present value of the working capital was estimated assuming the Hospital is operating with a normal level of working capital at the expiration of the lease. This balance was discounted at a cost of capital of 10%.

[3] The fixed asset value is equal to an estimated book value near the end of the lease. Note that Huron estimated this value assuming a capital expenditure rate of 2.5% of net revenue and a 10-year depreciable life for new acquisitions.

[4] Hospital facilities typically do not hold significant value due to their special use purpose, unless the properties generate positive cash flows that are sufficient to provide a fair return on the underlying assets. This assumes that the facility is not significantly renovated prior to the expiration of the lease.

[5] Based on a multiple scenario analysis of the future performance of the Hospital, we have anticipated that the Hospital will be depleted of cash and investments by the time the lease ends. Note the analysis excludes the liability of on-going operating losses after cash is fully depleted.

(In Millions)

Present Value of Lease Payments ^[1]	\$8.0
Present Value of Working Capital at Lease Expiration ^[2]	2.0
Fixed Assets ^[3]	9.6
Present Value of Facility at Lease Expiration ^[4]	0
Present Value of Cash & Investment Portfolio ^[5]	0
Total	\$19.6

Lakewood Hospital Financial Assessment

Lakewood Hospital Financial Assessment

Current Financial Position

The final step in Huron's analysis involves a review of Lakewood Hospital's current financial position. We investigated trends in revenue and earnings as well as the Hospital's liquidity, performance ratios and leverage position. Huron compared the Hospital's performance levels to industry indications contained in Risk Management Association's Financial Ratio Benchmarks 2014 - 2015 ("RMA") for general medical and surgical hospitals with greater than \$25 million in revenues, Ingenix's Almanac of Hospital Financial and Operating Indicators 2014 ("Ingenix") for hospitals with \$100 million to \$150 million in revenue, and a portfolio of publicly traded hospital systems¹ (the "Guideline Companies"). The results of our analysis are shown in the following pages, with a summary provided below.

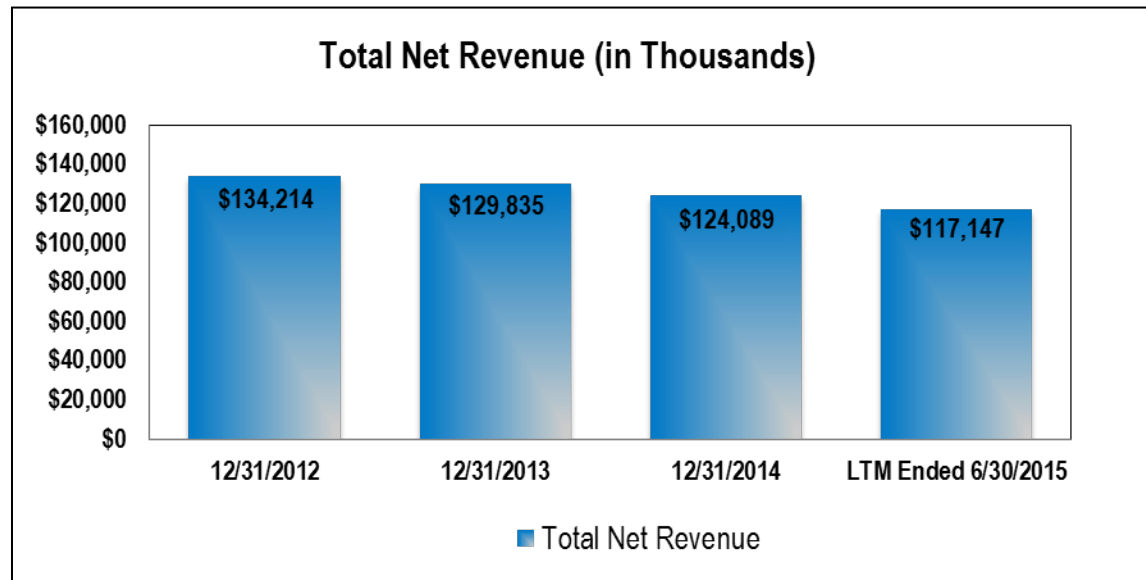
- The Hospital has experienced revenue and EBITDA growth rates well below those of industry standards. Further, the Hospital has an EBITDA margin well below the industry norm.
- Lakewood Hospital is in a strong liquidity position as a result of its high cash and investment balances. This liquidity provides the Hospital with a cushion to survive temporary dips in financial performance. However, the cushion is not sufficient to address identified facility reinvestments, especially given the projected net losses forecast for the Hospital.
- The Hospital's activity ratios are near the industry benchmarks, thus implying that management has done a reasonable job of managing the assets of the Hospital.
- Lakewood Hospital is in a favorable leverage position due to its minimal amount of debt.
- Capital expenditures were generally on par with industry norms until the 2013 and 2014 period, when they dropped to 2.5% and 1.6% of net revenue, respectively. The recent levels are well below the levels necessary to maintain the facility in good working order over the long-term.

[1] The selected publically traded guideline companies include Community Health Systems, Inc., LifePoint Health, Inc., Tenet Healthcare Corp., Universal Health Services, Inc., and HCA Holdings, Inc.

Lakewood Hospital Financial Assessment

Net Revenue

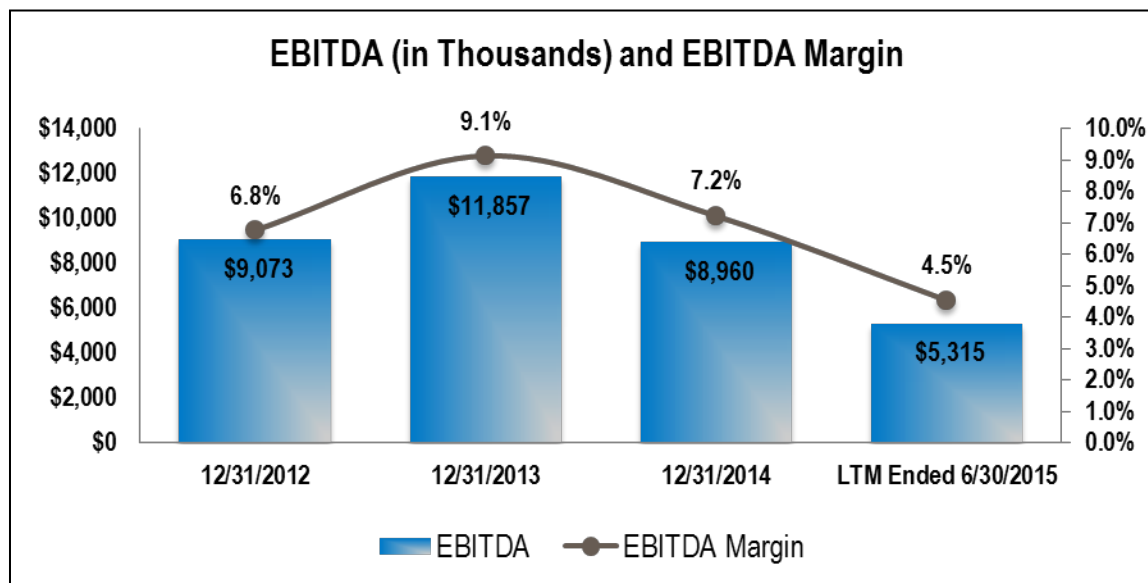
Lakewood Hospital's net revenue for the period from fiscal 2012 to the LTM period ended June 30, 2015 is provided below. Over this period, net revenue has decreased at a compound annual rate of 5.6%. From fiscal 2013 to fiscal 2014, the last year-over-year period, Lakewood Hospital's net revenue decreased -4.4%. This compares to a median growth rate of 21.9% for the Guideline Companies.



Lakewood Hospital Financial Assessment

Earnings

Lakewood Hospital's operating expenses decreased at a compound annual rate of 5.2%, from \$130.735 million to \$114.352 million, between fiscal 2012 and the LTM period. As a percent of revenue, operating expenses remained relatively flat from 97.4% to 97.6% over the associated period. The resulting EBITDA decreased from \$9.073 million to \$5.315 million, as shown in the graph below. The year-over-year growth rate from fiscal 2013 to fiscal 2014 was -24.4%, which compares to a median growth rate of 17.7% for the Guideline Companies. The EBITDA margin decreased from 6.8% to 4.5% over the associated period. This compares to median industry margins of 9.7%, 8.9%, and 14.9% per RMA, Ingenix and the Guideline Companies, respectively. By any measure the Hospital's EBITDA is inferior to industry norms.



Lakewood Hospital Financial Assessment

Liquidity

Liquidity ratios measure the ability of a business to meet its current obligations and support its operating needs. Various indicators of liquidity include the current ratio, working capital-to-revenue ratio and days cash on hand. The Hospital's current ratio (current assets divided by current liabilities) was 2.44x in the most recent period, above the indications from RMA, Ingenix and the Guideline Companies, as presented below. Additionally, the Hospital's working capital (current assets less current liabilities) equated to 14.5% of revenues in the most recent period, once again above the median levels from RMA and the Guideline Companies. Lastly, Lakewood Hospital's days cash on hand level of 172.89 is well above the indications per Ingenix and the Guideline Companies. Note that the cash indications include investments. According to Lakewood Hospital's 2014 audit, the Hospital's investments primarily consist of equity and debt securities. Overall, the Hospital has relatively strong liquidity.

Liquidity Measure	Lakewood Hospital	RMA	Ingenix	Guideline Companies
Current Ratio	2.44	1.70	1.93	1.43
Cash / Net Revenue	46.2%	11.4%	n/a	3.2%
Cash / Total Debt	555.1%	42.6%	n/a	4.2%
Working Capital / Net Revenue	14.5%	13.8%	n/a	8.1%
Net Working Capital / Net Revenue	11.6%	3.8%	n/a	9.0%
Days Cash on Hand	172.89	n/a	90.30	45.20

Lakewood Hospital Financial Assessment

Activity Ratios

Activity ratios measure an organization's ability to efficiently manage its assets. Two primary activity ratios are accounts receivable days and total asset turnover. Accounts receivable days indicate how quickly the organization collects from patients/payors. The Hospital is similar to the median indications from RMA, Ingenix and the Guideline Companies in this regard with a current level of 53.38 days outstanding, as presented in the table below. Total asset turnover indicates the revenues that are generated by each dollar invested in assets. The Hospital's total asset turnover ratio of 0.75x is below the various industry medians. Note that Lakewood Hospital's accounts receivable turnover ratio related to net patient revenue and patient receivables only.

Activity Measure	Lakewood Hospital	RMA	Ingenix	Guideline Companies
Accounts Receivable Turnover	6.84	7.60	8.00	6.37
Days in Accounts Receivable	53.38	48.03	45.60	57.30
Accounts Payable Turnover	54.66	14.92	n/a	9.96
Total Asset Turnover	0.75	1.10	1.04	0.93

Lakewood Hospital Financial Assessment

Leverage

Leverage can be utilized to finance operations and potentially boost returns to shareholders, though excessive leverage can increase the risk of insolvency. A common measure of leverage is the ratio of debt-to-total assets. The Hospital's debt-to-total assets was 6.2% in the most recent period, significantly less than the median indication per RMA and the Guideline Companies. Additionally, the Hospital's debt-to-EBITDA ratio of 1.84x is lower than the median market indications. Accordingly, the Hospital is in a favorable position in terms of leverage.

Leverage Measure	Lakewood Hospital	RMA	Ingenix	Guideline Companies
Debt / Total Assets	6.2%	29.8%	n/a	62.9%
Debt / EBITDA	1.84	2.76	n/a	3.85

Lakewood Hospital Financial Assessment

Capital Expenditures

As shown in the table below, Lakewood Hospital's capital expenditures declined significantly in the last two years. As mentioned previously, the facility requires renovation in the amount of over \$90 million. Given the age and condition of the facility, the current expenditure level will likely contribute to the deferred maintenance and hasten the obsolescence of the facility. The median level of total capital expenditures (maintenance plus project capital expenditure) for the Guideline Companies, as a percent of net revenue, is 4.9%. HCA Holdings, Inc. has the highest level of capital expenditures in the most recent period at 5.9% of net revenue. Universal Health Services Inc. had the lowest level at 3.9% of net revenue.

	2009	2010	2011	2012	2013	2014
Capital Expense	\$6.544 million	\$10.510 million	\$5.519 million	\$6.043 million	\$3.184 million	\$1.984 million
As a % of Net Revenue	4.6%	8.2%	4.0%	4.5%	2.5%	1.6%

Lakewood Hospital Financial Assessment

Forecast

Based on Subsidiary's forecast, the Hospital is anticipated to run out of cash in fiscal 2018 in the "base case" scenario and in fiscal 2019 in the "best case" scenario. Even in Huron's more optimistic forecast scenarios the Hospital will exhaust its investment portfolio before the end of the lease term. Such a forecast indicates that the ability of the Hospital to continue operating as a going concern is highly speculative, especially as the investment portfolio trends downward.

Lakewood Hospital Financial Assessment

Summary

While Lakewood Hospital has little or no leverage and a significant cash/investment portfolio, its financial performance is deteriorating to the point that the Hospital's forecast shows the elimination of the cash and investments within the next couple years. Considering this plus the considerable expenditures that will be needed to bring the facility to a competitively functional level, we view the Hospital's financial condition as highly speculative.

Conclusion

Conclusion

As summarized herein, there are numerous factors impacting the ability of Lakewood Hospital to continue to operate as an acute care facility:

- Lakewood Hospital was marketed to most local health systems and a select group of national organizations that met established criteria for consideration. While several local systems expressed initial interest, the only active offer is the one from Cleveland Clinic that is under consideration.
- There is a consistent national trend of increasing outpatient procedures combined with decreasing inpatient volume. This trend is not expected to abate for the foreseeable future.
- The local market is highly competitive with five hospitals serving a population of 153,752 and a sixth under development. When compared to national or regional statistics, the local area appears to have excess inpatient capacity (beds per population). The competitive facilities tend to be larger and financially stronger than Lakewood Hospital and have newer facilities and more extensive physician networks.
- Cleveland Clinic is building a hospital roughly 12 miles from Lakewood Hospital. Cleveland Clinic physicians accounted for approximately 30% of Lakewood Hospital's inpatient cases in 2014. Thus, the potential loss of referral sources is significant.
- Lakewood Hospital's facility is relatively old and will need significant renovation in order to remain viable over the long-term. While the City may be able to force compliance with the lease terms through its expiration in 2026, it is expected that the City would then regain control of the Hospital. The potential operating losses and capital commitments would be material at that time based on the forecast developed by Subsidiary and the facility study prepared by Mr. Aucremanne.
- Stand-alone hospitals are increasingly dependent on strong physician support for survival. As the Hospital has a relatively small employed physician group and the market is primarily composed of physicians from Cleveland Clinic, University Hospitals, Premier Physicians and MetroHealth, there are few opportunities for Lakewood Hospital to expand its physician base. We have found that it is extremely difficult to sell hospitals facing similar physician shortages.
- Based on our engagements providing strategic consulting services to hospitals across the country, we have witnessed a consistent desire among hospital leadership to expand their continuum of care, physician networks, patient populations and management skillsets in order to compete in an evolving healthcare marketplace, whether this means transitions to ACOs, bundled payments or other risk-based models. Lakewood Hospital may not have the necessary attributes to succeed under such models.

Conclusion

- In order for Lakewood Hospital to remain viable from a financial standpoint, we believe that the Hospital will need to replace or renovate the facility (with a reduced number of inpatient beds and expanded outpatient capabilities) and rebuild the physician network. Facility renovations and other initiatives could be funded through the investment portfolio, philanthropy and/or municipal support (tax dollars). However, the rebuilding of the physician network may prove difficult without the support of a hospital partner.
- If the Hospital were to continue to operate under the 1996 Lease and Definitive Agreement, it would likely be necessary to preserve liquidity, stem the outmigration of patients from the Lakewood area, and control costs. Pursuing these initiatives will provide the City with additional time to search for viable partners and explore alternative options.

In summary, the Lakewood community has a sufficient population base to support an inpatient hospital with a modest number of beds. However, due to a variety of factors (most of which are described above), the Hospital's financial performance has declined significantly. Given the above factors, we believe that it will be difficult for the Hospital to continue on a status-quo course of action. Further, as it appears that affiliation options with organizations other than Cleveland Clinic have been exhausted. Thus, the only viable options we see for the Hospital are:

- Pursue the proposed transaction with Cleveland Clinic, although we recommend that LHA and the City obtain a commitment for specific services that will be provided at the family health center and negotiate for the best financial deal possible; or
- Continue operating under the current lease agreement, while also pursuing strategic initiatives and affiliation discussions.

The former option is considered the least risky, but will come at the cost of removing inpatient services from the City. On the other hand, the family health center should be more suitable for outpatient services than the current facility. The latter option will require significant effort and likely additional study. In particular, LHA may want to prepare a CPT code analysis by zip code to fully understand the volume of health services originating from and leaving the market area. The City may also consider other factors not specifically investigated in this report such as (i) the impact on employment in the City and (ii) whether or not the City feels it has a responsibility to ensure that acute care services are provided within Lakewood. This option may require additional access to capital such as philanthropy or public-use dollars. We do not believe that any strategic option should result in the City operating the Hospital independently. Accordingly, a partnership with a larger health system, either as an outpatient center or acute care hospital, is recommended.

Appendix

Appendix

Doctors Hospital Nelsonville – Nelsonville, Ohio – 2014

Overview:

- "With only 20% of people in Nelsonville coming to Doctors Hospital Nelsonville for inpatient care, and with an average inpatient census of about four patients per day, it became obvious that keeping the hospital open was not a viable option," LaMar Wyse, COO of Doctors Hospital Nelsonville, said in a press release. "In fact, what the community is saying it needs — both in their words and actions — is more robust, convenient outpatient care."
- Average daily inpatient census was 4 when closing was announced.
- Inpatient services represented 10% of revenue but accounted for 20% of expenses.
- The hospital was profitable at the time of the closing announcement.
- Designated critical-access hospital - located in rural area with a population of 5,400.



Result:

- Emergency care and outpatient clinic built to replace the hospital.
- Services at the outpatient center will include urgent care, imaging, laboratory and physician offices.
- The ER and other outpatient services will remain open at the hospital until the outpatient clinic is opened.
- Concerns were expressed from Athens County EMS Chief that ambulance times may rise dramatically (45 to 90 minutes) because of distance needed to travel to other hospitals.
- As of April 2015, a location for the outpatient clinic had been selected. The new facility is not anticipated to open until 2017.
- Some concerns from residents that the new facility will not be open 24 hours.

Comparison to Lakewood Hospital:

- Similarities: Closing mainly a result of a drop in occupancy rates.
- Differences: Less competition in the market (closest hospitals are 14 and 16 miles away), rural setting and small size (15 beds).

Appendix

Confidential Metropolitan Hospital - 2015

Overview:

- This municipal owned medical center has a poor payor mix, low occupancy and a history of operating losses. The hospital operates in an underserved area; however, a thin physician network and an aging facility resulted in low volumes throughout the hospital. Huron's healthcare team improved operations but advised that the hospital explore strategic options as the net losses and capital needs were deemed to be unsustainable.
- The hospital conducted a broad search for potential partners but received only two expressions of interest, one of which was a management agreement. The only acquisition offer was received from a joint venture formed between a private equity-backed firm and an academic medical center. The latter proposal was accepted and the deal is currently under LOI.

Result:

- The municipality and the joint venture are discussing the potential shuttering of both the hospital and the academic medical center, combined with the construction of a single replacement facility with far fewer beds than those contained in the existing facilities. The deal would include significant investments in outpatient services, including the potential use of one of the campuses as an outpatient facility.

Comparison to Lakewood Hospital

- Similarities: Closing mainly a result of a drop in occupancy rates and poor payor mix; thin physician network; operates on the outskirts of a major metropolitan area; and operates in an aging facility that needs to be replaced in the near term.
- Differences: Operates in an underserved marketplace.

Appendix

Huron Hospital – East Cleveland, Ohio – 2011

Situation:

- Owned by Cleveland Clinic and had been operating for 137 years.
- The hospital had been losing about \$4 million per year for much of the preceding decade.
- Surrounding area saw a 20% reduction in population during the preceding decade.
- Recession hit the area surrounding Huron particularly hard. The number of uninsured and on Medicare and Medicaid increased for an already lower income area.
- Closest hospital is University Hospital, which is 1.7 miles away.
- University Hospital increased its number of beds and grew its emergency department.



Result:

- Outpatient care has transferred to Cleveland Clinic Stephanie Tubbs Jones Health Center
 - \$25 million outpatient clinic next door
- Hospital's outpatient services remained open until outpatient clinic was completed.

Comparison to Lakewood Hospital:

- Similarities: Owned/operated by Cleveland Clinic; declining population (though it was much greater than in Lakewood); low occupancy; experienced public backlash; located on the outskirts of Cleveland (northeast side); and aging facility with high maintenance costs.
- Differences: Slightly less competition in the market; Cleveland Clinic owned hospital in its entirety - not just operations; had a trauma center (which was also shut down); and emergency room was shut down entirely.

Appendix

UPMC South Side Hospital – Pittsburgh, Pennsylvania – 2009

Situation:

- University of Pittsburgh Medical Center (“UPMC”) purchased South Side Hospital in 2006.
- South Side Hospital had an aging facility and was one of the weakest performing hospitals in western Pennsylvania.
- In 2008, UPMC announced that it would close South Side Hospital and consolidate operations with UPMC Mercy. The site would remain open as an outpatient clinic treating minor illnesses and offering other outpatient services.
 - UPMC Mercy increased its staff to help serve old South Side patients.
- Public backlash included demonstrations to protest the decision. Most citizens and public officials were concerned with the time it would take to reach UPMC Mercy, which is approximately two miles away.



Result:

- UPMC Mercy South Side Outpatient Center opened, creating a “new concept” that focuses on convenient, localized health care to the community.
- Services include diagnostic testing & imaging, surgical procedures, specialized foot, ankle, and podiatric services, and primary care & physician services.

Comparison to Lakewood Hospital:

- Similarities: Aging facility; weak performer; experienced public backlash; nearby affiliated hospital (2 miles away); urban/suburban location; and several other competing and/or affiliated hospitals in the surrounding areas.
- Differences: UPMC also moved the emergency room to a new location.

Appendix

Union Hospital – Lynn, Massachusetts – 2015

Situation:

- Partners HealthCare will close its community hospital in Lynn as part of a \$200 million plan to consolidate medical services over the next three years.
- The plan calls for adding 58 beds at Salem Hospital while shuttering the 126-bed Union Hospital in Lynn. Salem Hospital is less than 6 miles away.
- The emergency room in Lynn will stay open for at least three years, and a 16-doctor medical practice will remain open and add physicians.
- Service area includes many low-income individuals and families as well as an older population.
- The hospital has struggled for years to attract patients and recruit physicians.
- Roughly 100 jobs will be cut.



Result:

- Grass-roots groups have formed to try to save the hospital; however, Partners HealthCare has responded that they have made enough concessions with promising to keep the emergency room open for at least three more years.

Comparison to Lakewood Hospital:

- Similarities: Weak performer due to poor payor mix; hospital – which is the owner, not operator or affiliate - owns another facility nearby (6 miles away); and experienced public backlash.
- Differences: The hospital will leave behind the emergency center and a physician medical group, which it plans on expanding; no new facility nor is plans for a patient-centered medical home.

Appendix

Novant Health – Franklin Medical Center – Louisburg, North Carolina - 2014

Situation:

- Novant purchased Franklin Medical Center but later reduced the number of inpatient beds from 70 to two. The facility was on pace to lose \$6.1 million in 2014.
- "Hospitals in North Carolina and across the nation feel the effects of declining demand for inpatient care combined with reduced payer reimbursement. With the changes occurring in health care, a realignment of our services is necessary to preserve our ability to provide care for our community," Patrick Easterling, Novant's senior vice president for consumer operations, said in a statement.
- Novant shut down the operating room at the hospital and opened an outpatient facility nearby.
- 59 employees (29% of workforce) were laid off.



Result:

- Novant wanted to expand its footprint and open a new hospital nearby but the state granted the license to a competing hospital system. In May 2015, Novant announced that it will sell Franklin Medical Center.

Comparison to Lakewood Hospital:

- Similarities: Strategic move from inpatient to outpatient service lines, new entrant into the market, poor payor mix and area demographics.
- Differences: Location in a rural area.

Appendix

CHS – Haywood Park Community Hospital – Brownsville, Tennessee - 2014

Situation:

- Community Health Systems discontinued both inpatient and emergency services at Haywood Park Community Hospital in July 2014, with plans to open an outpatient urgent care center in its place. The hospital previously operated with 62 beds.
- In its official statement, Community Health Systems said, “Recent years have seen many changes and challenges for hospitals across the U.S., as fewer patients require inpatient acute care and reimbursement is less for the care provided.”
- The hospital’s chief executive officer noted that “maintaining a full-service hospital for the current inpatient demand from acute and emergency patients is not sustainable. Changes in admission guidelines have caused a steady decline in patients admitted [and] emergency room visits.”
- The company said it would work to retain as many employees as possible and those that lost their jobs would be provided with outplacement services and severance packages.



Result:

- Major inpatient services were moved to Jackson, Tennessee, which is also the closest emergency room (25 miles away).
- The new clinic/urgent care center opened on August 1, 2014 and offers physicals, immunizations and outpatient services such as X-rays.

Comparison to Lakewood Hospital:

- Similarities: Financially distressed prior to closure as a result of low volume.
- Differences: Hospital was located in a rural area with the closest hospital 25 miles away; hospital management attributed the closure to the state’s failure to expand its Medicaid program; and the emergency department was also shut down

Appendix

Commonwealth Health – Mid-Valley Hospital – Pecksville, Pennsylvania - 2014

Situation:

- As a result of a sharp decline in hospital admissions and emergency department visits, Mid-Valley Hospital elected to stop offering inpatient and emergency department services and relaunch as a walk-in clinic.
- The hospital had been operational for over 100 years.
- A release from the hospital's chief executive officer stated that “these are challenging times for all hospitals and we must evolve and adjust to new realities. Urgent care and outpatient services are the most used at our facility and our investment will support this community need.”
- Closest hospital is 6.3 miles away.



Result:

- Commonwealth Health invested \$2 million-plus to convert the 25-bed critical access hospital into an urgent care and outpatient services center, now named Commonwealth Health Mid Valley Outpatient Center.
- Services offered include a walk-in clinic, lab and imaging services.

Comparison to Lakewood Hospital:

- Similarities: Long-standing presence in the community and poor financial performance due to low volumes.
- Differences: Rural area, and the hospital was renovated to house outpatient services (not demolished).

Appendix

Mercy Health – Mount Airy & Western Hills Hospitals – Cincinnati, Ohio - 2013

Situation:

- Mercy Hospital in Cincinnati, Ohio had two aging, over-sized hospitals on the same side of town, neither of which were full-service. Meanwhile, several competitors were entering the market (two built new outpatient centers and one acquired an urgent care center).
- Mercy decided to close the two hospitals in favor of a 250-bed state-of-the-art facility that cost \$240 million to build.
- Mount Airy, which opened in 1971 and had about 270 beds, closed in November 2013, but the two physician office buildings there remained.
- On the Western Hills campus, Mercy maintained the 24-hour emergency department, its HealthPlex, imaging center, labs and sleep center. The 287-bed hospital, which opened in 1982, closed.



Result:

- The number of beds in the market declined by 55%.
- Mount Airy Hospital's land and property was donated to Hamilton County.
- The Mercy Health – Western Hills Medical Center will also offer an anticoagulant clinic and outpatient physical therapy.

Comparison to Lakewood Hospital:

- Similarities: Aging facilities within an over-bedded, urban/suburban market; and both were operating in an increasingly competitive market.
- Differences: Two hospitals closed in favor of opening another hospital plus expansion of services on an outpatient basis at one location.

Appendix

Corcoran District Hospital – Corcoran, California - 2013

Situation:

- Corcoran District Hospital opened in 1949 and had been operating with 32 beds plus an emergency room.
- In 2013, the hospital was in dire straits financially and, after the loss of surgery revenue from a state prison, had to shut down inpatient and emergency department operations.
- The public hospital applied for state approval to reopen its emergency department as an urgent care center plus outpatient surgery, radiology and laboratory services.
- The efforts to remain open were unsuccessful as the hospital eventually closed completely with the exception of its rural health clinic.



Result:

- In September 2013, the Board of Directors voted to sell the operations of the rural health clinic to Adventist Health. A majority of the staff was laid off.

Comparison to Lakewood Hospital:

- Similarities: Municipal-owned hospital that would eventually lease operations to a separate hospital-operator.
- Differences: Corcoran is in a rural area (with a clinic that has a rural health designation); the closest hospital was 20 miles away; and the hospital unsuccessfully attempted to keep their outpatient center open.

BIOGRAPHIES

John Bodine

Managing Director

John has more than 20 years of experience providing corporate finance and advisory services to the healthcare industry. He has advised clients on mergers and acquisitions, recapitalizations, leveraged buyouts, joint ventures, restructurings and corporate planning matters. He is an officer and principal of Huron Transaction Advisory LLC, the firm's broker-dealer. John has worked on over 200 transactions in the healthcare segment, including engagements with hospitals, ASCs, physician practices, dialysis centers, diagnostic imaging centers, HCIT firms, pharmaceutical companies, medical device manufacturers, managed care organizations and others. He is a frequent speaker and author on transactional and valuation topics.

Professional experience

Prior to joining Huron Healthcare, John was a Senior Vice President at the investment bank Houlihan Lokey Howard & Zukin, where he was registered with FINRA as a General Securities Representative (Series 7 and 63). John provided transaction advisory services as a member of the firm's Financial Advisory Services group and also served on the firm's Technical Standards Committee.

Prior to joining Houlihan Lokey Howard & Zukin, John served as managing director of the Chicago office of Valuation Counselors/CBIZ Valuation Group. He was previously employed as a senior financial consultant at American Appraisal Associates.

Representative examples of John's engagement experience include:

- Provided buy-side advisory services in connection with the acquisition of a regional hospital system by a Catholic health system.
- Provided transaction advisory services in connection with the sale of a physician-owned hospital to a publicly traded health system.
- Issued a fairness opinion to the special committee of a publicly traded company, associated with its acquisition of an HCIT company.
- Valued the businesses and assets associated with a regional health system for use in a redemption of the membership interest held by a national health system.

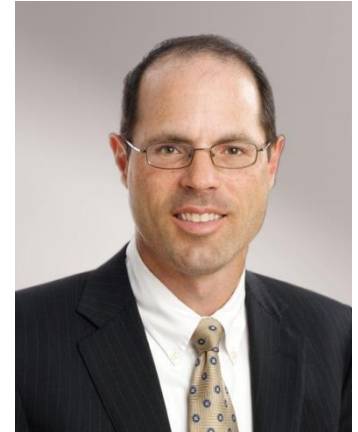
- Assisted a publicly traded health system in the syndication of membership units of its portfolio hospitals to physician investors.
- Valued the intellectual property of a portfolio of early stage pharmaceutical and medical device products. The analysis supported transactions among the limited partners of the private equity firm that owned the portfolio.
- Provided buy-side advisory services to a Medicare health plan in connection with the repurchase of a minority ownership interest.

Education and certification

- Master of Business Administration, Carlson School of Management, University of Minnesota, Minneapolis/St. Paul, MN
- Bachelor of Science, Business Administration, North Dakota State University, Fargo, ND
- Accredited Senior Appraiser, American Society of Appraisers
- FINRA registrations include Series 63 (Uniform Securities Agent State Law Examination), Series 24 (General Securities Principal), and Series 79 (Investment Banking Representative)

Professional associations

- Member, Business Valuation Association
- Member, Healthcare Financial Management Association



P 312-880-3411

jbodine@huronconsultinggroup.com

HuronBusinessAdvisory

John A. Lutz

Managing Director

John has over 30 years of executive leadership, strategy and consulting experience within all segments of the health care industry. His primary areas of responsibility include strategic development and operational improvement for academic medical centers (AMCs), health systems (including public and children's hospitals), physician organizations and clinically integrated networks (CIN). He has been responsible for multiple physician and hospital alignment transactions, strategy assessments, and tactical implementations; hospital and health system integrations; clinically integrated network (CIN) and accountable care strategy (ACO) development and implementations; physician compensation modeling and incentive development methodologies; academic medical center (including children's hospitals) strategic planning, clinical service line assessment, network development and management; physician practice assessment; management services organization (MSO) development; and strategic pricing.

Professional experience

Prior to joining Huron Healthcare, John served as a Director & Team Leader with Navigant's Healthcare Strategy practice. Prior to being acquired by Navigant, he formed his own consulting practice after spending 18 years as the CEO of Prime Care Physicians, a large, multi-specialty, private practice. John previously served as Director of program development for Ellis Hospital, and the Executive Director of the seven-hospital, Regional Health Systems Consortium of Northeastern New York. His responsibilities included strategic planning, operational leadership, mergers and acquisitions, financial performance improvement, turnaround activity, service line development, and joint ventures with physicians and strategic business partners.

Representative examples of John's engagement experience include:

- Redesign of a county health system's organizational structure, strategic plan and academic affiliation agreements.
- Designed, developed, and implemented a Clinically Integrated Network (CIN) strategy for an academic medical center, several hospitals, and a 3,500-physician CIN, initially covering over 75,000 lives.
- Created accountable care compensation methodology for over 300 physicians for a three-hospital system.

- Conducted CIN readiness assessments for physician-hospital organizations (PHO).
- Conducted cardiovascular, hospitalist and primary care compensation redesign for health systems.
- Directed multiple integrations of physician-hospital and health systems.
- Developed strategic, operational and clinical integration plans for children's hospitals and physician employees.
- Designed leadership/governance strategy for several large integrated healthcare systems.

Education and certification

- Administrative Fellow, Massachusetts General Hospital
- Masters of Public Health, Hospital Administration, Yale University
- Bachelor of Science, Chemistry, State University of New York
- Collective Negotiations Course, Harvard University

Professional associations

- Fellow, American College of Healthcare Executives – Young Regent's Award 1996
- Fellow, American College of Medical Practice Executives



P 518-491-4267

jlutz@huronconsultinggroup.com

HuronBusinessAdvisory

Christopher J. Luedtke

Manager

Christopher has more than 13 years of experience providing valuation services to a wide range of clients. He has provided valuation services for both real and personal property for, property tax, mergers and acquisitions, bankruptcy, insurance, and financing.

Professional experience

Prior to joining Huron, Chris was a Senior Associate at the financial advisory and investment banking firm Duff & Phelps. Chris provided valuation and consulting services while a member of the Specialty Tax group. Chris was previously employed as a senior valuation consultant at American Appraisal Associates from 1998 to 2007.

Representative examples of Chris's engagement experience include:

- Valued all equipment, spare, parts, engines and aircraft frames for one of the ten largest domestic airlines emergence from bankruptcy.
- Responsible for the monitor and reduction of property taxes for a multi-property portfolio of retail, office, residential, and industrial properties, realizing a reduction in taxes of over \$1,500,000.
- Assisted in valuation and court testimony prep for a multi-million dollar property tax case in upstate New York.
- Valued multiple Las Vegas casinos for insurance purposes.
- Valued retail equipment for a national department store chain for property tax purposes.
- Valued offshore oil platforms for financing purposes.

- Assisted in valuation of regional grocery store chain for an allocation of purchase price.
- Valued the tangible assets of a 100 million gallon per year ethanol manufacturing plant using the a discounted cash flow model to estimate economic obsolescence due to changes in raw material prices and government subsidies

Education and certification

- Bachelor of Science , Architectural Engineering, Milwaukee School of Engineering, Milwaukee, WI.
- Level I Assessor, State of Indiana

Professional associations

- Member, Appraisal Institute
- Member, Institute for Professionals in Taxation



P 312-880-0764

cluedtke@huronconsultinggroup.com

HuronBusinessAdvisory

Casey Webb

Manager

Casey has four years of valuation and transaction advisory experience within the healthcare industry. She has been involved with over 100 healthcare transactions, including acquisitions and divestitures of healthcare businesses, hospital/physician syndications, joint ventures and various intangible assets.

Professional experience

Prior to joining Huron Healthcare, Casey was a Wealth Management Intern at Merrill Lynch with a team of financial advisors that provided wealth management services to high net worth individuals. She developed weekly stock and mutual fund recommendation lists for a team of financial advisors, as well as streamlined and automated processes in almost every aspect of their business.

Representative examples of Casey's valuation and transaction advisory engagement experience include:

- A small health system acquiring a local critical access hospital.
- A specialty hospital looking to be acquired by a larger system.
- A community hospital seeking an affiliation with a larger system sharing similar values.
- An electronic medical record system within a health system seeking to spin out and become independent.
- Strategic forecasting analyses for numerous health systems.
- Investment analyses, including a pro forma revenue analysis, an internal rate of return analysis, and a payback period calculation for the potential acquisition of a large health system.
- Valuation of a regional health system with 10+ hospitals.

- Transaction advisory services to three platform physician practices, including a management company.
- Valuation of two sleep centers to be consolidated into a joint venture to be owned by a local health system.
- Valuation of non-compete provisions, management services agreements, certificates of need, trade names and customer relationships.

Education and certification

- DePaul University, Chicago, IL
 - Major: Finance (Honors Program)
 - Minors: Accounting and Economics
- American Society of Appraisers designation (in progress)
- FINRA registrations include Series 63 (Uniform Securities Agent State Law Examination) and Series 79 (Investment Banking Representative)

Professional associations

- Member, American College of Healthcare Executives / Chicago Health Executives Forum
- Member, American Society of Appraisers



P 312-880-3115

cwebb@huronconsultinggroup.com

HuronBusinessAdvisory

Paul S. Colarusso

Associate

Paul joined Huron Consulting Group in January, 2011. At Huron, Paul has gained experience with valuation modeling, reporting and financial analysis within the healthcare industry. He has been involved with numerous healthcare engagements including hospital/physician syndications, joint ventures, acquisitions, and transaction advisory services of healthcare facilities.

Professional experience

Prior to joining Huron, Paul provided financial services in the insurance and private equity industries. His responsibilities included due diligence, deal analysis and investment advisory.

Representative examples of Paul's engagement experience include:

- Provided valuation and transaction advisory services to various health systems including the acquisition of local physician practices, hospitals, and various outpatient ancillary services.
- Developed a pro forma analysis utilizing a variety of volume scenarios to provide a range of value for large physician practices and multi-specialty centers.
- Analyzed the Centers for Medicare and Medicaid Services ("CMS") rulings on reimbursement and impact to various entities.
- Provided valuation and consulting services for the acquisition of a 17 member physician practice with over 100 full-time equivalent employees.
- Provided valuation and consulting services for the acquisition of a 16 physician oncology group with over 140 full-time equivalent employees and over \$70 million in annual net revenue.

- Provided valuation and consulting services for the acquisition of a 16 physician cardiology center with over 95 full-time equivalent employees, including 11 mid-level providers, and over \$23 million in annual net revenue.
- Provided valuation and consulting services for the acquisition of a distressed 115-licensed bed acute-care hospital.
- Assisted in the determination of reorganization value and allocation of value in connection with fresh-start financial reporting principals required under Accounting Standard Codification 852 – Reorganization (SOP 90-7) and ASC 805 – Accounting for Business Combinations for a home medical equipment provider with approximately \$530.0 million in annual net revenue.

Education and certification

- Bachelor of Science – Finance, Michigan State University, East Lansing, MI

Civic involvement

- Volunteer – Fox Valley United Way
- Member – Ready When the Time Comes – American Red Cross Society of Greater Chicago



P 312-880-5617

Pcolarusso@huronconsultinggroup.com

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