DR. PHILIP DWYER, MD

VALUATION REPORT

DECEMBER 31, 2016

March 14, 2018

Jeffrey Vidmar
VP, Strategic Planning
Medical Care System
123 Any Street
City, State ZIP

Dear Mr. Vidmar:

We have prepared and enclose herewith our Valuation Report (the "Report") of the fair market value of Dr. Philip Dwyer, MD (the "Practice") as of December 31, 2016. The purpose of this engagement is to render a conclusion as to the fair market value of the Practice for a potential acquisition. This Report should not be used for any other purpose or by any other party for any purpose. The value conclusion is considered a cash or cash equivalent value. The distribution of this Report is restricted to the Practice's management and the management of Medical Care System ("MCS"). This Report may not be distributed to any other outside parties without our prior written consent.

Based on our valuation analysis and procedures, our conclusion of the fair market value of the Practice (excluding cash) on a controlling, non-marketable basis as of December 31, 2016 is:

$76,000

A description of the analysis, procedures and assumptions relied upon to reach this conclusion is presented in the accompanying Report. This letter should not be separated from, or considered independent of, the attached Report. This valuation is subject to the assumptions and limiting conditions detailed in **Appendix A** to this Report.

Very truly yours,

VALUATION FIRM

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1 INTRODUCTION

1.1 Overview

We have performed a valuation engagement and present our detailed report in conformity with the "Statement on Standards for Valuation Services No. 1" ("SSVS") of the American Institute of Certified Public Accountants. The American Institute of Certified Public Accountants defines an engagement to estimate value as "an engagement, or any part of an engagement (for example, a tax, litigation, or acquisition-related engagement), that involves determining the value of a business, business ownership interest, security, or intangible asset." More specifically, it defines a valuation engagement as "an engagement to estimate value in which a valuation analyst determines an estimate of the value of a subject interest by performing appropriate valuation procedures, as outlined in SSVS, and is free to apply the valuation approaches and methods he or she deems appropriate in the circumstances. The valuation analyst expresses the results of the valuation engagement as a conclusion of value, which may be either a single amount or a range."

Our analysis is also in conformity with the National Association of Certified Valuators and Analysts' ("NACVA") standards. NACVA defines a valuation engagement as an engagement that is undertaken "to establish the value for an entire or partial interest in a closely-held business or professional practice, taking into account both quantitative and qualitative tangible and intangible factors associated with the specific business being valued."

Finally, our analysis takes into consideration various revenue rulings, including Revenue Ruling 59-60, which outline the approaches, methods and factors to be considered in valuing shares of capital stock in closely-held entities for Federal tax purposes. Revenue Ruling 65-192 extended the concepts in Revenue Ruling 59-60 to income and other tax purposes as well as to business interests of any type.

In performing a valuation of a closely-held company or other business entity, certain steps must be undertaken in order to perform a conceptually sound and commonly accepted method of determining value. Although valuing a business is an imprecise science, by following established guidelines and references, a reasonable conclusion of value can be determined. These guidelines or practices include establishing the purpose of the valuation, determining the type of value being estimated, establishing the premise of value, analyzing the industry and economic climate, evaluating the entity's historical results of operations and normalizing financial activity to present a true "economic" picture of the entity's operations. The next step is selecting the valuation methodologies that are appropriate for the characteristics of the specific entity being valued and then properly applying the necessary steps associated with the methodologies in arriving at a determination of value. The last step in formulating a conclusion of the value of an entity is evaluating the nature of the underlying ownership interest and applying any necessary control or marketability adjustments to reflect characteristics specific to the nature of the ownership interest being valued.

1.2 Purpose of Valuation

The purpose of this engagement is to render a conclusion as to the fair market value of Practice for a potential acquisition. This Report should not be used for any other purpose or by any other party for any purpose. The distribution of this Report is restricted to the Practice's management and MCS's management. This Report may not be distributed to any other outside parties without our prior written consent.

1.3 Type of Value to be Determined

While there are many types of value that can be determined, we have been engaged to render a conclusion of the "fair market value" of the Practice. Fair market value is defined in The International Glossary of Business Valuation Terms issued by the American Institute of Certified Public Accountants (AICPA), the American Society of Appraisers, the Canadian Institute of Chartered Business Valuators, the National Association of Certified Valuators and Analysts and the Institute of Business Appraisers as:

> "The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."

Alternatively, for purposes of compliance with the Stark law, fair market value is defined as:

> "the value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring as the result of bona fide bargaining between well-informed buyer and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with the comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals." [42 C.F.R. § 411.351]

1.4 Level and Premise of Value

We have valued the Practice on a controlling, non-marketable basis as a going concern. It is assumed that management will maintain the Practice's character and integrity as of the valuation date into the future.

1.5 Approach to Valuation

The objective of this valuation engagement was to render a conclusion as to the fair market value of the Practice as of the date prescribed above, presented in this detailed Report, which would provide a fair and reasonable return on investment to an investor or owner using the facts available to us at the time of valuation.

Our conclusion is based on, among other things, our assessment of the risks facing the Practice and the returns that would be realized on alternative investments with similar levels of risk.

Both internal and external factors which influence the value of the Practice were reviewed, analyzed and interpreted. Internal factors include the Practice's financial position and results of operations and projected results. External factors include, among other things, the status

of the economy, the economic outlook, the status of the Practice's industry, the position of the Practice within the industry and the marketability of the ownership interest being valued.

1.6 Limiting Conditions of Value

The conclusion of value rendered in this Report is based on information provided in whole or in part by management of MCS and the Practice. We have not audited, reviewed or attested to this information and provide no assurance pertaining to its accuracy or completeness. A complete list of the documents reviewed in connection with this engagement is provided in **Appendix B**. We also had discussions with Jeffrey Vidmar of MCS, Dr. Philip Dwyer (owner and practicing physician), and Bill Visor of Accountants, LLP (the Practice's external CPA) on various dates regarding the Practice's operations.

We have no present or contemplated financial interest in the Practice. Our fees for this valuation engagement are based upon our normal hourly billing rates, and are in no way contingent upon the results of our findings. Our compensation is also not contingent on any action or event resulting from the analyses, opinions, conclusion in, or the use of, this Report.

Valuation Firm is not a guarantor of value. The valuation of entities is an imprecise science, with value being a question of fact, and reasonable individuals can differ in their conclusions of value. Valuation Firm has, however, performed conceptually sound and commonly accepted methods of valuation in determining the conclusion of value included in this Report. The reported analyses, opinions and conclusion of value are limited only by the reported assumptions and limiting conditions and were developed in conformity with SSVS and are our personal, impartial, independent, unbiased, objective professional analyses, opinions and conclusions.

This valuation reflects facts and conditions existing at the valuation date. The valuation and Report are to be used only as of this date and are not valid as of any other date. Subsequent events have not been considered, and we have no obligation to update our Report for such events and conditions, although we reserve the right to do so.

Appendix A, attached hereto, more fully details our assumptions and limiting conditions.

2 GENERAL INFORMATION

2.1 Company Background

The Practice is a nephrology practice located at 456 Some Avenue, City, State ZIP. The Practice started on January 1, 2008 and has operated as a nephrology practice since that time. The Practice has been supported by Dr. Philip Dwyer ("Dr. Dwyer").

Nephrologists specialize in treating kidney-related issues, including hypertension, kidney stones, and kidney failure. Nephrologists commonly manage the kidney failure of their patients using dialysis.

Dr. Dwyer received his medical degree from State Medical School. He has over 40 years of experience and has staff affiliations with Hospital #1, Hospital #2, Hospital #3, and Hospital #4.

2.2 Industry Overview[1]

In the valuation of any entity, it is important to gain an understanding of the industry in which the entity operates, including the industry's composition, trends, and opportunities. The Practice's primary business is to treat patients with kidney issues and offer dialysis services. The success of the Practice is tied heavily not only to the healthcare sector, but also the practice of nephrology and kidney treatment.

2.2.1 Health Care Sector

Industry Overview

Companies in this industry provide a wide range of health care and social services through hospitals, doctors' offices, nursing homes, outpatient surgery centers, and other facilities. Major companies include Ascension Health, HCA, Kaiser Permanente, and Tenet Healthcare (all based in the U.S.), as well as Fresenius (Germany), National Hospital Organization (Japan), and Ramsay Health Care (Australia).

Worldwide, health care expenditures total about $7.2 trillion annually, or about 10 percent of global GDP, according to the World Health Organization. Total health spending (both public and private) as a portion of GDP ranges from about 5 percent in countries such as Turkey to about 17 percent in the U.S., according to the Organization for Economic Co-Operation and Development.

The U.S. health care sector includes more than 840,000 establishments (single-location companies and units of multi-location companies) with combined annual revenue of about $2.3 trillion.

Competitive Landscape

Demand for health care services is driven by demographics and advances in medical care and technology. The profitability of individual companies depends on efficient operations and, in the case of many nonprofit health care providers, obtaining grants and federal funds. Large companies have advantages in accessing the latest medical research, buying supplies,

[1] FirstResearch – "Health Care Sector" (January 9, 2017), "Kidney Dialysis Centers" (January 9, 2017), and "Physicians" (March 6, 2017)

offering a wide range of services, and negotiating contracts with health insurers. Small institutions can compete successfully by serving a limited geographical area, offering specialized services, or building a local reputation for quality care. The U.S. health care sector is highly fragmented: the top 50 organizations generate about 15% of revenue.

Products, Operations and Technology

Major services include hospital medical care (45 percent of industry revenue) and outpatient care provided by physicians (20 percent). Other services include dental work, urgent care, elderly and hospice care, medical labs, home health, rehabilitation, and social assistance. Leading health care entities in the U.S. include a number of for-profit entities, an exception to the global norm of nationalized medicine. However, of the 7,100 U.S. hospitals, around 75 percent are not-for-profit. Most doctor's offices and ambulatory care centers are run as for-profit enterprises.

Hospitals can be operated by the government, charitable organizations, or for-profit corporations. Hospitals typically have between 50-1,000 beds and provide both inpatient and outpatient services, with larger facilities providing more complex care. Many hospitals are part of multi-facility health systems. About 75 percent of hospitals are general medical and surgical hospitals, while about 20 percent provide psychiatric and other specialized services. Physician practices are typically small, with fewer than 10 employees, but a growing number of doctors are joining group practice organizations (GPOs) or affiliating with hospitals.

Federal and state governments are heavily involved in the U.S. health care sector, as a direct-care provider (the Department of Veterans Affairs); an operator of health insurance programs (Medicare for the elderly, Medicaid for the low-income and disabled), and as providers of various social services programs.

About 90 percent of Americans are covered by some form of private or government health insurance; about 10 percent are uninsured. Many are covered by combinations of private and government policies. More than half of Americans are covered by employer-sponsored health insurance, the most common type; others are covered by Medicare, Medicaid, direct-purchase, and military plans. The 2010 Affordable Care Act (ACA) has reduced the uninsured rate by extending health care coverage to more Americans through state health exchanges, subsidy programs, and expanded Medicaid programs. The combination of employer-sponsored plans, individual insurance, subsidized insurance, and the uninsured spins a complex web of payers (private insurance companies, the government, and self-payers), known in the industry as a multi-payer system.

In total, US government expenditures account for around 45% of total health care costs and private expenditures 55%. US health care spending is about 17% of GDP, highest among industrialized nations, and is expected to reach 19% of GDP by 2022 according to the Centers for Medicare and Medicaid Services.

The U.S. is a leader in health care technology, scientific advances, and medical research. Many of these advances are led by research hospitals that maintain a staff of PhDs specializing in research and discovery. Molecular biology, largely federally funded, has advanced understanding of the cellular processes involved in disease, largely by identifying defective proteins and gene mutations. New drug treatments, often developed in partnership with pharmaceutical firms, counter the effects of these abnormalities. Advances in computer technology have produced new diagnostic imaging systems like ultrasound, MRI, CAT, and PET that can detect abnormalities in their earliest stages, often preventing the onset of diseases like cancer and organ failure. The R&D that drives these discoveries is costly.

In response to health care reform mandates aimed at improving efficiencies, health care providers are implementing health information technology (HIT) systems. Electronic health records (EHRs) are used to share information and coordinate patient care among doctors at multiple facilities. By the end of 2014, 74% of office-based physicians had adopted certified EHRs (systems that meet federal meaningful use criteria). About 76% of hospitals adopted basic EHR systems. With the increased use of EHR systems, the industry is struggling to improve interoperability among providers. The U.S. Office of the National Coordinator for HIT is working with technology firms to standardize system structures, data security methods, and services, including through open and accessible application programming interfaces (APIs).

Some physician practices are adopting personal health record (PHR) systems, where consumers can contact health professionals and access certain parts of their EHR, as a method of reducing repetitive in-person patient encounters. Other HIT systems include medical coding, billing, inventory, and prescription management software. Some hospitals have adopted wireless technologies to give doctors and nurses access to records at bedside.

Sales and Marketing

Typical customers are individuals requiring urgent medical care, routine check-ups, and long- or short-term help ranging from nursing home care, day care, and social services.

Marketing efforts vary depending on the type of service provided. Doctors typically stick with traditional approaches like word-of-mouth, referrals, and insurance approved-provider lists. A growing number of physicians use TV and print advertisements and have websites and even personal blogs -- though doctors must avoid violating patient's rights and privacy laws when writing about specific cases or incidences. Hospitals market to doctors, insurers, and individuals using a variety of means, including medical presentations, brochures, magazine and newspaper ads, targeted press releases, informational websites, and TV ads.

Prices vary depending on the services offered, the length of the patient stay, the patient's insurance policy, and the level of government support. For hospitals, the mean length of stay is about five days; the mean cost of a stay is about $10,000. Medicare (and, in many cases, supplemental state insurance policies) sets limits on reimbursable charges. In a typical scenario, a doctor visit costs around $90-$100, but Medicare may pay less than half that. The patient pays the rest through Medigap insurance or out of pocket. To offset these losses, doctors often limit the number of Medicare patients they accept, shorten patient time, or raise prices on private payers through what's known as "cost shifting."

Finance and Regulation

Hospital operating margins average between 3 and 7 percent. Some hospitals have high levels of uninsured patients, and about 30 percent of hospitals have a negative operating margin. As competitive and regulatory pressures rise, hospitals are looking to reduce wasteful processes. Hospitals, as well as ambulatory care providers, are consolidating to gain scale and are outsourcing noncore functions such as revenue cycle and environmental services.

Accounts receivable in the sector can be high, as payments from insurers may not arrive for months after a patient has been treated. Disputes with insurers are common, as insurers often deny or reduce reimbursement requests. Health care providers can lower the amount of write-offs from uncollected bills by working with insurance programs to increase the number of patients covered. Overall, the health care sector is labor-intensive: average annual revenue per employee in the US is about $125,000.

Health care providers are subject to extensive state and federal regulations. Almost all health care providers participate in Medicare or Medicaid programs, run by the Centers for Medicare & Medicaid Services (CMS). Medicare and Medicaid participants must abide by a large number of regulations concerning their operating, accounting, and billing procedures. Medicare has a major influence on the payments hospitals receive, as many other payers use Medicare payment schedules as their benchmark.

Recent federal legislation has tried to address the rapid growth in national health care costs, especially the health care reform law of 2010 (the Affordable Care Act, or ACA), which substantially expands health care coverage to previously uninsured Americans. Other important laws affecting the health care system include the Balanced Budget Act of 1997 (BBA); the Medicare Balanced Budget Refinement Act of 1999; the Medicare, Medicaid, and State Children's Health Insurance Program (S-CHIP) Benefits Improvement and Protection Act of 2000; the False Claims Act; the Criminal Health Care Fraud statute; the False Statement statute; the Social Security Act; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

State health and finance regulations can vary widely. MCOs and HMOs fall under state insurance laws. Some states mandate a specific level of staffing per patient, or require a "certificate of need" before a hospital can invest in capital improvements. Most states manage a network of state health regulators to inspect health care facilities to ensure safe working conditions and a low risk of infectious diseases. Physicians must pass exams and be licensed by a state medical board to practice in a particular state. State boards respond to complaints about doctors but typically don't monitor activities or inspect offices.

Regional Highlights

In the U.S., health care costs and availability vary from state to state. The number of doctors per 100,000 people averages about 265 for the U.S., ranging from a high of 430 in Massachusetts to a low of 185 in Mississippi. Consumer spending on health care is highest in the Midwest and lowest in the South.

The Midwest also has the highest number of hospital beds per capita, between 2.2 and 4.8 per 1,000 people. The western states have the fewest, between 1.7 and 3.6 beds per 1,000. In the Mid-Atlantic, the District of Columbia has more than 5 beds per 1,000 population, but surrounding states have far fewer (Maryland and Virginia have just about 2 beds per 1,000).

Hawaii, California, the District of Columbia, New Mexico, and Oregon residents have some of the highest participation rates in HMOs. Some states -- often less populated states like Wyoming and Alaska -- have HMO participation of 3% or less. States with high Hispanic populations (California and Texas) often require doctors and staff to speak basic Spanish. Signs, disclosures, and forms are often printed in both English and Spanish.

Critical Issues and Other Business Challenges

Containing Rising Costs - Prescription drug prices, aging populations that require more care, and the increasing cost of medical technology have contributed to the rising cost of health care in recent years. Countries around the globe are working to control costs through proposals including the adoption of electronic health records, more focus on quality and efficiency, emphasis on less-expensive preventive care over more expensive services, and government regulation to keep insurance premiums and treatment payments low.

Dependence on Reimbursement Rates - Most medical bills are paid by various third-party health care insurers, and health providers are dependent on gaining competitive managed care contracts with payers. Exclusion from provider lists and reductions in reimbursement rates could have a significant effect on revenues. The consolidation of third-party payers in the past decade has produced a number of large payers that frequently follow Medicare's lead in setting rates. Large hospital organizations such as Tenet deal with thousands of managed care contracts, which can make it difficult to efficiently bill and process accounts.

Medical Errors - The incidence of medical errors resulting in patient death is an issue of critical importance to the health care industry. A 2013 study published by the Journal of Patient Safety estimated that medical errors cause between 210,000 and 440,000 deaths each year. To encourage hospitals to improve care quality, Medicare has established penalties for hospitals with high rates of preventable medical errors, such as catheter-associated urinary tract infections. Hospitals are looking at ways to reduce patient deaths, including electronic medication tracking, procedural checklists, and safety training.

Malpractice Insurance - Malpractice insurance premiums rose sharply in recent years, sometimes such that doctors practice defensive medicine by ordering more tests or performing more C-sections. Many doctors support tort reform, which would reduce or limit jury awards for damages. Several states impose caps on awards, which state officials say help them retain and recruit physicians.

Costs vs. Benefits - The U.S. spends about 17% of its GDP on health care, more than any other nation, yet the health of Americans, on average, is no better than in many countries that spend less. A WHO ranking of life expectancy lists the US as 37th in the world; among developed nations, the US has one of the highest infant mortality rates, at about 6 per 1,000 live births. Adult and childhood obesity rates are among the highest in the world.

Disclosure Rules - Under the U.S. Sunshine Act, manufacturers of covered drugs, medical devices, biological products, and medical supplies have to report to Medicare any payments to physicians and teaching hospitals, such as investment interests, ownership, or other transfers of value. The law took effect in 2014, requiring manufacturers to compile the information annually. The Sunshine Act is designed to make transactions between manufacturers and physicians transparent to patients and others.

Business Trends and Industry Opportunities

Increasingly Informed Patients - Consumers are more aware of their health status and appropriate diagnostic care. Many patients use the Internet to access websites such as WebMD to research diseases and symptoms, and join online communities to discuss health issues and concerns. With insurance companies limiting doctor office visits to as little as five minutes, many patients are now taking it upon themselves to increase their medical knowledge, unwilling to rely solely on the advice of hurried medical professionals.

Employment Continues to Rise - Despite a pending shortage of doctors and nurses in the coming decade, employment in the health care sector increased over 20 percent in a recent 10-year period. Employment in the sector is expected to increase about 17 percent by 2024 (from 2014), with the strongest growth expected in health care support occupations, health care practitioners, and technical occupations.

Consolidation - Changing reimbursement practices and other reform measures have spurred unprecedented consolidation in the health care industry, altering the competitive landscape. Hospitals have been buying competitors, independent physician groups, and insurance

companies, all to get a better handle on cost containment, patient care data, and revenue streams. Physicians are joining group practice organizations or affiliating with hospitals to gain efficiencies and reduce risk. Participation is growing in accountable care organizations (ACOs), which are networks of hospitals, physicians, and other providers that coordinate patient care.

Outsourcing Services - To lower operating costs, hospitals and clinics are increasingly outsourcing services to third-party providers. Food service, housekeeping, laundry, IT, pharmacy, inpatient care management, and ER services can be outsourced to independent contractors, boosting margins and increasing efficiencies.

Health Information Technology ("HIT") - Health information technology (HIT) integrates electronic health records, decision support systems, and computerized physician order entry for medications. Hospitals and physicians that invest in HIT may be able to improve scheduling, lower nurse administrative time, improve drug use, and lower the risk of adverse drug reactions. The U.S. government has put financial incentives in place to encourage the adoption of HIT as a way to ultimately improve medical care and lower costs. However, hospitals have found that development of HIT is complex and expensive and may outweigh eventual cost savings. Interoperability among providers is a barrier to success, as companies may use software programs that don't speak to each other.

Aging U.S. Population - The aging U.S. population both strains and presents opportunities for the American health care system over the next decade. Health care spending per person for those over 65 is about three times as much as for the rest of the population. The U.S. population 65 and older is expected to increase by 38 percent between 2015 and 2025.

Personalized Medicine - Personalized medicine uses a person's genetic profile to identify potential risk for diseases such as cancer, diabetes, heart disease, and kidney failure. Since the 2003 sequencing of the human genome, scientists and physicians have begun to identify treatments and strategies for complex conditions that can be tailored to individuals.

Preventive Medicine - Medical advances show that many disorders can be prevented or delayed through early intervention, such as lowering cholesterol. Insurers and employers that provide health care benefits have a vested interest in promoting less-expensive preventive care to avoid expensive surgical procedures. This may benefit physicians who actively manage their patients' overall health. Hospitals are hiring professionals tasked with overseeing a patient's stay and providing preventive care counseling to reduce readmissions, length of stay, and errors.

Telemedicine - Doctors are accustomed to using videoconferencing and online technology to consult with other doctors; now they are using the same technology to treat patients. Telemedicine allows doctors to consult with and treat patients who live in rural areas. It also lets patients see specialists who may be unavailable in a local market. Insurance companies are rolling out telemedicine consultations to their networks as a way to increase access to care and control costs.

Handheld Technology - Handheld devices such as GE's Vscan portable ultrasound will let doctors and emergency responders to gather medical data in the field and transmit it to a hospital or emergency room. Other devices such as smartphones and health applications are making into inroads into the health care field as well. However, the FDA has determined that certain smartphone health apps (those that could put patients at risk if they don't work properly or that impact the functionality of traditional devices) are to be classified as medical devices requiring approval.

Growth of Noninsurance Practices - Some doctors are seeing fewer patients, but charging them more, with the bulk of the cost paid for by the patient rather than a third-party payer. So-called "concierge" practices may serve only 300 patients rather than the typical 1,000, but charge each an annual fee of $1,500 to $2,000 for regular checkups and advice. At the other end of the spectrum, doctors are offering similar services to patients who can't afford health insurance and who may pay between $15 and $75 per month. Though the costs are low, doctors can recoup expenses because they avoid complex insurance billing systems.

Industry Forecast

Revenue (in current dollars) for U.S. healthcare, a sector that includes physicians, dentists, hospitals, home healthcare, nursing homes, and daycare services, is forecast to grow at an annual compounded rate of 6 percent between 2017 and 2021.

2.2.2 Kidney Dialysis Centers

Industry Overview

Companies in this industry provide outpatient kidney dialysis services. Major companies include U.S.-based DaVita and Dialysis Clinic, Inc., and Germany-based Fresenius Medical Care and B. Braun Melsungen.

The global dialysis services market generates annual revenue of about $60 billion, according to Fresenius. Nearly million people worldwide receive dialysis treatment. Demand for kidney dialysis services is growing in emerging economies where access to care has been historically insufficient. In countries such as India, China, and Pakistan, incidences of diabetes-related kidney disease is rising.

The U.S. kidney dialysis industry includes about 6,100 centers with combined annual revenue of about $19 billion.

Competitive Landscape

Demand depends on the number of people who suffer from kidney disease. The profitability of individual companies is linked to efficient operations and good marketing. Large companies have economies of scale in administrative costs, which has driven consolidation in the industry. Small operators can compete successfully if they have centers in desirable locations or good relations with doctors who refer patients. The U.S. industry is highly concentrated with the four largest companies operate more than 75 percent of all centers.

More than 660,000 people in the U.S. receive treatment for end-stage renal disease (ESRD), and about 440,000 of them receive treatment in dialysis centers. The number of people receiving dialysis grew at a compound annual rate of 4% between 2000 and 2012, according to the U.S. Renal Data System.

Products, Operations and Technology

Advanced chronic kidney disease, also called end-stage renal disease (ESRD), is characterized by the irreversible loss of kidney function and requires regular dialysis treatment or a kidney transplant to sustain life. Scarcity of available donor kidneys limits the number of transplants, so most ESRD patients rely on dialysis treatments. Dialysis is not a cure but a blood-filtering process that prolongs life through the removal of toxic waste products and excess fluids from the body. ESRD patients must undergo dialysis for the rest of their lives.

A number of conditions, including diabetes, hypertension, glomerulonephritis, and inherited diseases, can cause chronic kidney disease. Diabetes and high blood pressure are the top two causes; diabetes alone accounts for more than 40% of all new cases. Patients with acute kidney injury (also known as acute kidney failure) suffer sudden loss of kidney function from an injury, drug use, or illness. These patients may also sometimes need dialysis, but the condition is reversible.

Hemodialysis is the most common form of dialysis treatment for ESRD. The hemodialysis process involves passing a patient's blood through a machine that includes pumps; monitors; a dialysis filter (dialyzer); and various chemical solutions to remove toxins, fluids, and chemicals. The treatment process lasts about four hours and patients require treatment three times per week. Machines are made by several companies, including Baxter, Fresenius, and B. Braun Avitum.

A typical dialysis center provides more than 30 treatments per day. Center operations involve acquiring and maintaining dialysis machines and other equipment, managing staff, scheduling appointments, providing treatments, and billing. Although larger centers would be more efficient, the size of centers is limited by the distance patients can reasonably travel to get there. A new center can cost about $2.7 million for building, equipment, and first-year working capital, according to DaVita.

In addition to dialysis treatments, centers may provide lab testing services, support for home dialysis, in-hospital dialysis services for acutely sick patients, and infusion services for drugs such as erythropoietin (EPO). Some companies also manage in-hospital centers for a fee.

Scientists have worked to improve the effectiveness of the hemodialysis process through the use of better filters and dialysis chemicals. An alternative to hemodialysis is "peritoneal dialysis," which spreads chemicals through the abdomen. Of the nearly 3 million dialysis patients treated, approximately 90% received hemodialysis and about 10% received peritoneal dialysis, according to Fresenius. Kidney transplantation, the only current cure for ESRD, is becoming more effective, but is limited by the availability of suitable donor kidneys. Less than 5% of patients receive a kidney transplant.

Health reform is driving kidney dialysis centers to become involved in integrated care delivery and patient management programs, which can help coordinate treatment programs for chronically ill patients. The use of comprehensive and sophisticated information technology systems is essential to efficient care management programs. Examples include electronic health records (EHR), claims analysis, and disease registry systems. Dialysis centers are also upgrading billing and collection systems to comply with new Medicaid bundled payment requirements.

Sales and Marketing

Kidney dialysis patients are typically referred to a particular dialysis center by physicians, especially nephrologists who specialize in treating kidney disease. Most doctors prefer to have their patients treated at centers where they or other members of their practice can supervise the care.

The industry advertises little, if at all. Dialysis centers market their services to physician groups, hospitals, and managed-care companies. A large percentage of patients may come from just a few doctors. Large chains often hire a nephrologist to be medical director of a local dialysis center, with the expectation that many of the doctor's patients will be treated at the center.

Finance and Regulation

The majority of revenue of most dialysis centers comes from Medicare payments. The Medicare end-stage renal disease (ESRD) program is available as the payer of last resort and makes payments for most ESRD patients in the U.S. Under the system, Medicare makes a single bundled payment to providers instead of reimbursing for separately billed services. This has had the effect of reducing reimbursements and made it more difficult for providers to document and track payments.

Some payments are also made by private insurers (at higher rates) and state Medicaid plans. Receivables can be high because of the time required to get paid by Medicare and other payers. Medicare pays 80% of the amount set by the Medicare system for each covered dialysis treatment; the patient is responsible for the remaining 20%. Write-offs of receivables can be high if many patients can't afford to make their 20% share of payments.

Operating costs for dialysis centers are high, and facilities may find cost-cutting difficult to achieve in the face of government mandates on staffing levels and quality control measures. Skilled personnel shortages are common, driving up costs or forcing centers to cut back on patient volume. Dialysis centers may also face costly litigation from dialysis patients who become ill or die due to dialysis machine, tubing, or material malfunctions. Suits alleging negligence, malpractice, and product liability are common.

U.S. dialysis centers are regulated by federal, state, and local agencies. In addition to certification from the Centers for Medicare and Medicaid Services (CMS), some states require operational licenses and permits, as well as inspections by state health departments.

Centers must also comply with federal regulations including anti-kickback statutes (governing physician referral payments), patient privacy laws (including the Health Insurance Portability and Accountability Act of 1996), and health reform measures implemented through the Affordable Care Act of 2010. Kidney dialysis centers are exempt from some (but not all) provisions of the Stark Law, which restricts physician ownership of a referral facility fraudulent billing and claims laws.

Regional Highlights

In the U.S., end-stage renal disease (ESRD) is more likely to occur in African Americans, Native Americans, Hispanics, and Pacific Islanders than in whites. Many dialysis centers are located in high-density urban areas and states with high populations. The states with the most dialysis centers are California, Texas, Florida, Georgia, and Pennsylvania.

Critical Issues and Other Business Challenges

Medicare Payment Bundling - Medicare reimburses renal clinics for all dialysis services together, including both treatments and drugs, rather than paying for each service separately. The bundled payment system was mandated by Congress as part of the Medicare Improvements for Patients and Providers Act (MIPPA) passed in 2008. The bundling was designed to reduce reimbursements for dialysis services, and reimbursements may be further reduced for clinics that don’t meet performance standards.

Health Care Reform - Dialysis centers treat a mix of patients who are on Medicare, Medicaid, and private insurance. The patient population with employee-sponsored insurance is the most profitable, as those plans reimburse at a higher rate than Medicare or Medicaid. The

Affordable Care Act may cause some to move from high-paying private insurance to policies sold on state insurance exchanges, which may reimburse for dialysis at a lower rate.

Rising Operating Costs - Operating costs for dialysis centers are rising faster than revenues, a situation that will likely be compounded by efforts to control Medicare reimbursement costs. Government mandates on staffing levels and quality control measures have limited opportunities for cost-cutting through staff reductions. A shortage of nurses also has pushed up labor costs.

Risks of Litigation - Litigation is an ongoing risk from dialysis patients who become ill or die due to dialysis machine, tubing, or material malfunctions. Suits alleging negligence, malpractice, and product liability are common. Dialysis patients are particularly vulnerable to infections because of the invasive nature of hemodialysis.

Dependence on Skilled Personnel - The operation of dialysis centers depends on the availability of skilled nurses and technicians. Staffing levels are mandated by government regulations. The availability of nurses, in particular, isn't always secure. Local shortages are common, driving up costs or forcing centers to cut back on patient volume.

Business Trends and Industry Opportunities

Industry Growth Continues - Demand for dialysis services continues to increase as the elderly population grows and the prevalence of chronic conditions such as diabetes, hypertension, and heart disease rises. Industry jobs have increased nearly 50% in the past 10 years due to the labor-intensive nature of the industry. While the number of end-stage renal disease cases plateaued in 2010, the number of ESRD prevalent cases continues to rise by about 21,000 cases per year, according to U.S. Renal Data System.

Home Dialysis - Providing home dialysis to more patients could save time, improve quality of life, and be more cost effective. Dialysis is a time-consuming process that can take several hours at least three times per week, not including travel time or waiting for services. Some patients are turning to home dialysis, in which they perform the procedure with the help of family members or home health aides. More dialysis centers are adding training stations for home dialysis.

Technology Upgrades - Dialysis center operators invest in billing and collection technology to grow revenue and control costs. These improvements can also help companies comply with regulations. Upgrades to IT systems and processes allow companies to collect data required under new rules for Medicare bundled payments.

Government Oversight - The U.S. government is increasing scrutiny of health care providers to detect cases of fraud and abuse. Kidney dialysis centers are increasingly the subject of investigations into physician relationships under anti-kickback laws, as referring nephrologists are often closely involved in operations of dialysis centers.

Accountable Care Organizations - Dialysis centers can join accountable care organizations (ACOs), which were mandated under the Affordable Care Act as a way to cut costs and improve the quality of care for patients with chronic diseases. In an ACO, all providers share in the cost savings if the organization meets its quality and cost goals. Proponents say that ACOs and dialysis centers are a natural fit, because dialysis providers already treat factors common to other conditions, such as high blood pressure and heart disease. ACOs are new, however, and cost savings have not been demonstrated.

Demographic Changes - Changes in the U.S. population are expected to result in higher rates of diabetes and high blood pressure and more people having end-stage renal disease. Minority populations are expected to contract the disease at higher rates than the overall US population. And the number of Americans over 65, those most likely to have the disease, is forecasted to increase by about 38 percent between 2015 and 2025.

Managing In-Hospital Centers - Because of their expertise in managing efficient dialysis centers, commercial companies sometimes have contracts to manage in-hospital dialysis centers. These are usually smaller facilities that don't compete directly with larger independent dialysis centers. Some commercial centers provide mobile in-house dialysis treatments "as-needed" to hospitals without in-house dialysis facilities.

Industry Forecast

Revenue (in current dollars) for U.S. kidney dialysis centers and clinics is forecast to grow at an annual compounded rate of 6 percent between 2017 and 2021.

2.2.3 Physicians

Offices in this industry provide general or specialized medical care. No major companies dominate.

Globally, there are about 10 million physicians (not including midwives, dentists, or other health personnel), according to the World Health Organization. China has the largest number of physicians at around 2 million; followed by India, with around 880,000; and the U.S., with around 770,000. Countries with the most physicians per capita include Monaco and Qatar, with more than seven doctors per 1,000 population; Cuba, with more than six; and Austria and San Marino, with about five.

The U.S. physicians industry includes around 220,000 offices with combined annual revenue of about $465 billion.

Competitive Landscape

Demand for physician services is driven by population growth and demographics. The profitability of individual practices depends on the reputation and expertise of the physician and staff. Large practices have advantages in leveraging administrative processes and expensive diagnostic equipment. Small practices compete effectively by providing specialized skills and good customer service. Physicians generally have several direct competitors in the immediate geographic area.

The U.S. industry is highly fragmented with the top 50 firms account for about 15 percent of industry revenue. About 75 percent of all physician offices are small, with fewer than 10 employees (including the doctors); only about 2,000 offices have more than 100 employees; only about 1 percent of offices have 100 or more employees.

Products, Operations & Technology

Operations of physician offices revolve around patient care, appointment scheduling, records management, and insurance processing. Typically, a patient makes an appointment several days or weeks before being seen, a medical record file is retrieved, the patient sees the doctor for less than 20 minutes, the doctor orders tests or prescribes treatment, the doctor's consultation and any test results or treatments are entered into the medical records, and the cost of the visit is billed to an insurance plan.

The type of patient care that doctors provide depends on their area of expertise, advances in diagnostic and treatment knowledge, and on the type of insurance plan that covers the patient. Some plans limit the types of tests paid for and the types of treatments covered. Typically, the physicians in a group practice all specialize in the same general area of medicine. Offices with a mixture of specialties are more common in smaller communities. Though most offices remain small, an increasing number of physicians are joining group practices or healthcare organizations to improve coordination of care.

The two major types of physicians have medical doctor (MD) or doctor of osteopathic medicine (DO) degrees; both use similar methods of treatment, but DOs emphasize preventative, holistic, and musculoskeletal care. To provide a broad range of care, most doctors in private practice have affiliations with local hospitals. While general practitioners usually deliver most treatments in their office, surgeons often deliver treatment in a hospital or an ambulatory surgical center. Some doctor's offices have basic laboratory and x-ray equipment, but more sophisticated testing is usually handled by independent laboratories.

Rapid advances in medical knowledge have forced doctors to specialize in smaller areas of medicine, while making it more difficult for them to stay abreast of the latest diagnostic and treatment developments in their fields. Doctors keep up-to-date on new diagnostic devices and treatments with continuing education, reading medical journals, and through marketing materials or sales representative visits from device makers and drug companies.

The U.S. government has made the digitization of health care records a top priority and provided incentives to encourage their use. As of 2015, nearly 80% of office-based physicians reported using some kind of electronic health record (EHR) system, up from about 18% in 2001. EHRs work to increase efficiencies through information sharing and care coordination among physicians at multiple facilities.

The administrative functions of most physician offices are highly computerized, relying on software created specifically to manage medical offices. Many visits to a doctor's office last less than 20 minutes, but require scheduling, reminding, retrieving medical records, ordering tests, rescheduling, billing, reconciling payment, and accounting.

Research in fields such as genetics and molecular medicine is advancing how medications are administered. Genetic testing is allowing some physicians to use personalized medicine, where a certain course of treatment is used for patients with specific genetic traits. Advances in equipment and devices including implants, surgical instruments, and diagnostic imaging machines are also revolutionizing care methods.

Sales & Marketing

Doctors get new patients largely through referrals from existing patients and other doctors, and from being included on approved lists of corporate insurance plans. Doctors who contract with managed care plans may get new patients from the membership. TV and print

advertising, formerly banned, have become common, as has direct mailing. Location is important for many patients, as are the hospitals and insurance plans with which the doctor has contracts.

While health care prices are set by physicians, most insurance plans' fee schedules determine what physicians will receive for their services. Medicare also sets price schedules for procedures.

Finance & Regulation

Participation in various medical insurance plans is required for most physician offices, as insurers pay for most doctor services. Nationwide, about 45 percent of payments to doctors are by private insurance; another 25 percent come from public plans, mainly Medicare and Medicaid. Many insurance plans have extensive fee schedules that specify how much the insurer will pay for a particular service, as well as an approved list of drugs doctors can prescribe and a list of approved tests and treatments for specific medical conditions. Reimbursement rates may be negotiable with some insurers but are non-negotiable for Medicare and Medicaid.

Medicare and Medicaid are government-sponsored health insurance plans that cover people 65 and over and the poor. Both are funded mainly by the federal government, but Medicaid plans are administered by the states. As the largest payer for health services in the U.S., Medicare has enormous leverage with providers of health services.

Physician offices typically have high receivables, as payments from insurers may not be received for several weeks after treatment. Disputes with insurers are common and insurers often deny or reduce reimbursement requests. Capital investments for new equipment, including computer systems, are necessary every few years because of rapid technological advances.

State medical boards regulate the practice of medicine. Physicians must graduate from medical school, complete residency training, and pass exams to become licensed. They can also seek voluntary certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). Once a doctor is licensed to practice in a particular state, however, active regulation is virtually nonexistent. State boards respond to complaints about doctors but don't monitor activities or inspect offices.

Offices that participate in Medicare and Medicaid programs are subject to investigation by federal and state investigators and must adhere to medical fraud and abuse laws including the Stark Law and the Anti-Kickback statute. Physicians are also subject to changes in reimbursement and patient privacy standards under the Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA), and other health reform measures. To prescribe certain "controlled" drugs, doctors must be registered with the Drug Enforcement Administration (DEA).

A more indirect regulatory role over the activities of physician offices is exercised by managed care plans and other insurers, which monitor the quality of care provided to members and often actively prescribe "best practices" for patient care. Some plans prepare and publish "scorecards" for individual doctors or physician groups. The Health Insurance Portability and Accountability Act (HIPAA) restricts doctors from releasing patient information and imposes standards on physician practices for electronic record-keeping and communication.

Critical Issues and Business Challenges

Health Care Reform - Government health reform efforts are changing how medical care is accessed and paid for in countries around the globe. In the US, reform laws are working to lower medical expenses and make health insurance available to all Americans. The increase in insured patients creates new revenue opportunities for physicians, but also may cause some practices to exceed capacity and influence a growing doctor shortage in some regions.

Dependence on Reimbursement Rates - Although doctors serve individuals, most medical bills are paid by various third-party health care insurers and MCOs as well as by Medicare and Medicaid. One of the mandates of the ACA is to reduce Medicare and Medicaid reimbursements, which are already considered low by most doctors. The consolidation of third-party payers in the past decade has produced a number of large payers that frequently follow Medicare's lead in setting rates. Further reductions in reimbursement rates could have a significant effect on revenues of physician offices.

Operational Costs Increasing - Doctors' costs for labor, supplies, and liability insurance have increased faster than insurers' reimbursement rates, which have risen only modestly in recent years. Some doctors charge fees to cover services that insurance doesn’t pay for, such as annual administrative fees or penalties for missed appointments.

High Malpractice Insurance Premiums - Malpractice claims have risen steadily in recent years, according to insurance industry experts, leading to an increase in premiums. The number of claims in excess of $500,000 have also grown, which also drives rate increases. Many doctors support tort reform, which would reduce or limit jury awards for damages, and thus help keep premiums low. Several states impose caps on awards, which state officials say help them retain and recruit physicians.

Receivables Difficulties - Payments for doctors' services can be delayed or denied by insurers. Even though most states have enacted prompt-payment laws, physician payments are often delayed because their billing is not "clean"; that is, payers have questions about it. Some health plans insist that when claims are clean, up to 90 percent are paid within 14 days. Since many regions are dominated by only one or two insurance providers, insurers have more leverage than doctors in pay disputes.

Vulnerability to Unintentional Billing Fraud - Like other health care providers, doctors' offices sometimes bill for services that weren't rendered, or they "upcode" - claim a more expensive type of treatment than was actually performed. The complexity of billing several third-party payers can easily result in unintentional fraud; the associated penalties can devastate a practice.

Doctor-Patient Distrust - The doctor-patient relationship, long the basis of the U.S. medical system, is facing issues of trust. News about medical errors and the increasing influence of drug companies fuels consumer mistrust. In addition, doctors are no longer the only source of medical information, due to increased drug company advertising directly to consumers and the availability of medical information on the Internet. Patients increasingly want to be listened to, while cost pressures limit the time that doctors can spend with them.

Business Trends & Industry Opportunities

Practice Associations - Group practice associations (GPAs) provide risk-sharing arrangements among doctors to gain efficiencies of scale in facility, equipment, and administrative costs. Members of GPAs share income and staff. Through Independent

Practice Associations (IPAs), single-physician practices can contract with managed care plans without having to join a large group practice or sign exclusive agreements, allowing them to remain small and independent. Under pressure to control health costs, an increasing number of physicians are joining GPAs and IPAs. Some existing associations are looking to convert to accountable care organizations (ACOs) under new health reform laws.

Growing Demand for Health Care Services - Between 2015 and 2025, the number of Americans 65 or older will increase 38 percent; health expenses for those over 65 are about 44 percent higher than average. Additionally, health care reform means that millions more Americans are expected to obtain health insurance. Doctors may find that an increase in demand means an increase in income as well as a strain on capacity.

Physician Shortage - Experts estimate there will be a shortage of 62,000 to 95,000 doctors in the U.S. by 2025, which will be compounded by the increased demand brought on by health care reform. The shortage is especially acute in rural areas. Doctors are also working fewer hours. Some doctors say that lower reimbursement rates by Medicare and private insurance has made them disinclined to work longer hours. Medical schools have increased enrollments to address the shortage, but the number of federally funded residency positions remains inadequate, according to the Association of American Medical Colleges.

Hospital Affiliations - Physicians are forming relationships with hospitals as federal reform measures encourage use of new health care delivery and payment models. Hospitals are increasing physician practice acquisitions and joint ventures to increase outpatient revenue, cut costs, and avoid a potential shortage of health professionals. Physicians working for hospitals can also benefit from greater financial security. The number of hospital-employed physicians has risen by more than 70 percent over the past decade, according to *DHealthcare Daily*. More than half of physicians are employed by a hospital or care delivery system.

Growing Demand for Preventative Medicine - Advances in medicine show that many medical disorders can be prevented or delayed through early intervention, such as lowering cholesterol. Health insurance providers and employers that provide health care benefits have a vested interest in keeping medical usage low by promoting less expensive preventive care to avoid expensive surgical procedures. This may benefit general practitioners Industry Opportunities who manage their patients' overall health.

Some Specialties Growing in Popularity - As the U.S. population ages during the next decade, demand for cardiologists, gerontologists, and neurologists is expected to grow rapidly, while demand for pediatricians and obstetricians will increase more slowly. More extensive use of new imaging technology, such as MRI, will boost demand for radiologists.

Growth of Noninsurance Practices - Some doctors are seeing fewer patients, but charging them more, with the bulk of the cost paid for by the patient rather than a third-party payer. So-called "concierge" practices may serve only 300 patients rather than the typical 1,000. The national average annual fee for a concierge practice is $1,600 to $1,800, according to the American Academy of Private Physicians. Many doctors have also moved to a fee-for-service model, in which they don’t accept insurance for office visits. Though the fees are low, doctors can recoup expenses because they avoid complex insurance billing systems.

More Physicians Adopt e-Technology - Electronic devices, including handhelds and high-speed Internet access, are being used by physicians to take notes, communicate with hospitals, and even perform diagnostic tests. Doctors are using the devices at rates much higher than consumers, because the technology is affordable and helps doctors access information faster and stay organized. The adoption of electronic health records (EHR) is also

growing because of federal health care initiatives. Doctors are also moving into telemedicine, in which they offer online consultations. Large insurers are beginning to reimburse such e-visits, which will likely encourage greater usage.

Industry Forecast

U.S. personal consumption expenditures on physicians are forecast to grow at an annual compounded rate of 6 percent between 2017 and 2021.

2.2.4 Conclusion and Impact on the Practice

As discussed throughout this section of the Report, there are numerous industry factors, both positive and negative, which impact the Practice.

Beginning with the positive aspects, the aging U.S. population is expected to benefit the Practice in the form of additional healthcare needs and patient volume. In addition, demographic changes in the U.S. population are expected to result in higher rates of diabetes and high blood pressure, which in turn may result in an increased number of patients in need of kidney-related healthcare. The Practice can also improve both efficiency and quality of care by use of home dialysis along with technological advances in billing and other IT areas, lowering operating costs and improve profitability. Lastly, long-term forecasts for the healthcare industry are strong at 6 percent annually from 2017 through 2021.

There are, however, negative factors affecting the industry as well. First, there is significant pressure from the Affordable Care Act for healthcare providers to keep costs down. There may also be lower reimbursement rates if a practice's payer mix shifts from private insurance to policies sold through state exchanges, resulting in a decline in profit margins and lower revenues for healthcare providers. Also, the risk of rising malpractice premiums along with an increase in operating costs create significant financial challenges for companies operating in the healthcare sector, particularly small medical practices.

These industry risk factors and growth rates have been taken into consideration in our determination of the Practice's growth and specific company risk rates discussed in **Section 4.1** of this Report.

2.3 Economic Outlook[2]

In the valuation of any company, it is important to note the economic climate in which it operates. Gaining an understanding of the economic outlook is essential to developing reasonable expectations about the future of the economy and its impact on the value of the Practice as of the valuation date.

Economic Update at a Glance

The U.S. economy – as indicated by GDP – grew at an annual rate of 1.9% in the fourth quarter of 2016, which is slower than the 3.5% rate reported in the third quarter of 2016. The slowing rate is due to a decline in exports and federal government spending. Imports, however, which are subtracted in the calculation of GDP, increased. For the year 2016, GDP increased 1.6% compared with 2.6% in 2015. Consumer spending rose 2.5% in the fourth quarter. Increased spending on big-ticket items drove the fourth-quarter rise in consumer spending. Spending on long-lasting or durable goods leaped nearly 11.0%. Comparatively, consumer spending rose at a rate of 3.0% in the third quarter, although both quarters suggest the economy is growing at a steady pace. Private inventory investment also helped boost GDP. Excluding inventories, GDP rose at a 0.9% rate in the fourth quarter. Total government spending rose 1.2% in the fourth quarter, marking the second consecutive quarterly increase, while state and local government spending increased following two consecutive quarters of declines. Private fixed investment, which includes residential and business spending, increased 4.2%. This marks a trend reversal after private fixed investment dropped for four straight quarters. The trade deficit widened in the fourth quarter, lowering by 1.7 percentage points.

Gross Domestic Product

The Bureau of Economic Analysis (BEA) reported that the nation's economy – as indicated by GDP – grew at an annual rate of 1.9% in the fourth quarter of 2016. GDP growth for the fourth quarter represents a slowdown from the 3.5% growth the economy experienced in the third quarter and is also below analysts' estimates of 2.2%. This also marked the 11th straight year the economy failed to grow at a 3.0% rate. GDP growth for the quarter saw contributions from personal consumption expenditures, private inventory investment, residential fixed investment, nonresidential fixed investment, and state and local government spending that were partly offset by negative contributions from exports and federal government spending. Imports, which are subtracted in the calculation of GDP, increased.

Consumer Spending

Consumer spending grew at a rate of 2.5% during the fourth quarter of 2016, maintaining a healthy rate despite a slowdown in GDP. Consumer spending growth decelerated from the third-quarter rate of 3.0%. For the year, consumer spending grew 2.7%. Consumer spending, also referred to as "personal consumption," accounts for approximately 70% of the U.S. GDP.

The fourth quarter's figures in consumer spending reflected a slowdown in spending on services but growth in long-lasting goods. Consumer spending contributed 1.70 percentage points to the fourth-quarter GDP rate.

[2] Economic Outlook Update – 4Q 2015

Government Spending

Total government spending grew at a rate of 1.2% in the fourth quarter of 2016, after growing at a rate of 0.8% in the prior quarter. The fourth-quarter rise in government spending added 0.21 percentage point to the GDP rate. In 2016, government spending increased at 0.9% compared to 1.8% in 2015.

Business Investments

Business spending on structures declined at an annual rate of 5.0% in the fourth quarter, a sharp reversal from the growth rate of 12.0% in the prior quarter. Business spending has increased three times in the past 10 quarters (in one quarter where spending on structures rose, the rate was only 0.1%). Business spending on equipment increased at a rate of 3.1% in the fourth quarter, breaking a four-quarter consecutive decline. Business spending on intellectual property products continued to be positive, rising for the 14th consecutive quarter and increasing at a rate of 6.4%.

Residential fixed investment, often considered a proxy for the housing market, grew at a rate of 10.2% in the fourth quarter. Residential fixed investment has grown in nine of the past 11 quarters. The fourth-quarter growth in residential fixed investment added 0.37 percentage point to the fourth-quarter GDP.

Consumer Prices and Inflation Rates

According to the Bureau of Economic Analysis, the price index for gross domestic purchases rose 0.2% in the fourth quarter of 2015, less than the 1.3% increase in the previous quarter. The price index for gross domestic purchases measures prices paid by U.S. residents. Excluding food and energy prices, the price index for gross domestic purchases rose 0.9% in the fourth quarter, compared with an increase of 1.3% in the previous quarter.

Interest Rates

The Federal Open Market Committee (FOMC) met twice during the fourth quarter of 2016, issuing a statement from each meeting. In the December meeting, the FOMC decided to raise the target range for the federal funds rate to between 0.5% and 0.75%. The federal funds rate is the interest rate at which a commercial bank lends immediately available funds in balances at the Federal Reserve to another commercial bank. The FOMC establishes a target rate and expands or contracts the money supply with the aim that the federal funds rate, a market rate, will approximate the target rate.

Unemployment and Personal Income

Job growth continued to be solid in December, as employment rose by 156,000. Job growth has averaged 165,000 jobs per month over the past three months, well above the 80,000-jobs-a-month pace the White House Council of Economic Advisers believes is needed to maintain a low and stable unemployment rate. The unemployment rate increased 0.1 percentage point in December, to 4.7%, while the labor-force participation rate remained unchanged, at 62.7%. In 2016, job gains totaled nearly 2.2 million, a decline of about a half a million from the previous year.

Employment in professional and business services rose by 15,000 in December and has now risen 522,000 over the year. The healthcare sector added 43,000 jobs in December and averaged 35,000 jobs per month in 2016. Employment in the food services industry continued

to rise, increasing by 30,000 in December and 247,000 over the past year. Jobs in social assistance increased, growing by 20,000 over the month and 92,000 over the last 12 months. Employment in mining, construction, wholesale trade, retail trade, information, and government changed little in December.

Consumer Confidence

Following a considerable increase in November, the Consumer Confidence Index increased in December by 6.6 points, to 113.7. This is the best reading since August 2001. The post-election surge in the index reflects consumer optimism in the economy, jobs, and their personal income. The survey is a leading indicator of consumer attitudes, measures of confidence toward business conditions, short-term outlook, and personal finances and jobs.

Stock Markets and Volatility

The major stock indexes recorded gains in the fourth quarter, carrying on the previous quarter's upward momentum. The Nasdaq Composite Index saw strong gains, as did the Russell 2000 index. Within the S&P 500 sectors, financial stocks jumped 21.1%, while telecommunication services stocks—which are dividend-heavy—fell nearly 4.4% as expectations grew for competition from higher bond yields.

Economic Outlook

The following table summarizes major historical economic indicators, as well as estimates for these figures through 2026.

Historical Economic Data 2011-2016 and Forecasts 2017-2026

	Historical Data (Annual % Change)						Consensus Forecasts (Annual % Change)					
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022-2026
Real GDP	1.6	2.2	1.7	2.4	2.6	1.6	2.3	2.3	2.2	2.2	2.2	2.2
Industrial production	2.9	2.8	1.9	2.9	0.3	(1.0)	1.5	2.3	2.4	2.5	2.4	2.3
Consumer spending	2.3	1.5	1.5	2.9	3.2	2.7	2.5	2.5	2.3	2.3	2.3	2.3
Real disposable personal income	2.5	3.1	(1.4)	3.5	3.5	2.7	2.5	2.7	2.5	2.3	2.2	2.3
Business investment	7.7	9.0	3.5	6.0	2.1	(0.4)	0.8	1.2	NA	NA	NA	NA
Total government spending	(3.0)	(1.9)	(2.9)	(0.9)	1.8	0.9	2.4	2.3	2.3	2.3	2.3	2.3
Consumer price inflation	3.2	2.1	1.5	1.6	0.1	1.3	2.1	2.1	2.3	2.3	2.2	2.2
Unemployment rate	8.9	8.1	7.4	6.2	5.3	4.9	4.6	4.5	NA	NA	NA	NA
Housing Starts (millions)	0.609	0.781	0.925	1.003	1.112	1.166	1.260	1.350	NA	NA	NA	NA

Source of historical data: U.S. Department of Commerce, U.S. Department of Labor, U.S. Census Bureau, and The Federal Reserve Board.
Source of forecasts: Consensus Forecasts—USA, December 2016.

Conclusion and Impact on the Practice

On the positive side, job growth was strong in December with 165,000 jobs created (43,000 jobs in the healthcare sector). This job growth fueled an increase in consumer confidence in the fourth quarter of 2016 while the unemployment rate held relatively steady in the high 4% range. In addition, the stock market continued its momentum in the fourth quarter with strong returns in the financial sector. On the negative side, GDP grew at an annual rate of 1.9% during fourth quarter 2016, down from 3.5% in the third quarter. GDP growth in 2016 was 1.6% compared to 2.6% in 2015.

The factors above, when considered as a whole, tend to have a positive impact on the Practice in the short-term and the long-term. These factors have been considered in developing the specific company risk rate and long-term growth rate utilized in our valuation analysis.

3 FINANCIAL ANALYSIS

3.1 Financial Review

In determining the value of the Practice as of December 31, 2016, we analyzed its management-prepared income statements for the years ended December 31, 2012 through 2016. The Practice's historical income statements are presented in **Exhibit 1**. We were not furnished with balance sheets. However, management represented that the only meaningful asset of the Practice was a small cash account with a balance of $47,000 as of December 31, 2016. Management represented that the Practice had no liabilities as of the valuation date.

Income Statement Analysis

Practice revenue fluctuated during the years reviewed, ranging from a low of $202,278 (2013) to a high of $466,029 (2014). Management indicated that the fluctuations in practice revenue were primarily attributable to timing differences in billings between the years under review. We learned that the Practice encountered administrative billing issues during 2013, whereby the Practice billed customers in 2014 for services rendered in 2013. However, on average from 2012 through 2016, revenue was $346,878.

From an expense perspective, operating expenses ranged from a low of 29.0% of revenue (2014) to a high of 68.6% of revenue (2012). Management indicated that this fluctuation was primarily attributable to timing differences of when expenses were recorded each year. Although it should be noted that as a percentage of revenue from 2013 through 2015, expenses remained relatively consistent from a total amount and percentage of revenue standpoint (ranging from 29.0% to 37.7% during the 2013 to 2015 time period). In 2016, operating expenses increased again to 63.8% of revenue. In addition, based on discussions with management, we recorded normalization adjustments to the historical financial results as further discussed in **Section 3.3** of this Report and reflected in **Exhibit 3**.

No physician compensation was recorded by the Practice over the historical years analyzed. Because Dr. Dwyer reports his Practice income on Schedule C of his personal tax return (Form 1040), no compensation is recorded in the Practice's books. Therefore, we recorded an adjustment to the historical financial results to account for a normalized physician compensation, which is discussed in **Section 3.3** of this Report.

Historical net income fluctuated from a low of $83,772 (2016) to a high of $330,718 (2014) over the years examined. On a percentage of revenue basis, net income ranged from a low of 25.0% (2012) to a high of 71.0% (2014).

Balance Sheet Analysis

While we were furnished with a balance sheet as of December 31, 2016, we did not perform any financial analysis on it for the following reasons. First, a meaningful portion of the assets and liabilities on the balance sheet are personal in nature (e.g. bank accounts, investments, and loans). Second, it is our understanding that MCS does not intend to acquire any of the tangible assets of the Practice nor assume any of its liabilities. Therefore, it was determined that any analysis of the Practice's balance sheet (the balances of which are negligible) would not be useful in determining the value of the Practice.

Financial Review Conclusion

Overall, the Practice's revenue averaged approximately $347,000 per year over the five-year period reviewed. In addition, before taking into consideration any physician compensation, the Practice was profitable over the years examined, with 2013 through 2015 showing the most profitability. Similarly, based on the timing of when certain expenses were recorded (as further discussed in **Section 3.3** and presented in **Exhibit 3**), operating expenses fluctuated significantly over the years examined. Although it should be noted that certain normalizing adjustments were recorded in **Exhibit 3** to account for any one-time, non-recurring expenses incurred by the Practice. We have factored these financial implications into our calculation of specific company risk in our discount rate analysis in **Section 4.1**.

3.2 Ratio Analysis

In **Exhibit 2**, the Practice's historical results were compared to those of other companies in its industry. For this analysis, we analyzed data from RMA Annual Statement Studies for the following NAICS code:

621111 – Offices of Physicians, except Mental Health Specialists

We then compared certain industry ratios for this NAICS code to the historical results of the Practice to determine its performance relative to its competitors.

Because of the reasons noted in **Section 3.1**, we did not evaluate industry balance sheet metrics relative to the Practice.

From a profitability standpoint, the Practice generated normalized pre-tax profits below that of the industry medians on a historical basis for all years except one (2014).

Our consideration of these industry factors are addressed further in the determination of the Practice's specific company risk in **Section 4.1** of this Report.

3.3 Normalized Financial Statements

Performing a thorough analysis of the historical financial statements of a business is a prerequisite to performing a meaningful valuation. A company should be analyzed in comparison with its industry peers, as well as to itself, at different points in time. This analysis, which was performed in **Sections 3.1 and 3.2** of this Report, is an integral part of establishing any trends or relationships that may affect the conclusion of value. In addition, the valuator must search for normalizing adjustments to be made to the historical financial information in order to reflect the true economic financial position and results of operations of the business being valued. The adjustments are necessary to remove the effect of certain standard accounting principles that may contradict or imperfectly reflect economic reality, or, to eliminate any discretionary, non-essential or non-recurring expenditures that may distort the normal results of operations or financial position of the Practice as of the valuation date. It is by performing this normalizing process that the analyst can more accurately determine the fair market value of the business.

Income Statements

Based on our analysis, valuation procedures, and discussions with MCS management and the Practice's representatives, the following normalizing adjustments, summarized in **Exhibit 3**, were made to the historical income statements:

Physician Compensation – Based on discussions with MCS management and review of relevant physician compensation data published by the Medical Group Management Association ("MGMA"), a normalizing adjustment was made to physician compensation in each of the years examined. We considered two different data points in calculating the level of reasonable physician compensation.

Our first approach is based on the expected level of compensation that MCS will incur to service the Practice's patient group upon completion of the acquisition. In that regard, it was determined that MCS would expect to pay $205,000 plus benefits to service patients at the current time. We used $225,500 ($205,000 base salary plus benefits which were estimated to be 10% of base salary) as the starting point for reasonable compensation in 2016. This figure was reduced from 2015 to 2012 to reflect cost of living adjustments, resulting in reasonable compensation (inclusive of benefits) of $220,000 (2015), $214,500 (2014), $209,000 (2013) and $203,500 (2012), respectively.

Second, we computed reasonable compensation using the median compensation to collections ratio for each year for nephrology practices as published by MGMA. As shown, this ratio ranged from 0.72 (2012) to 0.82 (2016) during the period examined.

Based on the foregoing analysis and as shown in **Exhibit 4**, we determined normalized physician compensation in each year using a weighting technique. The first approach was given a weighting of two due to the fact that it used the likely level of compensation that MCS will incur after the purchase transaction is completed. The second approach, however, was also given consideration (a weighting of one) as it is reflective of the market for nephrologists.

Accounting Fees – A normalizing adjustment was made to adjust the historical accounting fee expense incurred by the Practice. Management expects to incur approximately $5,000 in accounting fees going forward. Therefore, the historical accounting fee expenses were adjusted to $5,000 per year.

Bank Service Charges – A normalizing adjustment was made to adjust the 2012 through 2014 historical bank service fee expense incurred by the Practice. The 2012 through 2016 historical amounts were normalized to the average of the 2015 and 2016 expense amounts ($845), as management indicated that this is a reasonable amount of bank services fees expected to be incurred going forward.

Billing Service – A normalizing adjustment was made to adjust the historical billing service expense incurred by the Practice in 2015. The 2015 expense amount was normalized to 4.0% of revenue, which is the average billing service expense level for the years 2012 through 2014 and 2016 as a percentage of revenue.

Computer Repairs – A normalizing adjustment was made to adjust the historical amount of computer repairs incurred by the Practice. Management indicated that the practice incurred a one-time expense in 2014 related to electronic medical records. Therefore, the 2014 expense was normalized to 0.25% of practice revenue, consistent with the 2015 and 2016 expense levels and management's expectation for computer repair expense to be incurred going forward.

Contract Labor – A normalizing adjustment was made to adjust the 2012 historical contract labor expense incurred by the Practice for a non-recurring expenses. The 2012

expense level was normalized to $3,300, consistent with the average expense from 2013 through 2016.

Life Insurance – A normalizing adjustment was made to adjust the historical life insurance expenses incurred by the Practice, which are considered discretionary in nature.

Legal Fees – A normalizing adjustment was made to add back non-recurring legal fees.

Interest Expense – A normalizing adjustment was made to add back discretionary interest expense incurred by the Practice for a personal loan held by the Dr. Dwyer. It was assumed that the Practice could operate at a debt-free level going forward without having an adverse impact on operations.

Malpractice Insurance – A normalizing adjustment was made to adjust the historical malpractice insurance expense incurred by the Practice. Management indicated that the practice prepaid the 2013 malpractice insurance in 2012. Therefore, a normalizing adjustment was made in both 2012 and 2013 to allocate the 2012 prepaid expense amount into 2013.

Donations – A normalizing adjustment was made to add back discretionary donations incurred by the Practice.

Miscellaneous – A normalizing adjustment was made to add back non-recurring miscellaneous expenses incurred by the Practice.

Medical Supplies – A normalizing adjustment was made to adjust all years' medical supplies expenses to the four-year average expense level of $1,730.

Property Tax – A normalizing adjustment was made to add back non-business property taxes paid by the Practice.

Cuyahoga Tax – A normalizing adjustment was made to add back non-business taxes paid by the Practice.

Auto Expense – A normalizing adjustment was made to add back non-business related auto expenses.

Credit Card – A normalizing adjustment was made to add back discretionary credit card charges.

Based upon our analysis, valuation procedures and discussions with MCS management and the Practice's representatives, no other normalizing adjustments for non-recurring, extraordinary or unusual items or expenses were identified.

Following these normalizing adjustments, we arrive at normalized pre-tax income margins ranging from (27.9%) to 25.7%. Because we are valuing a controlling interest, the normalized benefit streams shown in **Exhibit 3** include certain control-based adjustments (e.g., physician compensation). Therefore, the normalized income statements reflect a controlling benefit stream that would be available to a controlling owner.

4 BUSINESS VALUATION ANALYSIS

4.1 Capitalization of Cash Flow Method

The method of valuation we used in reaching our conclusion of the fair market value of the Practice's equity is the capitalization of cash flow method, which is an income-based approach to valuation. The capitalization of cash flow method values a business based on an expected cash flow stream, capitalized by a risk-adjusted rate of return. A single-period capitalization approach is most appropriate when a company's current or historical level of operations is believed to be representative of future operations and is expected to grow at a relatively stable and modest rate. It is expected that future revenues, earnings and cash flows will be consistent with the Practice's most recent historical results, so the application of this valuation methodology is appropriate. Based on this analysis, there is sufficient evidence to suggest that the Practice's historical operations provide a reliable indication of how it will operate in the future.

The steps taken in applying the capitalization of cash flow method include determining a sustainable earnings base (i.e., benefit stream), making the necessary adjustments to convert projected earnings into projected cash flow, developing an appropriate rate of capitalization, and applying the capitalization rate to the cash flow base to arrive at a conclusion of the fair market value of Practice's equity.

Benefit Stream

As discussed earlier in this Report, given the nature of the Practice's operations as of the valuation date, analysis of the historical financial statements, research of the trends and characteristics of the Practice's industry, and discussions with MCS management and the Practice's representatives concerning the Practice's future operating performance, it was determined that the Practice's historical operations offer a reliable indication of how it can be expected to operate in the future. Since the most recent years' activity is considered most reflective of future operating performance, particularly in terms of revenue and physician compensation, the most recent years were given the most weight in our analysis.

Our analysis led us to conclude that the Practice's weighted-average, normalized after-tax net income was $16,000 (rounded) as shown in **Exhibit 5**. Because we are valuing a controlling interest in the Practice, the benefit stream includes certain control-based normalizing adjustments such as physician compensation and other discretionary items. This means that the benefit is controlling in nature and reflects the cash flows that would be available to a controlling investor. The Practice's weighted-average, normalized after-tax net income was based on the results for 2012 through 2016. Our analysis in this regard is presented in **Exhibit 5**.

Calculation of Distributable Cash Flow

Calculation of a single-period cash flow benefit stream requires certain adjustments to a company's projected after-tax net income for depreciation and amortization, capital expenditure requirements, changes in net working capital, and changes in long-term debt. We did not adjust the benefit stream for changes in depreciation or capital expenditures as the Practice does not have any significant fixed assets and management does not expect to invest in fixed assets in the near term. Based on our discussions with management, it was determined that the Practice would not need any capital expenditures to fuel continuing operations. Similarly, we did not adjust for working capital as the Practice has historically operated on a cash basis and does not carry working capital on its books. Finally, we did not adjust the benefit stream for changes in long-term debt because the Practice currently carries no debt and has no intention to take out any debt to support operations. As a result of the above analysis, we arrive at a sustainable, distributable annual cash flow of $16,480 (**Exhibit 6**).

Capitalization Rate

Capitalization rates vary among particular sizes and types of businesses from one period of time to another. Providers of capital require returns that will compensate them for the time value of money, plus the inherent risk in the specific investment being made. The capitalization rate reflects the total rate of return that would be expected by a reasonable investor given the nature, size and risks inherent in the underlying investment.

In calculating the appropriate capitalization rate for the Practice, we utilized a build-up method. This method begins with a theoretical risk-free rate of return and then incorporates amounts to account for the risk of investing in a small closely held entity. The capitalization rate is further adjusted for characteristics that are specific to the company being valued, as well as its expected growth. The capitalization rate build-up is presented in **Exhibit 7**.

Risk-Free Rate – Since an investment in a closely-held entity is generally a long-term investment, the risk-free rate must be expected to exist over a long-term investment horizon. Treasury rates incorporate a premium for the risk of holding the security over the long-term. In our valuation, we used the 20-year Treasury bond yield, which at December 31, 2016 was 2.79%.

Equity Risk and Size Premium – The next step in the build-up process was to incorporate an equity risk and size premium, which serves to value the additional return required by an average investor investing in a higher risk security (than a 20-year treasury bond), such as the stock of a public or closely-held company.

A widely utilized study in developing equity risk premiums is the *2017 Duff & Phelps Valuation Handbook*. The study includes the long-term expected equity risk premium as well as additional premiums related to size (based on market capitalization).

The long-term supply-side expected equity risk premium as stated in *2017 Duff & Phelps Valuation Handbook* is 5.97%.

Since the equity risk premium includes the general equity risk premium associated with the entire equity market, we must consider adding an additional premium associated with the Practice's size relative to the market as a whole. Based on the *2017 Duff & Phelps Valuation Handbook* size premium data, the Practice falls into the 10th decile. Therefore, we also added the 10th decile size premium of 5.59% in our build-up

summation method to reflect the size premium associated with investing in a company the size of the Practice.

Industry Risk Premium – The *2017 Duff & Phelps Valuation Handbook* also provides information on the risk premiums associated with various industries. The industry most applicable to the Company is Health Services (SIC 80XX). Based on the industry risk adjustment indicated by the *2017 Duff & Phelps Valuation Handbook*, we applied a 0.71% industry risk adjustment to account for the risk associated with the Practice's industry compared to the market as a whole.

Specific Company Adjustments – After arriving at our equity risk and size premium, other risk factors must be evaluated for adjustments to the capitalization rate to account for risks specific to the Practice, as opposed to risks in the equity market in general. These other risk factors can include the industry in which the Practice operates, its financial risk and other operational and management characteristics.

In the case of the Practice, a specific company adjustment was considered for the following factors: economic and industry risk, financial risk, operational characteristics, key employee risk and the size of the Practice relative to the companies that were analyzed in the Duff & Phelps study.

Economic

As stated in **Section 2.3** of this Report, the fourth quarter economic results showed slower growth, but long-term growth prospects are stable. Improvement in the job market and stock market, particularly in the healthcare sector indicate an improving economy as it relates the Practice. Overall, the economic environment was determined to have a positive impact on specific company risk.

The economic factors impacting the Practice, when examined as a whole, translate to a slight increase to specific company risk.

Financial Risk

As discussed in **Section 3.1** of this Report, the Practice's sales and net income history has been relatively stable. Normalized earnings have fluctuated throughout the four-year period reviewed with no discernable trend. Revenues and earnings are a function entirely of Dr. Dwyer's efforts and hours devoted to the Practice, which are expected to decrease as he approaches retirement. Thus, the level of the Practice's financial risk translates to an increase in specific company risk.

Key Man Risk

The Practice is operated entirely by Dr. Dwyer and the success of the Practice hinges on his ability to continue to serve patients and generate revenue. As evidenced by stable normalized revenues, Dr. Dwyer has a consistent base of patients from which additional physicians could build if they joined the Practice. Nonetheless, there is significant risk associated with Dr. Dwyer being the only person responsible for and capable of continuing to operate the business as a going concern. Thus, the level of the Practice's key man risk translates to an increase in specific company risk.

Size

The Duff & Phelps study indicates that size and risk are inversely related. Because the Practice is significantly smaller than the smallest companies included in the Duff & Phelps study, an increase to company specific risk for this factor was also considered.

Specific Company Risk Conclusion

Based the analysis above, we concluded that an increase to Practice's required cost of equity of 11.0% was appropriate to account for its specific company risk.

Based on the build-up summation method, the required cost of equity was determined to be 25.0%, as detailed in **Exhibit 7**.

Growth Rate

Capitalizing is a process applied to an amount representing some measure of income for a single period. However, the overall theory in determining value incorporates a present value calculation of the earnings stream for the years going forward. Our build-up analysis up to this point has generated a discount rate of return. Accordingly, it is necessary to account for the single period estimate of the benefit stream in such a way as to be reflective and inclusive of all periods going forward, which is accomplished through a growth rate adjustment. If growth is anticipated for the single-period benefit stream that is being capitalized, the discount rate should be reduced by subtracting out the growth rate. As Shannon Pratt posits in his book *Valuing A Business - The Analysis and Appraisal of Closely Held Companies*, "for an investment with a perpetual life, the difference between the discount rate and capitalization rate is the annually compounded percentage rate of growth or decline in perpetuity in the economic income variable being discounted or capitalized."

In determining the growth rate for the practice, we considered the industry growth expectations of 6%, projected inflation of 2%, projected GDP growth of approximately 2% to 3%, and the Practice's revenue CAGR from 2012 through 2016 (-8.1%). While these growth rates suggest a wide range (-8.1% to 7%), each of the relevant data points were considered indicative of the Practice's future growth prospects. As such, we concluded that the appropriate long-term growth rate for the Practice is 3.0%.

After adjusting the discount rate for Practice's long-term projected growth, the capitalization rate was determined to be 22.0%, as presented in **Exhibit 7**.

Capitalization of Cash Flow Value

By dividing the after-tax distributable cash flow projected for the following year by the capitalization rate of 22.0%, as well as making a mid-period adjustment to take into account the fact that the projected cash flows are expected to be earned relatively evenly throughout the year, the value of the Practice's equity was determined to be $84,000 prior to the consideration of cash. We have been asked to determine the value of the Practice before the consideration of cash and therefore we made no additional adjustment for this item. It was determined that the controlling, marketable value of the Practice's equity (excluding cash) was $84,000, as presented in **Exhibit 6**.

Capitalization of Cash Flow Value Conclusion

Based on our analysis, the fair market value of the Practice's equity (excluding cash) on a controlling, marketable basis based on the capitalization of cash flow method is $84,000 as of December 31, 2016, as detailed in **Exhibit 6** to this Report.

4.2 Valuation Methods Considered But Not Used

Performing a proper valuation of any company requires the valuator to consider all of the available approaches when determining a value. The three types of approaches in valuing a company include the asset approach, income approach and market approach. Within each approach, there are several commonly accepted methods used to value companies. While the following methods are required to be considered in valuing the Practice, each method had limitations in its application in determining the proper value of its equity.

Adjusted Net Asset Method

The adjusted net asset method is an asset-based approach to valuation. This method is used to value a business on the basis of the difference between the fair market value of a company's assets and its liabilities. Under this method, the assets are adjusted from their book value to their fair market value, and the total adjusted assets are then reduced by recorded and unrecorded liabilities. Tangible, as well as intangible, assets are valued in determining the total adjusted net assets.

This methodology is appropriate in the case of a holding company or a capital-intensive company, when losses are continually generated, or when valuation methodologies based on a company's net income or cash flow levels indicate a value lower than its net asset value. The Practice, however, is not a holding company and it has generated profits on a normalized basis in three of the last four years. Furthermore, while we did not assemble a normalized balance sheet, it is our understanding that the Practice does not hold any meaningful assets or liabilities. Furthermore, the proposed structure of the potential transaction would not include the acquisition of any assets or the assumption of any liabilities on the part of the buyer. Therefore, we have not utilized this methodology in determining the value of the Practice.

Capitalization of Excess Earnings Method

The capitalization of excess earnings method is an income and asset-based approach to valuation where the adjusted tangible and intangible assets of a business are valued independently. These component assets are then combined to determine the total fair market value of the business. The adjusted net tangible assets are comprised of the fair market value of the total tangible assets of the business less the total liabilities as of the valuation date. The intangible assets are valued by capitalizing the excess earnings of the business, where the excess earnings represent the earnings of the business in excess of the level that would provide a reasonable rate of return on the business' net tangible assets, as determined by industry standards.

There are inherent limitations in utilizing the capitalization of excess earnings method in valuing any type of business. One such limitation is the fact that there is no literature indicating what level of earnings should be utilized in determining a base level of earnings to which the comparison would be made in determining "excess earnings". Additionally, there is no readily observable market rate of return directly applicable to many tangible assets and, therefore, determining "excess earnings" is a highly subjective calculation. As stated in

Revenue Ruling 68-609, this methodology should only be utilized when no other method is appropriate. Based on the discussion above, we have not utilized this methodology in determining the value of the Practice.

Discounted Cash Flow Method

The discounted cash flow method is an income-based approach to valuation that is based upon the theory that the total value of a business is the present value of its projected future benefits, plus the present value of its terminal value. The terminal value does not assume the actual termination or liquidation of the business, but rather represents the point in time when the earnings level off or flatten (assumed to level off into perpetuity). The amounts for the projected earnings and the terminal value are discounted to the valuation date using an appropriate discount rate, which encompasses the risks specific to investing in a small equity interest, as well as to investing in the specific company being valued. Inherent in this method is the incorporation of forecasts or projections of the future operating results of the Practice. Projections were not available, however, and based on discussions with MCS management and the Practice's representatives, the Practice's recent historical results were a reliable indicator of its future operating prospects. Based on this information, coupled with the fact that the capitalization of cash flow method was utilized to value the Practice, we did not use the discounted cash flow method in determining its fair market value as of December 31, 2016.

Guideline Transaction Method

The guideline transaction method values a business based on pricing multiples derived from the sale of companies that are similar to the subject company. The steps taken in using the guideline transaction method include finding transactions involving the purchase of comparable companies, selecting the transactions that closely mirror the company's operations and which occurred in similar industry and economic conditions, and finally, applying the indicated pricing multiples from the representative transactions.

We used Pratt's Stats (a widely-utilized private company transaction database) to search for guideline transactions using the SIC Codes for Medical Practices (8011) and Dialysis Centers (8092). While we were able to find 38 transactions in the last 5 years in SIC 8011 (we did not find any transactions in the last 5 years in SIC 8092), we do not believe use of these transactions is appropriate in valuing the Practice. We were not able to identify any nephrology practices in this group of 38 transactions. Furthermore, the physician practice industry is very fragmented geographically, so it is imperative that use of guideline transactions in similar regions be used when applying this method. The group of 38 transactions occurred in a number of states, further limiting the comparability and reliability of applying this method in valuing the Practice. Therefore, we did not utilize the private company transaction method in determining the value of the Practice.

Guideline Public Company Method

The guideline public company method values a business based on trading multiples derived from publicly traded companies that are similar to the subject company. The steps taken in using the guideline public company method include identifying comparable public companies, eliminating potential comparables that have thinly-traded stock that does not trade on major exchanges (NYSE, NASDAQ, AMEX) because the trading prices may be speculative rather than reflective of fair market value, and applying the adjusted pricing multiples from the representative companies.

We performed a search for guideline companies using the SIC Code for Offices and clinics of Doctors of Medicine (8011) and Dialysis Centers (8092), resulting in only two comparable public companies that are currently traded on major domestic exchanges. Furthermore, two is not a large enough sample to use for valuation purposes. Therefore, we did not utilize the guideline public company method in determining the value of the Practice.

Recent Transactions

We were not made aware of any transactions involving the Practice's shares that would provide an indication of its fair market value.

5 NATURE OF THE UNDERLYING SECURITY

Before a final conclusion of value can be rendered for the Practice, the nature of the security being valued must be considered. The value of a security is influenced by many of its characteristics, including marketability and control.

5.1 Control (Minority Interest)

As noted in **Section 1.3**, the standard of value in this case is fair market value. Fair market value is defined in The International Glossary of Business Valuation Terms issued by the American Institute of Certified Public Accountants (AICPA), the American Society of Appraisers, the Canadian Institute of Chartered Business Valuators, the National Association of Certified Valuators and Analysts and the Institute of Business Appraisers as:

> "The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."

Alternatively, for purposes of compliance with the Stark law, fair market value is defined as:

> "the value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring as the result of bona fide bargaining between well-informed buyer and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with the comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals." [42 C.F.R. § 411.351]

The methodology employed in arriving at our conclusion of value (capitalization of cash flow) produced a controlling level of value. In the case of the capitalization of cash flow method, a controlling level benefit stream was capitalized in arriving at fair market value. As such, no further adjustment was necessary to the value determined under the capitalization of cash flow method to arrive at a level of value consistent with fair market value.

5.2 Marketability

As noted throughout this Report, we have been engaged to determine the fair market value of the Practice. Therefore, an adjustment to convert the value from a marketable to a non-marketable value was necessary. The following discussion provides the basis for this adjustment.

There are certain marketability differences between an interest in the Practice and an interest in the stock of publicly-traded companies. An owner of publicly-traded securities can know at

all times the market value of his or her holding. He or she can sell that holding on virtually a moment's notice and receive cash, net of brokerage fees, within several working days.

This would not be the case with an interest in the Practice. Consequently, liquidating a position in the Practice would be a more costly, uncertain and time-consuming process than liquidating stock in a publicly-traded entity. An investment in which the owner can achieve liquidity in a timely fashion is worth more than an investment in which the owner cannot liquidate the investment quickly. Privately-held companies sell at a discount that reflects the additional costs, increased uncertainty and longer time commitments associated with liquidating these types of investments.

The data most frequently used to compute lack of marketability adjustments for controlling ownership interests in privately-held entities come from the factors identified in *Bernard Mandelbaum et al. v. Commissioner.*

Mandelbaum Factor Analysis

Financial Statement Analysis – A detailed analysis of the Practice's financial statements was conducted in **Section 3.1**. The Practice has exhibited relatively consistent levels of revenue on average, earnings have been erratic due to non-recurring expenses recorded by the Practice and earnings and a balance sheet consisting entirely of cash as of the valuation date. These factors considered as a whole tend to indicate that a slightly higher lack of marketability adjustment is appropriate.

Company's Dividend/Distribution Policy – The Practice is 100% owned by Dr. Dwyer, who has sole discretion to distribute excess cash flows. Because Dr. Dwyerhas the ability to do this, a decrease to the marketability adjustment is appropriate.

Nature of the Company, the Company's History and Position Within the Industry, and Economic Outlook – These items are addressed in **Sections 2.1 to 2.3** of this Report. The economic environment and the Practice's position in the industry were considered in our analysis of marketability.

Company's Management – As discussed in the capitalization rate analysis in **Section 4.1**, the Practice relies heavily on Dr. Dwyer and his absence would negatively impact the performance of the Practice. Taking this into account, a slightly higher lack of marketability adjustment is appropriate.

Restrictions on Transferability of Stock – There are no material restrictions that would limit an owner's ability to transfer his or her stock in the Practice. Therefore, no adjustment to the applicable lack of marketability adjustment is necessary for this factor.

Amount of Control in Transferred Shares – The ownership interest being valued is a 100% interest. A 100% ownership interest has a lower marketability discount than a non-controlling interest because the 100% owner generally has unilateral ability to sell the company, elect board directors, establish or change business policies or authorize dividends/distributions than would a true minority interest holder.

Holding Period for Stock – While an investment in a closely-held entity is generally a long-term investment, there are plans to sell the Practice. While there are alternatives to selling the Practice (e.g., hiring another physician to take over Dr. Dwyer's practice), the Practice's ongoing discussions with buyers would indicate a shorter holding period than typically observed. This has a downward impact on the marketability discount.

Redemption Policy – To our knowledge, the Practice does not have a stated redemption policy, which indicates that a higher lack of marketability adjustment is appropriate.

Costs Associated with Making a Public Offering – Costs of flotation, or the costs associated with taking a company public, are generally recognized as an accepted approach in estimating the lack of marketability of a controlling ownership interest in a closely held company.

The SEC Cost of Flotation Study, which indicated an average flotation cost of 12.6% (sum of compensation and other expenses) of the total public offering. Specifically, equity values under $0.5 million (similar to the Practice) had an average flotation cost of 19.1%.

SEC Cost of Flotation Study (1974)

Size of Issue ($ Millions)	Number	Compensation (% of Gross Proceeds)	Other Expense (% of Gross Proceeds)	Total Expense (% of Gross Proceeds)
Under 0.5	3	8.2%	10.9%	19.1%
0.5 - 0.99	227	12.5%	8.3%	20.7%
1.0 - 1.99	271	10.6%	5.9%	16.5%
2.0 - 4.99	450	8.2%	3.7%	11.9%
5.0 - 9.99	287	6.7%	2.0%	8.7%
10.0 - 19.99	170	5.5%	1.1%	6.6%
20.0 - 49.99	109	4.4%	0.6%	5.0%
50.0 - 99.99	30	3.9%	0.3%	4.3%
100.0 - 499.99	12	3.0%	0.2%	3.2%
Over 500.0	0	0.0%	0.0%	0.0%
Total/Averages	1,559	8.3%	4.3%	12.6%

A more recent study published by Jay R. Ritter in 1987 indicated that total cash expenses incurred in IPOs were approximately 14% for firm-commitments and 18% for best-efforts. Specifically, equity values of $0.00 - $1.99 million (similar to the Practice) had average flotation costs ranging from 19.6% to 20.2%.

Ritter Study (1987)				
Gross Proceeds ($ Millions)	Number of Offers	Underwriting Discount (%)	Other Expenses (%)	Total Cash Expenses (%)
Firm-Commitment Offers				
0.0 - 1.99	68	9.9%	9.7%	19.6%
2.0 - 3.99	165	9.8%	7.6%	17.4%
4.0 - 5.99	133	9.1%	5.7%	14.8%
6.0 - 9.99	122	8.0%	4.3%	12.3%
10.0 - 120.2	176	7.2%	2.1%	9.3%
All Offers	664	8.7%	5.4%	14.0%
Best-Effort Offers				
0.0 - 1.99	175	10.7%	9.6%	20.2%
2.0 - 3.99	146	10.0%	6.2%	16.2%
4.0 - 5.99	23	9.9%	3.7%	13.6%
6.0 - 9.99	15	9.8%	3.4%	13.2%
10.0 - 120.2	5	8.0%	2.4%	10.4%
All Offers	364	10.3%	7.5%	17.8%

In Christopher Mercer's book "Quantifying Marketability Discounts," he notes that control shares in closely-held companies may be subject to marketability adjustments, but usually not nearly as much as minority shares. Dr. Shannon Pratt has noted that there is a lack of objective data to quantify this, but feels that most would agree that the range of adjustment is 5%-20%, with 10%-15% being the most commonly accepted.

Based on the analysis above, particularly the marketability characteristics associated with the Practice's history of generating positive earnings and operating in an active industry in terms of potential acquisitions, we determined that a discount for lack of marketability toward the lower end of the ranges discussed above is appropriate in determining the value of the Practice. As such, we have applied a 10% discount for lack of marketability under the capitalization of cash flow method.

6 CONCLUSION OF VALUE

A company's value is comprised of the market assessment of the predominant factors of value. The influence of each factor may vary among particular companies, or for the same company, from year-to-year.

The value of the Practice's equity (excluding cash) prior to any discounts under the capitalization of cash flow was determined to be $84,000 as reflected in **Exhibit 8**. After the application of a 10% discount for lack of marketability, we have concluded that the value of the Practice's equity (excluding cash) on a controlling, non-marketable basis as of December 31, 2016 is ***$76,000***.

7 REVENUE RULING 59-60

The final authoritative source of guidance that must be considered in performing a business valuation is Revenue Ruling 59-60. The factors discussed below are the components included within the Ruling that must be considered when rendering a conclusion of value. While the following discussion may be somewhat repetitive with previous sections, the importance of the components of Revenue Ruling 59-60 necessitates such discussion.

The concluded value of the Practice was determined after a detailed consideration of the following factors:

7.1 The Nature and History of the Business

A detailed description of the nature and history of the Practice was included in **Section 2.1** of this Report.

7.2 Economic Outlook

This factor has been described in great detail in **Section 2.3** of this Report and was considered in arriving at our conclusion of value.

7.3 The Book Value of the Stock and the Entity's Current Financial Condition

We were not furnished with historical balance sheets of the Practice. Furthermore, for the purposes of this valuation, we were asked to assume that the assets and liabilities of the Practice would not be exchanged in the proposed transaction. We understand that the Practice carries a small cash account and holds no debt, which was discussed in this Report.

7.4 Future Earnings Capacity

This factor involves analyzing potential future earnings, as well as current and historical earnings, and takes into consideration the nature of the business and its corresponding risks. The future earnings of the Practice were determined to be best represented by its historical earnings results. Historical earnings were utilized in developing our capitalization of cash flow method, as discussed in **Section 4.1** of this Report.

7.5 Dividend-Paying Capacity

Our analysis of the Practice considered the impact of dividend/distribution-paying capacity and its history of distributing its operating earnings to its owner-physician through salary and other benefits.

7.6 Marketability and Size of the Interest Being Valued

When assessing the value of a closely-held stock, the size of the interest being valued and the marketability of the stock are important factors in the valuation process. As noted throughout the Report, the standard of value (fair market value) required us to consider the lack of marketability associated with an ownership interest in the Practice.

7.7 The Value of Comparable Publicly-Traded Stocks

We analyzed comparable publicly-traded companies in our consideration of the guideline public company method as discussed in **Section 4.2** of this Report.

7.8 Goodwill and the Existence of Other Intangible Assets

In the case of the Practice, any goodwill that exists is present in its earnings. Therefore, it is appropriate to focus on the earnings of the Practice to determine the value of any goodwill that it may have. In utilizing the capitalization of cash flow method, proper consideration has been given to the existence of goodwill or other intangible assets.

8 CONCLUSION

We have performed a valuation engagement, as that term is defined in SSVS, of a 100% controlling, non-marketable ownership interest in Dr. Philip Dwyer, MD as of December 31, 2016 on a controlling, non-marketable basis. The resulting estimate of value is to be used only in connection the previously stated purpose and should not be used for any other purpose or by any other party for any purpose.

The valuation engagement was performed in accordance with SSVS and NACVA standards. The estimate of value that results from a valuation engagement is expressed as a conclusion of value. Other than those specifically mentioned previously in this Report and/or in the attached appendices, there were no restrictions or limitations in the scope of our work or data available for analysis.

This conclusion is subject to the statement of Assumptions and Limiting Conditions in **Appendix A** and the Valuation Analyst's Representation/Certification found in **Appendix C**. We have no obligation, but reserve the right, to update this Report or our conclusion of value for information that comes to our attention after the date of this Report.

On the basis of the foregoing, our conclusion of the fair market value of a 100% controlling, non-marketable ownership interest in Dr. Philip Dwyer, MD (excluding cash) as of December 31, 2016 is ***$76,000*** (rounded), as detailed in **Exhibit 8**.

EXHIBIT 1
DR. PHILIP DWYER, MD
SUMMARY OF HISTORICAL INCOME STATEMENTS
VALUATION DATE - DECEMBER 31, 2016

	12/31/2012		12/31/2013		12/31/2014		12/31/2015		12/31/2016	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Practice Revenues	$ 394,929	100.0%	$ 202,278	100.0%	$ 466,029	100.0%	$ 389,059	100.0%	$ 282,093	100.0%
Operating Expenses										
Accounting Fees	30,570	7.7%	-	- %	-	- %	2,000	0.5%	5,000	1.8%
Auto Expense	-	- %	-	- %	-	- %	-	- %	1,677	0.6%
Bank Service Charges	1,787	0.5%	-	- %	4,387	0.9%	703	0.2%	986	0.3%
Billing Service	13,813	3.5%	10,097	5.0%	10,527	2.3%	5,406	1.4%	14,759	5.2%
Building Repairs	1,109	0.3%	-	- %	-	- %	-	- %	-	0.0%
Computer Repairs	200	0.1%	135	0.1%	4,065	0.9%	650	0.2%	950	0.3%
Contract Labor	68,369	17.3%	2,237	1.1%	3,759	0.8%	3,887	1.0%	3,173	1.1%
Credit Card	-	- %	-	- %	-	- %	-	- %	4,268	1.5%
Donations	3,950	1.0%	3,750	1.9%	4,150	0.9%	4,084	1.0%	2,384	0.8%
Dues and Subscriptions	2,669	0.7%	5,029	2.4%	1,804	0.3%	6,507	1.6%	4,709	1.7%
Health Insurance	19,068	4.8%	3,623	1.8%	7,374	1.6%	7,222	1.9%	6,695	2.4%
Legal Fees	16,045	4.1%	13,000	6.4%	-	- %	5,468	1.4%	7,727	2.7%
Licenses and Permits	-	- %	-	- %	-	- %	731	0.2%	-	0.0%
Life Insurance	3,586	0.9%	-	- %	17,349	3.7%	14,421	3.7%	34,920	12.4%
Interest Expense	4,706	1.2%	-	- %	26,534	5.7%	24,323	6.3%	29,317	10.4%
Malpractice Insurance	32,154	8.1%	-	- %	15,195	3.3%	15,195	3.9%	15,195	5.4%
Meals	-	- %	200	0.1%	-	- %	996	0.3%	100	0.0%
Medical Supplies	3,675	0.9%	-	- %	2,659	0.6%	579	0.1%	-	0.0%
Miscellaneous Expenses	425	0.1%	-	- %	1,485	0.3%	946	0.2%	8,530	3.0%
Office Supplies	1,535	0.4%	328	0.2%	2,400	0.5%	1,235	0.3%	1,261	0.4%
Other Taxes	458	0.1%	150	0.1%	272	0.1%	272	0.1%	4,255	1.5%
Property Tax	13,917	3.5%	12,228	6.0%	-	- %	-	- %	-	0.0%
Cuyahoga Tax	23,023	5.8%	-	- %	-	- %	-	- %	-	0.0%
Professional Development	795	0.2%	-	- %	3,000	0.6%	-	- %	919	0.3%
Rent	18,628	4.7%	18,745	9.3%	17,187	3.7%	17,140	4.4%	18,140	6.4%
Telephone	10,505	2.7%	6,687	3.3%	13,164	2.8%	13,923	3.6%	15,770	5.6%
	270,987	68.6%	76,209	37.7%	135,311	29.0%	125,688	32.3%	180,735	63.8%
Income before Physician Compensation	123,942	31.4%	126,069	62.3%	330,718	71.0%	263,371	67.7%	101,358	36.2%
Physician Compensation	-	- %	-	- %	-	- %	-	- %	-	- %
Pre-Tax Net Income	123,942	31.4%	126,069	62.3%	330,718	71.0%	263,371	67.7%	101,358	36.2%
Income Taxes	25,296	6.4%	-	- %	-	- %	-	- %	17,586	6.2%
Net Income	$ 98,646	25.0%	$ 126,069	62.3%	$ 330,718	71.0%	$ 263,371	67.7%	$ 83,772	36.2%
EBITDA Calculation										
Pre-Tax Net Income	$ 123,942	31.4%	$ 126,069	62.3%	$ 330,718	71.0%	$ 263,371	67.7%	$ 83,772	36.2%
Interest Expense	4,706	1.2%	-	- %	26,534	5.7%	24,323	6.3%	29,317	10.4%
Depreciation	-	- %	-	- %	-	- %	-	- %	-	- %
EBITDA	$ 128,648	32.6%	$ 126,069	62.3%	$ 357,252	76.7%	$ 287,694	74.0%	$ 113,089	46.6%

Sources:
2012 through 2016 internal financial statements (Quickbooks)

EXHIBIT 2
DR. PHILIP DWYER, MD
RATIO ANALYSIS
VALUATION DATE - DECEMBER 31, 2016

	12/31/12	12/31/13	12/31/14	12/31/15	12/31/16
Profitability Ratios					
Pre-Tax Return on Revenues					
Practice - Normalized [1]	**17.1%**	**(27.9%)**	**25.7%**	**11.6%**	**(19.5%)**
Industry - 621111 (Offices of Physicians, except Mental Health Specialists)	12.1%	11.9%	12.7%	12.5%	11.9%

Growth Rates						
						CAGR **[2]**
Revenue Growth	n/a	(48.8%)	130.4%	(16.5%)	(27.5%)	(8.1%)
Normalized Pre-Tax Income Growth	n/a	(182.9%)	313.2%	(62.4%)	(221.8%)	n/m

Note: The industry ratios were taken from RMA Annual Statement Studies from 2012-2016.

Footnotes:

[1] The historical results in **Exhibit 1** were on a pre-physician compensation basis. Therefore, we used normalized pre-tax return on revenues when comparing to the industry ratios since it takes into consideration a fair market value physician compensation.

[2] Compound annual growth rate from 2012-2016.

EXHIBIT 3
DR. PHILIP DWYER, MD
NORMALIZED BENEFIT STREAM SUMMARY
VALUATION DATE - DECEMBER 31, 2016

	12/31/2012		12/31/2013		12/31/2014		12/31/2015		12/31/2016	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Reported Revenue	$ 394,929	100.0%	$ 202,278	100.0%	$ 466,029	100.0%	$ 389,059	100.0%	$ 282,093	72.5%
Historical Pre-tax Net Income	123,942	31.4%	126,069	62.3%	330,718	71.0%	263,371	67.7%	83,772	29.7%
Normalizing adjustments:										
1 Physician compensation	(230,450)	(58.4%)	(188,554)	(93.2%)	(262,614)	(56.4%)	(253,009)	(65.0%)	(227,439)	(80.6%)
2 Accounting Fees	25,570	6.5%	(5,000)	(2.5%)	(5,000)	(1.1%)	(3,000)	(0.8%)	-	- %
3 Bank Service Charges	943	0.2%	(845)	(0.4%)	3,543	0.8%	(142)	- %	142	0.1%
4 Billing Service	-	- %	-	- %	-	- %	(10,156)	(2.6%)	-	- %
5 Computer Repairs	-	- %	-	- %	2,900	0.6%	-	- %	-	- %
6 Contract Labor	65,069	16.5%	-	- %	-	- %	-	- %	-	- %
7 Life Insurance	3,586	0.9%	-	- %	17,349	3.7%	14,421	3.7%	34,920	12.4%
8 Legal Fees	16,045	4.1%	13,000	6.4%	-	0.0%	5,468	1.4%	7,727	2.7%
9 Interest Expense	4,706	1.2%	-	- %	26,534	5.7%	24,323	6.3%	29,317	10.4%
10 Malpractice Insurance	15,195	3.8%	(15,195)	(7.5%)	-	- %	-	- %	-	- %
11 Donations	3,950	1.0%	3,750	1.9%	4,150	0.9%	4,084	1.0%	-	- %
12 Miscellaneous Expenses	425	0.1%	-	- %	1,485	0.3%	946	0.2%	8,095	2.9%
13 Medical Supplies	1,945	0.5%	(1,730)	(0.9%)	929	0.2%	(1,151)	(0.3%)	(1,730)	(0.6%)
14 Property Tax	13,917	3.5%	12,228	6.0%	-	- %	-	- %	-	- %
15 Cuyahoga Tax	23,023	5.8%	-	- %	-	- %	-	- %	4,255	1.5%
16 Auto Expense	-	- %	-	- %	-	- %	-	- %	1,677	0.6%
17 Credit Card	-	- %	-	- %	-	- %	-	- %	4,268	1.5%
Normalized Pre-Tax Net Income (Loss)	67,866	17.1%	(56,277)	(27.9%)	119,993	25.7%	45,155	11.6%	(54,996)	(19.5%)
Less: Income Tax Expense (35%) **[1]**	(23,753)	(6.0%)	19,697	9.7%	(41,998)	(9.0%)	(15,804)	(4.1%)	19,249	6.8%
Normalized After-Tax Net Income (Loss)	**$ 44,113**	**11.1%**	**$ (36,580)**	**(18.2%)**	**$ 77,995**	**16.7%**	**$ 29,351**	**7.5%**	**$ (35,747)**	**(12.7%)**

Footnotes:

[1] 35% effective income tax rate was used to reflect Federal, state and local income tax liability.

Normalizing Adjustments:

1 Based on analysis in **Exhibit 4**.

2 To normalize earnings for variations in accounting fees. Management expects to incur approximately $5,000 in accounting fees going forward. Therefore, the historical expense were adjusted to $5,000.

3 To normalize earnings for fluctuations in bank service fees. The 2012 - 2016 historical amounts were normalized to the average of the 2015 and 2016 expense amounts ($845), as management indicated that this is a reasonable amount of bank services fees expected to be incurred going forward.

4 To normalize earnings for a decline in billing service fees in 2015. The 2015 expense amount was normalized to 4.0% of revenue, which is the average expense level for the years 2012 through 2014 and 2016 as a percentage of revenue.

5 To normalize earnings for computer repairs. Management indicated that the practice incurred a one-time expense in 2014 related to electronic medical records. Therefore, the 2014 expense was normalized to 0.25% of revenue, consistent with the 2015 and 2016 expense levels (as a percentage of revenue) and management's expectation for computer repair expense to be incurred going forward.

6 To normalize earnings for non-recurring contract labor expenses in 2012. The 2012 expense level was normalized to $3,300, consistent with the average expense from 2013 through 2016.

7 To add-back officer life insurance expense, which is discretionary in nature.

8 To normalize earnings for non-recurring legal fees.

9 To normalize earnings for discretionary interest expense. It was assumed that the Practice would operate at a debt-free level going forward without having an adverse impact on operations.

10 Management indicated that the practice prepaid the 2013 malpractice insurance in 2012. Therefore, a normalizing adjustment was made in both 2012 and 2013 to allocate the 2012 prepaid expense amount into 2013.

11 To normalize earnings for discretionary donations.

12 To normalize earnings for non-recurring miscellaneous expenses.

13 To normalize earnings for medical supplies. All years were normalized to the four-year average medical supplies expense of $1,730, which is consistent with management's expectation for expense levels to be incurred going forward.

14 To normalize earnings for discretionary property taxes.

15 To normalize earnings for non-business related taxes.

16 To normalize earnings for non-business related auto use.

17 To normalize earnings for discretionary credit card charges.

EXHIBIT 4
DR. PHILIP DWYER, MD
PHYSICIAN'S COMPENSATION ANALYSIS
VALUATION DATE - DECEMBER 31, 2016

	12/31/2012		12/31/2013		12/31/2014		12/31/2015		12/31/2016	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Revenues [1]	**$ 394,929**	**100.0%**	**$ 202,278**	**100.0%**	**$ 466,029**	**100.0%**	**$ 389,059**	**100.0%**	**$ 282,093**	**100.0%**
Historical Physician Compensation										
Dr. Philip Dwyer	$ -	- %	$ -	- %	$ -	- %	$ -	- %	$ -	- %
Normalized Physician Compensation - Approach 1										
Normalized Physician Compensation - Dr. Philip Dwyer **[2]**	203,500	51.5%	209,000	103.3%	214,500	46.0%	220,000	56.5%	225,500	79.9%
Normalized Physician Compensation - Approach 1	203,500	51.5%	209,000	103.3%	214,500	46.0%	220,000	56.5%	225,500	79.9%
Normalized Physician Compensation - Approach 2										
Benchmark Compensation to Collections Ratio - MGMA **[3]**	0.72		0.73		0.77		0.82		0.82	
Revenues	394,929		202,278		466,029		389,059		282,093	
Normalized Physician Compensation - Approach 2	284,349	72.0%	147,663	73.0%	358,842	77.0%	319,028	82.0%	231,316	82.0%
Normalizing Analysis										
Actual Physician Compensation	$ -	- %	$ -	- %	$ -	- %	$ -	- %	$ -	- %
Less: Normalized Physician Compensation **[4]**	(230,450)	(58.4%)	(188,554)	(93.2%)	(262,614)	(56.4%)	(253,009)	(65.0%)	(227,439)	(80.6%)
Physician Compensation Normalizing Adjustment	(230,450)	(58.4%)	(188,554)	(93.2%)	(262,614)	(56.4%)	(253,009)	(65.0%)	(227,439)	(80.6%)
Total Physician Compensation Normalizing Adjustment	**$ (230,450)**	**(58.4%)**	**$ (188,554)**	**(93.2%)**	**$ (262,614)**	**(56.4%)**	**$ (253,009)**	**(65.0%)**	**$ (227,439)**	**(80.6%)**

Footnotes:

[1] Revenues are considered a reasonable proxy for collections.

[2] Dr. Dwyer's expected level of compensation was adjusted based on discussions with MCS management, Dr. Dwyer's patient load and hours worked in the relevant years, and consideration of cost of living adjustments. See Report for details.

[3] Compensation to Collection Ratio based on each year's median ratio, as per MGMA database.

[4] Normalized physician compensation based on a weighted average of the two approaches considered.

EXHIBIT 5
DR. PHILIP DWYER, MD
WEIGHTED-AVERAGE NORMALIZED BENEFIT STREAM
VALUATION DATE - DECEMBER 31, 2016

Revenue

Year	Weight	Revenue	Weighted Amount
2012	1	$ 394,929	$ 394,929
2013	1	202,278	202,278
2014	1	466,029	466,029
2015	1	389,059	389,059
2016	1	282,093	282,093
Total	5		1,734,388
Total Weighted-Average Revenue (rounded)			**$ 347,000**

Normalized After-Tax Net Income (Loss)

Year	Weight	Normalized After-Tax Net Income (Loss)	Weighted Amount	% of Revenue
2012	1	$ 44,113	$ 44,113	11.2%
2013	1	(36,580)	(36,580)	(18.1%)
2014	1	77,995	77,995	16.7%
2015	1	29,351	29,351	7.5%
2016	1	(35,747)	(35,747)	(12.7%)
Total	5		79,132	
Total Weighted-Average Normalized After-Tax Net Income (rounded)			**$ 16,000**	**4.6%**

EXHIBIT 6
DR. PHILIP DWYER, MD
CAPITALIZATION OF CASH FLOW CALCULATION
VALUATION DATE - DECEMBER 31, 2016

Weighted-Average Normalized After-Tax Net Income	$	16,000
Adjustments to Determine Cash Flow to Equity:		
Depreciation **[1]**		-
Capital Expenditures **[1]**		-
Change in Net Working Capital **[2]**		-
Change in Long-Term Debt **[3]**		-
Estimated Sustainable, Distributable Cash Flow		16,000
Times: (1+Long-Term Growth Rate)		1.030
After-Tax Distributable Cash Flow Projected for the Following Year		16,480
Divided by: Capitalization Rate **[4]**		22.0%
Times: Mid-Period Adjustment Factor		111.8%
Value of the Practice's Equity Before Adjustment for Cash	$	84,000
Cash on hand at December 31, 2016 **[5]**		-
Value of the Practice's Equity (rounded)	**$**	**84,000**

Footnotes:

[1] The Practice does not carry any significant fixed assets on the books. Furthermore, management does not expect to invest in fixed assets in the near term.

[2] The Practice's historical financial statements were prepared on a cash basis, so any changes in net working capital are already reflected in the normalized net income stream.

[3] Management indicated that the Practice has no interest bearing debt as of the valuation date.

[4] Based on the analysis in **Exhibit 7**.

[5] For the purposes of this valuation, it was assumed that the seller (Dr. Dwyer) will keep any cash on hand and it will not be included in the purchase of the Practice.

EXHIBIT 7
DR. PHILIP DWYER, MD
COST OF EQUITY
VALUATION DATE - DECEMBER 31, 2016

Cost of Equity	
Build-Up Method	
Risk Free Rate of Return **[1]**	2.79%
Equity Risk Premium **[2]**	5.97%
Size Premium **[3]**	5.59%
Industry Risk Adjustment **[4]**	(0.71%)
Specific Company Adjustments **[5]**	11.00%
Calculated Return on Equity	24.64%
Cost of Equity (Rounded)	**25.00%**
Less: Long-Term Sustainable Growth Rate	(3.00%)
Equity Capitalization Rate	**22.00%**

Footnotes:

[1] 20-Year U.S. Treasury rate at December 31, 2016.
[2] Supply-side equity risk premium from *2017 Duff & Phelps Valuation Handbook.*
[3] 10th decile size premium from *2017 Duff & Phelps Valuation Handbook*.
[4] Based on the industry risk premium for SIC 80XX - Health Services (-0.71%).
[5] Based on consideration of economic risk, financial risk, operating risk, and other company-specific factors.

EXHIBIT 8
DR. PHILIP DWYER, MD
CONCLUSION OF VALUE
VALUATION DATE - DECEMBER 31, 2016

		Capitalization of Cash Flow Method
Control Adjustment		0.0%
Marketability Adjustment		10.0%
Value of the Practice's Equity Prior to Control Adjustment	$	84,000
Less: Control Adjustment		-
Value of the Practice's Equity Prior to Marketability Adjustment		84,000
Less: Marketability Adjustment		(8,000)
Controlling, Non-Marketable Value of the Practice's Equity	**$**	**76,000**
Concluded Controlling, Non-Marketable Value of the Practice's Equity	**$**	**76,000**

Appendix A

Assumptions and Limiting Conditions

This valuation is subject to the following assumptions and limiting conditions:

1. Information, estimates, and opinions contained in this Report are obtained from sources considered to be reliable. However, we assume no liability for such sources.

2. The Practice, its representatives, and MCS management warranted to us that the information they supplied was complete and accurate to the best of their knowledge, and that this information correctly reflects the results of operations and financial condition in accordance with generally accepted accounting principles (GAAP), unless otherwise noted. Information supplied to us has been accepted as correct without further verification.

3. At MCS's request, we valued the Practice excluding the value of any cash held by the Practice.

4. We were not furnished with the number of active patient medical charts owned by the Practice. Therefore, we were unable to ascribe any value to such medical charts. Had we been provided with an active patient chart count, the results of our valuation may have been different.

5. Possession of this Report, or a copy thereof, does not carry with it the right of publication of all or part of it, nor may it be used for any purpose by anyone but the client without the previous written consent of the client or us and, in any event, only with proper attribution.

6. We are not required to give testimony in court, or be in attendance during any hearings or depositions, with reference to the company being valued, unless previous arrangements have been made in writing. If required, these activities will be billed based on our standard hourly rates.

7. The conclusion of value presented in this Report applies to this valuation only and may not be used out of the context presented herein. This valuation is valid only for the purpose or purposes specified herein. The Report is only valid for the effective date specified herein.

8. This valuation reflects facts and conditions existing at the valuation date. Subsequent events have not been considered and we have no obligation to update our Report for such events and conditions, although we reserve the right to do so.

9. This Report was prepared under the direction of Valuation Expert, CPA/ABV, CVA, CFF. Neither the professionals who worked on this engagement, nor the partners of Valuation Firm, have any present or contemplated future interest in the Practice, or any other interest that might prevent us from performing an unbiased valuation. Our compensation is not contingent on an action or event resulting from the analyses, opinions, or conclusion in, or the use of, this Report.

10. Valuation Firm is not a guarantor of value. Valuation of closely held companies is an imprecise science, with value being a question of fact, and reasonable individuals can differ in their conclusions of value. Valuation Firm has, however, performed conceptually sound and commonly accepted methods of valuation in determining the conclusion of value included in this Report.

Appendix A

Assumptions and Limiting Conditions (Continued)

11. The historical financial statements included with this Report are to be used solely in the valuation process of the Practice. The presentation of these financial statements may be incomplete or otherwise contain departures from generally accepted accounting principles. Nothing has come to our attention that would indicate that the Practice, its officers, advisors, or MCS management intend to use this presentation for any purpose other than valuation.

12. The public, industry and statistical information has been obtained from sources we believe to be reliable. However, we make no representation as to the accuracy or completeness of such information and have performed no procedures to corroborate the information.

13. The conclusion of value arrived at herein is based on the assumption that the current level of management expertise and effectiveness would continue to be maintained, and that the character and integrity of the Practice, through any sale, reorganization, exchange or diminution of the partners, would not be materially or significantly changed.

14. This Report and the conclusion of value arrived at herein are for the exclusive use of our client for the sole and specific purposes as noted herein. They may not be used for any other purpose or by any other party for any purpose. Furthermore, the report and conclusion of value are not intended by the author, and should not be construed by the reader, to be investment advice in any manner whatsoever. The conclusion of value represents the considered opinion of Valuation Firm based on information furnished to us and from other sources.

15. Neither all nor any part of the contents of this Report (especially the conclusion of value, the identity of any valuation specialist(s), or the firm with which such valuation specialists are connected or any reference to any of their professional designations) should be disseminated to the public through advertising media, public relations, news media, sales media, mail, direct transmittal, or any other means of communication, including but not limited to the Securities and Exchange Commission or other governmental agency or regulatory body, without the prior written consent and approval of Valuation Firm.

16. The majority of the contents of the Economic Outlook section of this Report are quoted from the Economic Outlook Update™ 4Q 2016 published by Business Valuation Resources, LLC, reprinted with permission. The editors and Business Valuation Resources, LLC, while considering the contents to be accurate as of the date of publication of the Update, take no responsibility for the information contained therein. Relation of this information to this valuation engagement is the sole responsibility of the authors of this Report.

17. No change of any item in this appraisal report shall be made by anyone other than Valuation Firm, and we shall have no responsibility for any such unauthorized change.

18. Except as noted, we have relied on the representations of MCS management and the Practice's representatives concerning the value and useful condition of all assets, except as specifically stated to the contrary in this Report. We have not attempted to confirm whether or not all assets of the Practice are free and clear of liens and encumbrances or that the entity has good title to all assets.

19. No third parties are intended to be benefited. An engagement for a different purpose, or under a different standard or basis of value, or for a different date of value, could result in a materially different conclusion of value.

Appendix A

Assumptions and Limiting Conditions (Continued)

20. We have not examined or compiled the prospective financial information and therefore, do not express an audit opinion or any other form of assurance on the prospective financial information or the related assumptions. Events and circumstances frequently do not occur as expected, and there will usually be differences between prospective financial information and actual results, and those differences may be material.

21. We conducted interviews with the advisors of the Practice and MCS management concerning the past, present and prospective operating results of the entities.

22. Valuation Firm is not an environmental consultant or auditor, and it takes no responsibility for any actual or potential environmental liabilities. Any person entitled to rely on this Report, wishing to know whether such liabilities exist, or the scope and their effect on the value of the property, is encouraged to obtain a professional environmental assessment. Valuation Firm does not conduct or provide environmental assessments and has not performed one for the subject property.

23. Valuation Firm has not determined independently whether the Practice is subject to any present or future liability relating to environmental matters (including, but not limited to CERCLA/Superfund liability), nor the scope of any such liabilities. Valuation Firm's valuation takes no such liabilities into account, except as they have been reported to us by the Practice or by an environmental consultant working for the Practice, and then only to the extent that the liability was reported to us in an actual or estimated dollar amount. Such matters, if any, are noted in the Report. To the extent such information has been reported to us, Valuation Firm has relied on it without verification and offers no warranty or representation as to its accuracy or completeness.

24. Any decision to purchase, sell or transfer any interest in the Practice shall be your sole responsibility, as well as the structure to be utilized and the price to be accepted. An actual transaction involving the subject business might be concluded at a higher value or at a lower value, depending upon the circumstances of the transaction and the business, and the knowledge and motivations of the buyers and sellers at that time.

Appendix B

Principal Information Sources and References

1. The Practice's management-prepared financial statements (income statements only) for the years December 31, 2012 through 2016.

2. Valuing A Business – The Analysis and Appraisal of Closely Held Companies, Fifth Edition, Shannon Pratt, McGraw-Hill Publishing, 2009.

3. IRC, Revenue Ruling 59-60, Revenue Ruling 68-609, Revenue Ruling 65-193, Revenue Ruling 80-213, Revenue Ruling 81-253, Revenue Ruling 83-120, Revenue Ruling 93-12, and Revenue Ruling 2007-44.

4. Various articles appearing in the following professional publications: "Journal of Accountancy," "The Tax Advisor," "The Valuation Examiner," "Business Valuation Update," "US Economic Digest," and various other professional newsletters.

5. Quantifying Marketability Discounts, Z. Christopher Mercer ASA, CFA, Peabody Publishing.

6. Economic Outlook Update 4Q 2016. Business Valuation Resources, LLC.

7. Risk Management Association, *Annual Statement Studies*, 2012 – 2016.

8. 2016 Duff & Phelps Valuation Handbook, 2016.

9. Pratt's Stats Database from Business Valuation Resources, 2016.

10. Mergerstat Control Premium Study Database from Business Valuation Resources, 2016.

11. Pitchbook Database from Business Valuation Resources, 2016.

12. "Daily Treasury Long-Term Rates." www.treas.gov.

13. FirstResearch Industry Profiles: "Healthcare Sector," "Kidney Dialysis Centers," and "Physician Offices"

14. "Statement on Standards for Valuation Services No. 1." American Institute of Certified Public Accountants. June 2007.

15. "Choosing and Using the Right Valuation Methods for Physician Practices." Mark O. Dietrich CPA/ABV. BVR's Guide to Healthcare Valuation, 2009 Edition.

16. "Valuation of Physician Practices." AICPA Forensic and Valuation Services Section. Presented by David Cranford, CPA and Shannon Farr, CPA/ABV/CFF.

17. Medical Group Management Association's 2012 through 2016 (2011 through 2015 data) Physician Compensation and Production Survey.

Appendix B

Principal Information Sources and References (Continued)

18. "2008 Update: Marketability Discounts: A Comprehensive Analysis." Darrell D. Dorrell, MBA, CPA/ABV, CVA, ASA, CMA, DABFA, Gregory A. Gadawski, CPA/ABV, CVA, CFE, Thomas S. Brown, CPA/ABV, CVA, CFFA. The Value Examiner, September/October 2008, 10-33.

19. Miscellaneous accounting and legal information supplied by the Practice and its representatives.

20. Miscellaneous publicly available economic and financial information.

21. Discussions with Jeffrey Vidmar of the Medical Care System.

22. Discussions with Bill Visor of Accountants, LLP (the Practice's outside CPA).

23. Various other valuation resources, literature and articles.

Appendix C

Valuation Representation/Certification

I represent/certify that, to the best of my knowledge and belief:

- The statements of fact contained in this Report are true and correct.
- The reported analyses, opinions and conclusions of value are limited only by the reported assumptions and limiting conditions, and are my personal, impartial, independent, unbiased, objective professional analyses, opinions and conclusions.
- I have no present or prospective/contemplated financial or other interest in the business or property that is the subject of this Report and I have no personal financial or other interest or bias with respect to the property or the parties involved.
- My engagement in this assignment was not contingent upon developing or reporting predetermined results.
- My compensation for completing this assignment is fee-based and is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the outcome of the valuation, the amount of the value opinion, the attainment of a stipulated result or the occurrence of a subsequent event directly related to the intended use of this appraisal.
- The economic and industry data included in this Report have been obtained from various printed or electronic reference sources that I believe to be reliable. I have not performed any corroborating procedures to substantiate that data.
- My analyses, opinions, conclusions and this detailed appraisal Report were developed in conformity with the American Institute of Certified Public Accountants Statement on Standards for Valuation Services No. 1 and the National Association of Certified Valuators and Analysts' standards.
- The parties for which the information and use of the Report is restricted are identified. The Report is not intended to be, and should not be, used by anyone other than such parties.
- I have no obligation to update the Report or the conclusion of value for information that comes to my attention after the date of the Report, although I reserve the right to do so.
- This valuation and Report have been completed under the direction of Valuation Expert, CPA/ABV, CVA, CFF. Mr. Expert is a Certified Public Accountant licensed in State #1 and State #2 and is accredited in business valuation by the American Institute of Certified Public Accountants. Valuation Manager, CPA/ABV, CVA provided professional assistance in the preparation of this valuation and Report.

Valuation Expert, CPA/ABV, CVA, CFF