# EXHIBIT 26




**FINAL REPORT**

# Executive Total Compensation Review

May 17, 2017

Presented to:

MetroHealth

SullivanCotter AND ASSOCIATES, INC. 25 YEARS

INTEGRITY INDEPENDENCE INSIGHT INFORMATION

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# Introduction

- Sullivan, Cotter and Associates, Inc. (SullivanCotter) was retained by the management of The MetroHealth System (MHS) to review the competitiveness and reasonableness of the total compensation levels provided to its executives.
  - 44 executive and management positions are covered in our analysis, including the Chief Executive Officer.
- Our analysis covers all elements of MHS's total compensation (TC defined as base salaries plus variable compensation and the employer costs of standard and supplemental benefits and perquisites).
  - Information provided by MHS serves as the basis for our assessment. Our assessment is based on the accuracy of the data provided to us, which SullivanCotter has not independently validated. Any additional compensation provided to the covered executives and not included or accurately described in this report, is not covered by our assessment.
- Additionally, SullivanCotter was asked to provide management with directional guidance on restructuring the performance-based Variable Compensation Plan (PBVC) and to review the resulting plan design proposed by management.

# Introduction

- Our report provides
  - A ***prospective review*** of MHS's projected calendar year 2017 (CY2017) TC levels.
  - **Commentary on the proposed** new plan design for the PBVC, including new threshold and maximum incentive opportunities and a total cash compensation cap.
  - **A demonstration** of employer costs of estimated calendar year 2017 (CY2017) benefits and perquisites reflected in tally sheets for each executive.

# Introduction: Definitions Used

- The table below provides definitions of the compensation terms used in this report:

| | |
|---|---|
| **Custom Peer Group** | Custom executive compensation peer group of selected health systems with revenues ranging from $1B to $3B from SullivanCotter's *2016 Management and Executive Compensation in Hospitals and Health Systems* data base. Excludes for-profit health system and pediatric hospitals. A listing of the peer group organizations can be found in **Appendix C**. |
| **Base Salary** | Fixed amount of compensation paid to an individual for a specified position. Data in this report reflects current base salary. |
| **Proposed Annual Incentive Opportunities** | Threshold/target/maximum award opportunities (as a percent of base salary) based on the level of achievement of defined organizational performance goals. Target incentive opportunities are consistent with current plan; threshold and maximum opportunity levels have been revised to 50% of target and 150% of target, respectively. ***Proposed*** opportunity levels vary by level:<br>• CEO: 17.5%; 35.0%; 52.5%<br>• EVPs/SVPs: 12.5%; 25.0%; 37.5%<br>• VPs: 7.5%; 15.0%; 22.5%<br>• Service Line (Medical) Administrators: 7.5%; 15.0%; 22.5%<br>• Directors: 4.0%; 8.0%; 12.0% |
| **Total Cash Compensation (TCC)** | Threshold/target/maximum TCC includes base salary plus corresponding proposed potential annual incentive award. |
| **Tally Sheets** | Annual employer costs of each element of compensation, including cash compensation, broad-based benefits (medical, dental, vision, life insurance, paid time off, sick leave, disability, retirement) and supplemental benefits (life, disability, retirement, severance and retiree medical). Data in the tally sheet reflects estimated 2017 costs for purposes of the analysis. Tally sheets are provided in **Appendix A.** |
| **Total Compensation (TC)** | Threshold/target/maximum TC includes corresponding TCC plus annual cost of employer-provided benefits. |

# Key Findings and Observations

- The following findings are based on the methodology described in **Appendix B.**
- Information on the peer group used is detailed in **Appendix C.**
- **Base salary** positioning by cohort is presented in the table below:

| Cohort | Market Percentile Positioning of Base Salaries |
|---|---|
| CEO | 29P |
| SVP/EVP | 29P |
| VP | 26P |
| Medical Administrator | --- |
| Administrator | 39P |
| Director | 71P |

  - Individual base salary levels range from less than the 25th percentile (Lewis; Boulanger, M.D.; Richmond; Stern; Botros; Warman; Reichert; Kline; Himes and Yorko) to greater than the 90th percentile (Jacono and Mego).
  - Base salary market comparisons by executive are detailed in **Appendix D**.

# Key Findings and Observations

- **Proposed annual incentive** opportunities are competitive for the CEO and EVP/SVP level executives and slightly less than competitive at the VP/service line (medical) administrator levels.
  - Incentive prevalence by cohort is presented in **Appendix E**.
- **Total Cash Compensation** positioning by cohort and incentive opportunity level is presented in the table below:

| Cohort | Market Percentile Positioning of Total Cash Compensation[1] | | | |
|---|---|---|---|---|
| | No Incentive | Threshold | Target | Max |
| CEO | <25P | 33P | 47P | 61P |
| SVP/EVP | <25P | 30P | 45P | 58P |
| VP | <25P | 25P | 33P | 41P |
| Medical Administrator | --- | --- | --- | --- |
| Administrator | <25P | <25P | <25P | <25P |
| Director | 42P | 45P | 49P | 53P |

[1] TCC positioning assumes proposed annual incentive levels of 50% at threshold, 100% at target and 150% at maximum. There is no cap on maximum earnings.

  - Individual **Target TCC** levels range from less than the 25th percentile (Lewis; Boulanger, M.D.; Stern; Botros; Warman; Reichert; Kline; Himes; and Yorko) to greater than the 90th percentile (Jacono and Mego).
  - TCC market comparisons by executive are detailed in **Appendix D**.

# Key Findings and Observations

- As part of the TC assessment, SullivanCotter compared MHS executive benefits and perquisites to market practices for similar health care organizations. See **Appendix F** for a detailed benefits and perquisite assessment.
- Overall, executive benefits are reasonable and are generally consistent with typical market practices, although conservative with respect to market practice in the benefit levels they offer. The table below summarizes the market position of benefits by major program component:

| Summary of Benefits in Relation to Market Practice | | |
|---|---|---|
| **Lower End of Market** | **Middle Market** | **Higher End of Market** |
| • **Long-term disability** (coverage levels are typical, but benefit is employee-paid).<br>• **Life insurance** (particularly those without supplemental coverage or those at higher pay levels where the coverage is less than 1x base salary).<br>• **Sick leave/Short-term disability** (particularly for executives with low sick leave banks, including those with shorter service, that are not sufficient to bridge to long-term disability eligibility). | • **Medical, dental, and vision.**<br>• **Flexible spending accounts.**<br>• **Employee assistance program.**<br>• **Retiree medical** (while not a prevalent benefit, it is typical for executives to be eligible for broad-based coverage).<br>• **Life insurance.**<br>• **Paid time off (PTO).**<br>• **Qualified Retirement** (benefits for executives earning above the statutory pay cap are limited).<br>• **Nonqualified Retirement** (CEO-only supplemental retirement plan).<br>• **Severance benefits**.<br>• **Perquisites.** | • **Sick leave cash-out** (cash out of unused sick leave is atypical, though the total accrual available for cash-out is limited). |

# Key Findings and Observations

- No employer-provided long-term disability coverage is offered which is not consistent with typical market practice. MHS should consider providing long-term disability as an employer-paid benefit for executives.
- While the SERP eligibility has been expanded to cover EVPs and SVPS, and the contribution levels are consistent with the market, the use of three-year block vesting is not common, though is more common for retention awards. MHS could consider different vesting options (e.g., class year vesting or partial vesting) such that executives do not have periods where there is no benefit at risk.
  - Providing full vesting at a defined retirement age (e.g., age 65) is also common and should be considered.
- Sick leave banks, either due to short service or prior illness, may not be sufficient to provide income replacement through long-term disability eligibility (90 days). The trend in the market is to provide executives with full salary continuation through the long-term disability elimination period.
- Total employer-provided coverage through basic group life and executive GVUL policies is $500,000. Additional coverage (e.g., 2x to 3x salary coverage for executives) with a higher maximum benefit (e.g., $1 million) could be considered to closer align with the market.
- CEO severance term is a maximum of 24 months, which is consistent with market.

# Key Findings and Observations

- **Total Compensation** positioning by cohort and incentive opportunity level is presented in the table below:

| Cohort | Market Percentile Positioning of Total Compensation[1] | | | |
|---|---|---|---|---|
| | No Incentive | Threshold | Target | Max |
| CEO | 25P | 35P | 51P | 66P |
| SVP/EVP | <25P | 32P | 47P | 59P |
| VP | <25P | <25P | 27P | 34P |
| Medical Administrator | --- | --- | --- | --- |
| Administrator | <25P | 29P | 41P | 55P |
| Director | 37P | 40P | 43P | 46P |

[1] TCC positioning assumes proposed annual incentive levels of 50% at threshold, 100% at target and 150% at maximum. There is no cap on maximum earnings.

- Individual **Target TC** levels range from less than the 25th percentile (Lewis; Boulanger, M.D.; Stern; Botros; Warman; Reichert; Kline; Himes; Yorko and Fragapane) to greater than the 90th percentile (Jones and Jacono).
  - The Committee should document the business judgment factors that support the upper end compensation for executives over the 90th percentile.
- TC market comparisons by executive are detailed in **Appendix D**.

# Observations on Proposed PBVC

- SullivanCotter reviewed management's presentation of the new proposed PBVC plan (see **Appendix G**).
- The new PBVC structure results in a highly leveraged executive compensation model that will better position MHS to compete for executive talent in a local market with formidable and larger competitors.
- The highly-leveraged compensation model reduces the pressure to keep salary at pace with the market while creating greater total cash compensation opportunities.
- Separating the funding of the incentive pool from the distribution of the pool based on achievement of balanced scorecard goals better aligns incentives with MH's capital requirements for funding its future growth and expansion.
- As a financial proposition, the funding structure protects the Board – the funding curve is highly favorable to MHS. The new plan funds less than the prior plan at EBIDA levels below $90M. Funding of the plan commences at an EBIDA level that approximates BBB-bond rating.
- The performance dimensions embedded within the plan – Financial, Strategic Objectives, Quality, Community and Diversity, Efficiency and Patient Engagement – are consistent with the dimensions found in the incentive plans of other major health systems.
- Shifting to a 50% - 150% payout spread is consistent with market practice, creates greater leverage overall, creates upside for executives when goals are achieved beyond target, and rewards less for achievements below target.
- Changing from step-wise award determination to a sliding scale is appropriate and typical.
- Capping executive pay at the 90$^{th}$ percentile of the peer group is appropriate. However, because these values can be volatile from year to year, cap should be reset annually.
- Eligibility criteria and requirements associated with payout of awards should be established.
- Eliminating personal goals for the senior-most executives is appropriate assuming the CEO has the discretion to adjust payout based on individual performance and contribution.

# Recommendations

- Adopt and document a new compensation philosophy that establishes the new peer group approach. The peer group should apply to all executives – VP level and above. The peer group approach provides greater transparency (than a survey data approach) to the organizations MHS will compare executive pay to. This methodology allows MHS to include/exclude organizations based on organizational characteristics and market factors that is not possible when utilizing compensation surveys. Most importantly the peer group better reflects the executive talent market that MHS will more realistically compete within as it continues to grow in size, complexity, and relevance. Inherent in a peer group consisting of health systems between $1 Billion and $3 Billion revenue are the assumptions that:
  - MHS will continue to grow aggressively in the near-term.
  - MHS will source talent from larger rather smaller health systems.
  - MHS executives are more likely to be attracted to employment opportunities in larger rather than smaller health systems. As such, the need to pay competitively with organizations that are at least the size of MHS today is critical to MHS's executive talent management strategy.
- Adopt the new proposed PBVC plan to include:
  - Expanding the spread of incentive compensation opportunities to assure the relationship between performance results and incentive compensation is more elastic. Establish threshold levels at 50% of target and maximum levels at 150% of target. Target opportunity levels should remain unchanged. Assure that performance targets are set commensurate with potential award levels.
  - Modifying the award calculation methodology. Base incentive awards on a sliding scale such that awards are proportionate to the level of achievement.
  - Adjusting the current cap on cash compensation from 105% of the 75$^{th}$ percentile of total cash compensation to the 90$^{th}$ percentile of total cash compensation.
  - Adopting the requirement that to be eligible to participate in the plan for that year, the participant must have been employed for at least six months during the plan year.
  - Adopting the requirement to earn an award the recipient must be employed in "good standing" on the date of the payout.
  - Basing the award on the actual salary earned during the performance period which will allow new hires to become immediately eligible to participate in the plan.

# Recommendations

- To strengthen the alignment with MHS' strategy and future capital requirements explore the feasibility of introducing a new long-term incentive compensation as a compliment to PBVC. While the PBVC is oriented to annual operating and financial objectives within a defined annual period a new long-term plan would be aligned with MHS's strategic objectives and milestones. While the structure of long term plans vary and the metrics/targets are specific to each organization, the emerging practices center on driving:
  - Sustainable financial health.
  - Indicators of the organization's ability to manage population health and embed principles of value-based healthcare in their models of care and clinically integrated network.
  - Achievement of specific growth strategies. These plans are usually limited to the senior-most executives (CEO and SVP levels) and have goals established for a 3-year time horizon.
- Revise the vesting schedule under the SERP to assure a stronger retention element. Shift from "block vesting" to "class vesting" where all contributions vest on the third anniversary of the date of contribution. This assures there will significant value that the participant forfeits if they voluntarily terminate.
- Consider eliminating the cash out of accrued vacation and sick leave.
  - These elements of time off are not intended to be cash-based benefits.
  - Providing the availability of cash-outs creates the potential for misuse.

# Appendix A

## MHS Tally Sheet

# MHS Tally Sheet

- The tally sheet provided in this section displays CY2017 TC costs for the MHS executives included in this analysis.
  - SullivanCotter worked with MHS's compensation professionals to develop the tally sheet.
  - Tally sheets for Medical Administrators are excluded.
- The tally sheet reflects:
  - Current administrative base salaries.
  - Bonuses paid in CY2016 for CY2015 performance.
  - CY2016 miscellaneous cash payments, including top talent incentive payments, additional performance goals, and sign-on bonuses.
  - CY2017 estimated benefits and perquisites costs.
- The tally sheet is provided for informational purposes and in support of governance best practices regarding the full disclosure of TC.
- While the goal is to show all elements of compensation, the tally sheet is not intended to be a precise representation of the exact compensation paid for a certain time period.

# MHS Tally Sheet

| Name: | Boutros, M.D. | Lewis | Boulanger, M.D. | Chehade, M.D. | Richmond | Conners, M.D. |
|---|---|---|---|---|---|---|
| Title: | President CEO | EVP Chief Operating Officer | EVP Chief Clinical Officer | SVP Population Health | SVP Chief Financial Officer | SVP Chief Quality Officer |
| *a. Cash Compensation* | | | | | | |
| ♦ Base Salary | $869,003 | $450,008 | $450,008 | $435,011 | $420,014 | $418,766 |
| ♦ Annual Incentive Award | $316,319 | $114,169 | $0 | $0 | $112,354 | $105,878 |
| ♦ Other | $0 | $0 | $50,000 | $0 | $0 | $0 |
| **Total** | **$1,185,322** | **$564,177** | **$500,008** | **$435,011** | **$532,368** | **$524,645** |
| *b. Legally-Required Benefits* | | | | | | |
| ♦ Social Security | $0 | $0 | $0 | $0 | $0 | $0 |
| ♦ Medicare | 17,187 | 8,181 | 7,250 | 6,308 | 7,719 | 7,607 |
| **Total** | **$17,187** | **$8,181** | **$7,250** | **$6,308** | **$7,719** | **$7,607** |
| *c. Health Insurance* | | | | | | |
| ♦ Medical, Prescription Drug | | | | | | |
| ♦ Dental and Vision | | | | | | |
| **Total** | | | | | | |
| *d. Life Insurance* | | | | | | |
| ♦ Basic life and AD&D | | | | | | |
| ♦ Group Variable Universe Life (GVUL) | | | | | | |
| **Total** | | | | | | |
| *e. Disability* | | | | | | |
| ♦ Short-term disability/salary continuation | | | | | | |
| ♦ Long-term disability | | | | | | |
| **Total** | | | | | | |
| *f. Retirement/Deferred Compensation* | | | | | | |
| ♦ Qualified defined benefit pension plan contributions | | | | | | |
| ♦ Nonqualified supplemental retirement plan | | | | | | |
| **Total** | | | | | | |
| **Total Benefit/Perquisite Cost** | **$312,026** | **$121,882** | **$107,953** | **$125,664** | **$115,408** | **$132,534** |
| **Total Compensation Cost** | **$1,497,348** | **$686,059** | **$607,961** | **$560,675** | **$647,776** | **$657,179** |
| *h. Other information* | | | | | | |
| ♦ Paid Time Off (maximum value payable on termination) | $150,404 | $64,905 | $64,905 | $62,742 | $60,579 | $60,399 |
| ♦ Sick Leave (maximum value payable on retirement) | 100,270 | 51,924 | 51,924 | 50,194 | 48,463 | 48,319 |
| ♦ Potential severance payments | 1,754,622 | 458,156 | 458,319 | 444,669 | 428,322 | 425,074 |

Notes:

- Any partial-year benefits for mid-year hires were annualized.
- Phillips is a contract employee and not eligible for benefits.
- SERP amounts reflect annual accruals, regardless of possible mid-year entry dates. Actual SERP benefits were also estimated for all eligible executives except for the President and CEO.
- CEO is eligible for 24 months of severance through July, 2018. All other executives are eligible for 12 months of severance.

# MHS Tally Sheet

| Name: | Phillips | Stern | Jones | Allen | Brown | Botros |
|---|---|---|---|---|---|---|
| Title: | Chief Legal Officer | SVP Chief Of Staff | SVP Campus Transformation | SVP External Affairs | Chief Development Officer & President MH Foundation | VP Chief Strategy Officer/SI Administration |
| *a. Cash Compensation* | | | | | | |
| ♦ Base Salary | $360,000 | $345,010 | $280,010 | $247,520 | $225,014 | $320,008 |
| ♦ Annual Incentive Award | $90,000 | $25,000 | $0 | $42,655 | $23,556 | $48,336 |
| ♦ Other | $0 | $0 | $25,000 | $0 | $0 | $0 |
| **Total** | **$450,000** | **$370,010** | **$305,010** | **$290,175** | **$248,571** | **$368,344** |
| *b. Legally-Required Benefits* | | | | | | |
| ♦ Social Security | $0 | $0 | $0 | $0 | $0 | $0 |
| ♦ Medicare | 0 | 5,365 | 4,423 | 4,208 | 3,604 | 5,341 |
| **Total** | **$0** | **$5,365** | **$4,423** | **$4,208** | **$3,604** | **$5,341** |
| *c. Health Insurance* | | | | | | |
| ♦ Medical, Prescription Drug | | | | | | |
| ♦ Dental and Vision | | | | | | |
| **Total** | | | | | | |
| *d. Life Insurance* | | | | | | |
| ♦ Basic life and AD&D | | | | | | |
| ♦ Group Variable Universe Life (GVUL) | | | | | | |
| **Total** | | | | | | |
| *e. Disability* | | | | | | |
| ♦ Short-term disability/salary continuation | | | | | | |
| ♦ Long-term disability | | | | | | |
| **Total** | | | | | | |
| *f. Retirement/Deferred Compensation* | | | | | | |
| ♦ Qualified defined benefit pension plan contributions | | | | | | |
| ♦ Nonqualified supplemental retirement plan | | | | | | |
| **Total** | | | | | | |
| **Total Benefit/Perquisite Cost** | **$0** | **$96,892** | **$90,028** | **$75,805** | **$64,885** | **$43,671** |
| **Total Compensation Cost** | **$450,000** | **$466,902** | **$395,038** | **$365,980** | **$313,456** | **$412,015** |
| *h. Other information* | | | | | | |
| ♦ Paid Time Off (maximum value payable on termination) | $0 | $49,761 | $40,386 | $35,700 | $32,454 | $36,924 |
| ♦ Sick Leave (maximum value payable on re irement) | 0 | 39,809 | 32,309 | 28,560 | 25,963 | 36,924 |
| ♦ Potential severance payments | 0 | 353,318 | 288,318 | 249,579 | 227,073 | 320,255 |

Notes:

- Any partial-year benefits for mid-year hires were annualized.
- SERP amounts reflect annual accruals, regardless of possible mid-year entry dates. Actual SERP benefits were also estimated for all eligible executives except for the President and CEO.

# MHS Tally Sheet

| Name | Kaelber | Sedor, M.D. | Warman | Reichert | Kline | Rajki | Delp |
|---|---|---|---|---|---|---|---|
| Title | Chief Medical Informatics Officer | VP Research | VP Human Resources | VP Chief Information Officer | VP Chief Nursing Officer | Associate General Counsel | Exec Dir, Pop'n Health & Care Coordination |
| *a. Cash Compensation* | | | | | | | |
| ♦ Base Salary | $318,011 | $312,832 | $285,002 | $260,000 | $255,008 | $220,396 | $220,002 |
| ♦ Annual Incentive Award | $32,758 | $47,863 | $46,588 | $37,746 | $27,629 | $33,315 | $26,511 |
| ♦ Other | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total | $350,769 | $360,695 | $331,590 | $297,746 | $282,637 | $253,711 | $246,513 |
| *b. Legally-Required Benefits* | | | | | | | |
| ♦ Social Security | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ♦ Medicare | 5,086 | 5,230 | 4,808 | 4,317 | 4,098 | 3,679 | 3,574 |
| Total | $5,086 | $5,230 | $4,808 | $4,317 | $4,098 | $3,679 | $3,574 |
| *c. Health Insurance* | | | | | | | |
| ♦ Medical, Prescription Drug | | | | | | | |
| ♦ Dental and Vision | | | | | | | |
| Total | | | | | | | |
| *d. Life Insurance* | | | | | | | |
| ♦ Basic life and AD&D | | | | | | | |
| ♦ Group Variable Universe Life (GVUL) | | | | | | | |
| Total | | | | | | | |
| *e. Disability* | | | | | | | |
| ♦ Short-term disability/salary continuation | | | | | | | |
| ♦ Long-term disability | | | | | | | |
| Total | | | | | | | |
| *f. Retirement/Deferred Compensation* | | | | | | | |
| ♦ Qualified defined benefit pension plan contributions | | | | | | | |
| ♦ Nonqualified supplemental retirement plan | | | | | | | |
| Total | | | | | | | |
| **Total Benefit/Perquisite Cost** | $56,360 | $53,156 | $50,357 | $55,764 | $53,316 | $45,022 | $40,182 |
| **Total Compensation Cost** | $407,129 | $413,851 | $381,947 | $353,510 | $335,953 | $298,733 | $286,695 |
| *h. Other information* | | | | | | | |
| ♦ Paid Time Off (maximum value payable on termination) | $36,694 | $45,120 | $32,885 | $30,000 | $29,424 | $25,430 | $25,385 |
| ♦ Sick Leave (maximum value payable on retirement) | 36,694 | 120,320 | 32,885 | 30,000 | 29,424 | 25,430 | 25,385 |
| ♦ Potential severance payments | 324,635 | 312,832 | 287,060 | 266,624 | 261,632 | 226,859 | 222,060 |

Notes:

- Any partial-year benefits for mid-year hires were annualized.

# MHS Tally Sheet

| Name | Himes | Jacono | Carney | Hannu | Platten | Rentschler | Sukalac |
|---|---|---|---|---|---|---|---|
| Title | VP Finance | Exeutive Director, Ambulatory Network Operations | Associate CNO – Ambulatory Nursing Operations | Assoc CNO | Assistant To The CEO - Special Projects | Service Line Administrator (Oncology) | Service Line Administrator (Cardiology) |
| *a. Cash Compensation* | | | | | | | |
| ♦ Base Salary | $215,987 | $195,000 | $165,443 | $150,010 | $150,010 | $183,768 | $180,003 |
| ♦ Annual Incentive Award | $31,750 | $20,060 | $21,521 | $9,573 | $0 | $14,077 | $17,208 |
| ♦ Other | $0 | $37,500 | $0 | $0 | $0 | $0 | $0 |
| **Total** | **$247,737** | **$252,560** | **$186,964** | **$159,582** | **$150,010** | **$197,845** | **$197,211** |
| *b. Legally-Required Benefits* | | | | | | | |
| ♦ Social Security | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ♦ Medicare | 3,592 | 3,662 | 2,711 | 2,314 | 2,175 | 2,869 | 2,860 |
| **Total** | **$3,592** | **$3,662** | **$2,711** | **$2,314** | **$2,175** | **$2,869** | **$2,860** |
| *c. Health Insurance* | | | | | | | |
| ♦ Medical, Prescription Drug | | | | | | | |
| ♦ Dental and Vision | | | | | | | |
| **Total** | | | | | | | |
| *d. Life Insurance* | | | | | | | |
| ♦ Basic life and AD&D | | | | | | | |
| ♦ Group Variable Universe Life (GVUL) | | | | | | | |
| **Total** | | | | | | | |
| *e. Disability* | | | | | | | |
| ♦ Short-term disability/salary continuation | | | | | | | |
| ♦ Long-term disability | | | | | | | |
| **Total** | | | | | | | |
| *f. Retirement/Deferred Compensation* | | | | | | | |
| ♦ Qualified defined benefit pension plan contributions | | | | | | | |
| ♦ Nonqualified supplemental retirement plan | | | | | | | |
| **Total** | | | | | | | |
| **Total Benefit/Perquisite Cost** | **$53,069** | **$28,558** | **$34,886** | **$34,594** | **$26,826** | **$41,258** | **$35,570** |
| **Total Compensation Cost** | **$300,806** | **$281,118** | **$221,850** | **$194,176** | **$176,836** | **$239,103** | **$232,781** |
| *h. Other information* | | | | | | | |
| ♦ Paid Time Off (maximum value payable on termination) | $24,922 | $22,500 | $23,862 | $17,309 | $21,636 | $21,204 | $20,770 |
| ♦ Sick Leave (maximum value payable on retirement) | 24,922 | 22,500 | 63,632 | 17,309 | 17,309 | 21,204 | 20,770 |
| ♦ Potential severance payments | 224,295 | 195,408 | 169,838 | 156,633 | 151,767 | 190,392 | 185,350 |

Notes:

- Any partial-year benefits for mid-year hires were annualized.

# MHS Tally Sheet

| Name | Murphy | Yorko | Klinger | Dunn | Graham | Fragapane | Mego |
|---|---|---|---|---|---|---|---|
| Title | Service Line Administrator (Surgery) | Service Line Administrator (Ambulatory) | Service Line Administrator (Neuroscience) | Service Line Administrator/Business Development (Urgent Care) | Sr Director Revenue Cycle | Sr Director Of Access | Executive Director Managed Care Program |
| *a. Cash Compensation* | | | | | | | |
| ♦ Base Salary | $175,011 | $155,002 | $150,010 | $150,010 | $198,910 | $198,910 | $193,814 |
| ♦ Annual Incentive Award | $17,208 | $0 | $10,345 | $0 | $0 | $0 | $15,691 |
| ♦ Other | $0 | $5,000 | $0 | $0 | $10,000 | $5,000 | $0 |
| Total | $192,219 | $160,002 | $160,354 | $150,010 | $208,910 | $203,910 | $209,506 |
| *b. Legally-Required Benefits* | | | | | | | |
| ♦ Social Security | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ♦ Medicare | 2,787 | 2,320 | 2,325 | 2,175 | 3,029 | 2,957 | 3,038 |
| Total | $2,787 | $2,320 | $2,325 | $2,175 | $3,029 | $2,957 | $3,038 |
| *c. Health Insurance* | | | | | | | |
| ♦ Medical, Prescription Drug | | | | | | | |
| ♦ Dental and Vision | | | | | | | |
| Total | | | | | | | |
| *d. Life Insurance* | | | | | | | |
| ♦ Basic life and AD&D | | | | | | | |
| ♦ Group Variable Universe Life (GVUL) | | | | | | | |
| Total | | | | | | | |
| *e. Disability* | | | | | | | |
| ♦ Short-term disability/salary continuation | | | | | | | |
| ♦ Long-term disability | | | | | | | |
| Total | | | | | | | |
| *f. Retirement/Deferred Compensation* | | | | | | | |
| ♦ Qualified defined benefit pension plan contributions | | | | | | | |
| ♦ Nonqualified supplemental retirement plan | | | | | | | |
| Total | | | | | | | |
| **Total Benefit/Perquisite Cost** | $37,915 | $36,718 | $32,319 | $23,322 | $34,535 | $34,463 | $37,877 |
| **Total Compensation Cost** | $230,134 | $196,720 | $192,673 | $173,332 | $243,445 | $238,373 | $247,383 |
| *h. Other information* | | | | | | | |
| ♦ Paid Time Off (maximum value payable on termination) | $25,242 | $17,885 | $17,309 | $17,309 | $22,951 | $23,078 | $22,363 |
| ♦ Sick Leave (maximum value payable on retirement) | 67,312 | 17,885 | 17,309 | 17,309 | 22,951 | 23,078 | 22,363 |
| ♦ Potential severance payments | 181,635 | 163,310 | 154,405 | 150,010 | 200,605 | 200,527 | 197,536 |

Notes:

- Any partial-year benefits for mid-year hires were annualized.

# Appendix B

## Study Methodology

# Study Methodology

- SullivanCotter used a market pricing approach to assess the competitiveness and reasonableness of MHS's executive total compensation levels. Specifically, we:
  - Collected background information regarding MHS's operations, structure, size, and scope.
  - Collected information on the covered executives' current compensation.
  - Collected design information relative to the administration of the cash compensation programs.
  - Affirmed our understanding of each position's functional responsibilities and role within the organization through MHS's compensation professionals.
  - Selected the appropriate benchmark position match for each position.
  - Created a custom executive compensation peer group of selected health systems with revenues ranging from $1B to $3B from SullivanCotter's *2016 Management and Executive Compensation in Hospitals and Health Systems* data base. Peer group consists of 146 not-for-profit academic and community-based health systems with median net revenue of $1.53 Billion. Excludes for-profit health system and pediatric hospitals. Compared MHS's cash compensation levels to the custom peer group data.
- In this context, the cash compensation market data are:
  - Reflective of MHS's executive talent market, which is primarily based on not-for-profit health systems on a national basis.
  - Position-specific, based on our understanding of each role.
    - In some instances, we applied a market adjustment (i.e., premium or discount) to the market data to better reflect MHS's position relative to the available benchmark match.
    - MHS's compensation professionals reviewed the benchmark matches and the application of market adjustments.
  - Reported at the 25$^{th}$, 50$^{th}$, 75$^{th}$ and 90$^{th}$ percentiles.
  - Updated to July 1, 2017 at an annualized rate of 3.0%, which is consistent with projected 2017 merit increase budgets for executives within the health care marketplace.

# Study Methodology

- The following table summarizes the benchmark approach we utilized for each covered position:

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| President CEO<br>(Akram Boutros, M.D.) | President and Chief Executive Officer, Multiple Hospital System, Independent or Affiliated | Responsible for establishing and achieving short- and long-term objectives and the overall viability of the organization. Develops policies and procedures and provides guidance with their implementation. Typically reports to the Board or system senior management. This is the most senior executive. This position may have an MD. |
| EVP Chief Operating Officer<br>(Daniel Lewis) | Chief Operating Officer, Multiple Hospital System, Independent or Affiliated | Responsible for overseeing overall operations of the organization in accordance with plans and budgets. Leads the operations to ensure the organization's short- and long-term goals and objectives are achieved. Reports to the president and chief executive officer. This is the second highest senior executive. This position may have an MD. |
| EVP Chief Clinical Officer<br>(Bernard Boulanger, M.D.) | Chief Medical Officer, Multiple Hospital System, Independent or Affiliated + 10% premium for dyad structure responsibilities | Responsible for planning, coordinating and overseeing the strategic medical affairs of the organization. Establishes and implements standards and policies to align medical staff goals with those of the organization. Ensures medical staff complies with all legal and regulatory requirements. May be responsible for clinical integration or accountable care organization (ACO). Typically reports to the president and chief executive officer or chief operating officer. This position requires an MD. |
| SVP Population Health<br>(Nabil Chehade, M.D.) | Top Population Health Executive | Responsible for developing, leading and overseeing the organization's strategic direction and coordination of population health and care management. Collaborates with leadership, physicians, departments and business units to implement and promote the population health program. Typically reports to the president and chief executive officer. This position may have a MD. |
| SVP Chief Financial Officer<br>(Craig Richmond) | Chief Financial Officer, Multiple Hospital System, Independent or Affiliated | Responsible for planning, organizing and directing all functions related to financial management, budgeting, accounting, reimbursement, etc. of the organization. Establishes and implements policies and procedures related to accounting practices. May have responsibility for information systems. Typically reports to the president and chief executive officer or chief operating officer. |
| SVP Chief Quality Officer<br>(Alfred Conners, M.D.) | Chief Quality Officer | Responsible for planning, implementing and overseeing the guidelines for clinical quality, patient safety and value initiatives. This position requires an MD to provide physician leadership to quality staff. Typically reports to the chief medical officer or president and chief executive officer. This is not a total quality management (TQM) or continuous quality improvement (CQI) job. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Chief Legal Officer (Michael Phillips) | Top Legal Services Executive (General Counsel) | Responsible for planning and coordinating all legal activities of the organization. Directs in-house counsel and coordinates activities of outside counsel. Ensures organizational activities meet legal and regulatory requirements. Typically reports to the president and chief executive officer. |
| SVP Chief of Staff (Michael Stern) | Chief Administrative Officer | Responsible for overseeing three or more of the organization's major administrative functions (e.g., human resources, planning, legal services, public relations and marketing). Plans, develops and establishes policies involving administrative functions in accordance with the objectives of the organization. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| SVP Campus Transformation (Walter Jones) | Top Facilities Planning/Construction Executive | Responsible for facility planning, new construction and renovation projects. May also be responsible for facilities operations and maintenance. Typically reports to the chief operating officer or chief financial officer. |
| SVP External Affairs (Elizabeth Allen) | Top Marketing Executive +10% premium for government relations | Responsible for developing, directing and executing a comprehensive marketing strategy. This includes marketing new and existing programs and services, conducting market research, and advertising via various media. May have responsibility for internal and external communications. Typically reports to the president and chief executive officer or chief operating officer. |
| Chief Development Officer and President MH Foundation (Kate Brown) | Top Foundation/Fund Development Executive | Responsible for planning and developing programs and events designed to enhance charitable giving. May serve as president of a separate charitable organization formed for the purpose of supporting the organization. Typically reports to the president and chief executive officer. |
| VP Care Delivery/Exec Dir MH Select (Holly Perzy, M.D.) | Health Plan President/Chief Executive Officer | Responsible for establishing and achieving the health plan's short- and long-term objectives and overall viability. This is the top executive of a health plan. Typically reports to the Board or president and chief executive officer of the system or hospital. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| VP Chief Experience Officer (Sara Laskey, M.D.) | Chief Patient Experience Officer | Responsible for developing and leading the practices and innovations that enhance the patient experience for those receiving treatment and their families. Collaborates with leadership, physicians, departments and business units to build support for creating a positive patient experience. Identifies new and existing technologies to support and achieve the organization's patient experience vision. Typically reports to the chief operating officer, chief administrative officer or top clinical integration executive. |
| VP Chief Strategy Officer/SI Administration (Karim Botros) | Chief Strategy Officer +5% for oversight of Family Care | Responsible for developing and implementing strategies for short- and long-term growth of the organization. Develops and leads organization-wide strategic planning efforts. Identifies and pursues new business opportunities, investigates diversification into new businesses or service lines, and identifies and executes strategic alliances, joint ventures, and partnerships. May lead mergers, acquisitions and divestitures. This position is typically responsible for three or more strategic functions and reports to the president and chief executive officer. |
| Chief Medical Informatics Officer (David Kaelber) | Top Medical Informatics Executive | Responsible for developing, implementing and managing the organization's systems that underlie the tools and management of medical information. Typically reports to the chief medical officer or chief information officer. This position may have an MD. |
| VP Research (John Sedor, M.D.) | Top Clinical Research Executive | Responsible for planning, developing and implementing the organization's clinical research program. Establishes and oversees the implementation of quality standards and budget requirements and ensures the safety, integrity and accuracy of all clinical studies. Provides assistance to lower-level managers assigned to clinical research projects. Typically reports to the president and chief executive officer. This position may have an MD. |
| VP Human Resources (Debbie Warman) | Top Human Resources Executive +10% premium for oversight of protective services and LWSSH (on-site school). | Responsible for developing and implementing human resources policies and programs. Ensures all human resources programs (e.g., employment, compensation and benefits, employee or labor relations, education and training, and employee health and safety) support, and are aligned with, the organization's human resources strategies. Typically reports to the president and chief executive officer, chief operating officer or chief administrative officer. |
| VP Chief Information Officer (Donald Reichert) | Chief Information Officer | Responsible for the direction and planning of all information systems and services. Establishes and implements policies, procedures and standards for all information systems activities. May also oversee telecommunications. Typically reports to the president and chief executive officer or chief operating officer. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| VP Chief Nursing Officer (Melissa Kline) | Chief Nursing Officer | Responsible for organizing, planning, directing and evaluating nursing services. Recommends and implements policies and procedures to improve efficiency and delivery of quality nursing services. This position is responsible for nursing functions only. Typically reports to the president and chief executive officer or chief operating officer. This position requires an RN. |
| Associate General Counsel (Sonja Rajki) | Second-Level Legal Services Executive (Associate General Counsel) | Assists the top legal services executive (general counsel) in directing and overseeing all phases of the legal functions of the organization. This is the second-highest legal services executive position in an organization. Typically reports to the top legal services executive. |
| Executive Director, Pop'n Health & Care Coordination (Amy Delp) | Top Community Health Executive | Responsible for providing leadership for developing and overseeing the organization's community outreach programs such as health and wellness. Develops methods to measure improvements in the overall health status of the communities served by the organization. May be responsible for employee health services as well. Typically reports to the president and chief executive officer. This position may have a JD. |
| VP Finance (Geoff Himes) | Second-Level Finance Executive | Assists the chief financial officer in directing and overseeing the financial functions of the organization. Reviews policies and procedures related to the organization's accounting practices. This is the second-highest finance executive position in an organization. Typically reports to the chief financial officer or chief administrative officer. |
| Executive Director, Ambulatory Network Operations (Julie Jacono) | Head of Ambulatory/Outpatient Care Services | Responsible for directing, administering and coordinating the activities and operations of all non-emergency care services, including outpatient clinic, outpatient surgery and urgent care. Manages and directs personnel and support staff. Ensures non-emergency care services operate within budget and in accordance with performance standards. This position is not an MD. |
| Associate CNO – Ambulatory Nursing Operations (Katie Carney) | Head of Nursing Services | Responsible for managing and directing the operations of several nursing units. Establishes and monitors budgets, standards of care, and operating policies for assigned units. Typically supervises nurse managers. |
| Associate CNO (Theresa Hannu) | Head of Nursing Services | Responsible for managing and directing the operations of several nursing units. Establishes and monitors budgets, standards of care, and operating policies for assigned units. Typically supervises nurse managers. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Assistant to the CEO – Special Projects (Jane Platten) | Special Assistant to the Chief Executive Officer | Directs, monitors, and contributes to special/strategic projects, which are strategic in nature, highly complex, and involve creation and oversight of multifaceted teams. Advises, supports, assists, coordinates, and collaborates on special/strategic projects for the chief executive officer. Organizes, problem solves, raises issues, and integrates initiatives, solutions, and actions for the Chief Executive Officer. Acts as an executive liaison to resolve problems and ensure successful implementation of company initiatives. Requires a minimum of a Bachelor's degree with at least seven years healthcare experience. Note: This is generally a single incumbent position. Only one employee, the most senior individual, per organization entity should be reported. |
| Service Line Medical Administrator (Surgery) (Christopher Brandt, M.D.) | Top Service Line Executive – Surgery | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the surgery service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the surgery service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Administrator (Specialty) (Brendan Patterson, M.D.) | Top Service Line Executive – Other | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to a single service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of a single service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Administrator (Oncology) (Benjamin Li, M.D.) | Top Service Line Executive – Oncology | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the oncology service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the oncology service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Service Line Medical Administrator (Trauma/Surgery) (Jeffrey Claridge, M.D.) | Top Service Line Executive – Surgery | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the surgery service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the surgery service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Administrator (Cardiology) (William Lewis, M.D.) | Top Service Line Executive – Cardiology | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the cardiology service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the cardiology service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Administrator (Obstetrics) (Jennifer Bailit, M.D.) | Top Service Line Executive – Women's | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the women's service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the women's service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Service Line Medical Administrator (Rehab/Neuroscience) (John Chae, M.D.) | Top Service Line Executive – Neuroscience/Rehabilitation | Top Service Line Executive - Neuroscience: Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the neuroscience service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the neuroscience service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| | | Top Service Line Executive - Rehabilitation: Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the rehabilitation service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the rehabilitation service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Administrator (Other) (Kathryn Teng, M.D.) | Top Service Line Executive – Other | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to a single service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of a single service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |
| Service Line Medical Admin (Ambulatory) (Julia Bruner, M.D.) | Top Service Line Executive – Ambulatory | Responsible for the overall strategic leadership and operational oversight for all clinical operations contributing to the ambulatory service line. Works in collaboration with physician and administrative leadership for each division and department to develop and implement policies, procedures, budgets, and marketing plans to ensure the highest level of care and support and the continued growth and success of the ambulatory service line. Typically reports to the president and chief executive officer or chief operating officer. This position may have an MD. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Service Line Administrator (Oncology) (Brian Rentschler) | Head of Service Line – Oncology +10% premium for oversight of Women and Child | Responsible for the overall day-to-day management for all clinical operations contributing to the oncology service line. Works closely with physicians and senior leadership in the development of growth strategies, achievement of targets, and outcome improvement. Ensures oncology service line operates within budget and in accordance with performance standards. This position is not an MD. |
| Service Line Administrator (Cardiology) (Nicholas Sukalac) | Head of Service Line – Cardiology | Responsible for the overall day-to-day management for all clinical operations contributing to the cardiology service line. Works closely with physicians and senior leadership in the development of growth strategies, achievement of targets, and outcome improvement. Ensures cardiology service line operates within budget and in accordance with performance standards. This position is not an MD. |
| Service Line Administrator (Surgery) (Jill Murphy) | Head of Service Line – Surgery | Responsible for the overall day-to-day management for all clinical operations contributing to the surgery service line. Works closely with physicians and senior leadership in the development of growth strategies, achievement of targets, and outcome improvement. Ensures surgery service line operates within budget and in accordance with performance standards. This position is not an MD. |
| Service Line Administrator (Ambulatory) (Brian Yorko) | Head of Service Line – Ambulatory +15% premium for oversight of radiology, pathology and pharmacy | Responsible for the overall day-to-day management for all clinical operations contributing to the ambulatory service line. Works closely with physicians and senior leadership in the development of growth strategies, achievement of targets, and outcome improvement. Ensures ambulatory service line operates within budget and in accordance with performance standards. This position is not an MD. |
| Service Line Administrator (Neuroscience) (Beatrice Klinger) | Head of Service Line – Neuroscience | Responsible for the overall day-to-day management for all clinical operations contributing to the neuroscience service line. Works closely with physicians and senior leadership in the development of growth strategies, achievement of targets, and outcome improvement. Ensures neuroscience service line operates within budget and in accordance with performance standards. This position is not an MD. |
| Service Line Administrator / Business Development (Urgent Care) (Shailaja Dunn) | Head of Urgent Care Services | Responsible for directing, administering and coordinating the activities and operations of the urgent care services. Manages and directs personnel and support staff. Ensures urgent care services operate within budget and in accordance with performance standards. This position is not an MD. |

# Study Methodology

| Title/Executive | Survey Job Title | Survey Position Match |
|---|---|---|
| Sr. Director Revenue Cycle (Donna Graham) | Head of Revenue Cycle | Responsible for maintaining and enhancing the revenue cycle process, including patient accounting, billing, collections, registration, medical records, vendor management, etc. Reviews and develops processes and systems to improve admissions and financial performance, and generate cash flow. May supervise lower-level managers or supervisors over specific functions. |
| Sr. Director of Access (Jennifer Fragapane) | Top Contact Center Executive - Corporate | This is the top contact center position with responsibility for the organization's contact center operations. Oversees operating systems including policies, procedures, and operating structure. Establishes and implements product/service standards. Analyzes operations and efficiency of the contact center. May build industry relations, communicating technologies and identify operational concerns through industry networking. Frequently reports to a chief executive officer. Note: Reporting entity is either Subsidiary or Group. This is generally a single incumbent position. Only one employee, the most senior individual, per organization entity should be reported. |
| Executive Director, Managed Care Program (Susan Mego) | Head of Managed Care | Responsible for managing and directing the development and implementation of new and existing managed care contracts. Monitors existing managed care contracts' financial and operational performance. |

# Study Methodology

- The table below lists the surveys that were used to complete this analysis:

| Survey Source | Survey Description |
|---|---|
| **Sullivan Cotter and Associates Inc.** - *2016 Survey of Manager and Executive Compensation in Hospitals and Health Systems* | Executive compensation survey containing data from 1,835 organizations, including 417 health systems and 1,418 hospitals. Data selected based on health system/hospital setting, geographic region and revenue size. Data are effective as of January 1, 2016. |
| **Mercer (M:IHN) –** *2016 Integrated Health Networks Compensation Survey* | Compensation survey containing compensation data for 732 positions reported by 1,872 health care organizations. Data selected based on health system/hospital setting, geographic region and revenue size. Data are effective as of March 1, 2016. |
| **Mercer Consulting** - *2016 US Benchmark Database* | General industry compensation survey containing compensation data on over 1,500 functional positions representing more than 3,000 organizations. Data are effective as of March 1, 2016. |

# Study Methodology

- The assessment of standard and supplemental benefits and perquisites is based on:
  - Information from published and proprietary benefit surveys (including those used in the cash compensation analysis to the extent information was available).
  - Our experience and knowledge regarding the use of benefits and perquisites for executives in not-for-profit health care organizations.
- SullivanCotter compared the current benefits and perquisites provided to the covered executives with the market data to assess general competitiveness.
  - Please note that the executive benefits and perquisites review compares the nature and sources of the executive benefits to the market for executive positions only.
  - SullivanCotter has included the broad-based benefits in the review to understand what the executives receive from these programs, and has not compared the broad-based benefits to broad-based market practices.
  - SullivanCotter has not reviewed the cost structure for any of the benefits to determine whether pricing is competitive.
- SullivanCotter conducted a quantitative assessment of MHS's TC using our proprietary CompPlus360° valuation tool.
  - This methodology combines the cash compensation market data with typical market benefit and perquisites costs, from SullivanCotter's proprietary CompPlus360° database, to create TC market data.
- We then compared MHS's TC levels to the TC market data at the 25$^{th}$, 50$^{th}$, 75$^{th}$, and 90$^{th}$ percentiles.

# Appendix C

## Custom Peer Group

# Custom Peer Group

- The peer group consists of 146 organizations with median net revenues of $1.5 billion.

| Organization | City | State | Net Rev ($M) | Organization | City | State | Net Rev ($M) |
|---|---|---|---|---|---|---|---|
| [redacted] | | | | | | | |

# Custom Peer Group

- The peer group consists of 146 organizations with median net revenues of $1.5 billion.

| Organization | City | State | Net Rev ($M) | Organization | City | State | Net Rev ($M) |
|---|---|---|---|---|---|---|---|
| [redacted] | | | | | | | |

# Custom Peer Group

- The peer group consists of 146 organizations with median net revenues of $1.5 billion.

| Organization | City | State | Net Rev ($M) | Organization | City | State | Net Rev ($M) |
|---|---|---|---|---|---|---|---|
| [redacted] | | | | | | | |

# Custom Peer Group

- The peer group consists of 146 organizations with median net revenues of $1.5 billion.

| Organization | City | State | Net Rev ($M) | Organization | City | State | Net Rev ($M) |
|---|---|---|---|---|---|---|---|
| [redacted] | | | | | | | |

# Custom Peer Group

- The peer group consists of 146 organizations with median net revenues of $1.5 billion.

| Organization | City | State | Net Rev ($M) | Organization | City | State | Net Rev ($M) |
|---|---|---|---|---|---|---|---|
| [redacted] | | | | | | | |

# Appendix D

## Custom Peer Group Comparison Tables

# Base Salary Tables (Peer Group)

*$ in thousands*

| Title (Incumbent) | Base Salary | Base Salary Data Effective July 1, 2017 | | | | Approx. Market Position | Compa-Ratio | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | P25 | P50 | P75 | P90 | | P25 | P50 | P75 | P90 |
| President CEO (Boutros, M.D.) | $869.0 | | | | | 29 | | | | |
| EVP Chief Operating Officer (Lewis) | $450.0 | | | | | <25 | | | | |
| EVP Chief Clinical Officer (Boulanger, M.D.) | $450.0 | | | | | <25 | | | | |
| SVP Population Health (Chehade, M.D.) | $435.0 | | | | | 71 | | | | |
| SVP Chief Financial Officer (Richmond) | $420.0 | | | | | <25 | | | | |
| SVP Chief Quality Officer (Conners, M.D.) | $418.8 | | | | | 56 | | | | |
| Chief Legal Officer (Phillips) | $360.0 | | | | | 25 | | | | |
| SVP Chief Of Staff (Stern) | $345.0 | | | | | <25 | | | | |
| SVP Campus Transformation (Jones) | $280.0 | | | | | 77 | | | | |
| SVP External Affairs (Allen) | $247.5 | | | | | 26 | | | | |
| Chief Development Officer & President MH Foundation (Brown) | $225.0 | | | | | 25 | | | | |
| VP Care Delivery/Exec Dir MH Select (Perzy, M.D.) | --- | | | | | --- | | | | |
| VP Chief Experience Officer (Laskey, M.D.) | --- | | | | | --- | | | | |
| VP Chief Strategy Officer/SI Administration (Botros) | $320.0 | | | | | <25 | | | | |
| Chief Medical Informatics Officer (Kaelber) | $318.0 | | | | | 55 | | | | |
| VP Research (Sedor, M.D.) | $312.8 | | | | | 36 | | | | |
| VP Human Resources (Warman) | $285.0 | | | | | <25 | | | | |
| VP Chief Information Officer (Reichert) | $260.0 | | | | | <25 | | | | |
| VP Chief Nursing Officer (Kline) | $255.0 | | | | | <25 | | | | |
| Associate General Counsel (Rajki) | $220.4 | | | | | 47 | | | | |
| Exec Dir, Pop'n Health & Care Coordination (Delp) | $220.0 | | | | | 42 | | | | |
| VP Finance (Himes) | $216.0 | | | | | <25 | | | | |
| Exeutive Director, Ambulatory Network Operations (Jacono) | $195.0 | | | | | >90 (+2%) | | | | |
| Associate CNO – Ambulatory Nursing Operations (Carney) | $165.4 | | | | | 71 | | | | |
| Assoc CNO (Hannu) | $150.0 | | | | | 53 | | | | |
| Assistant To The CEO - Special Projects (Platten) (1) | $150.0 | | | | | --- | | | | |

# Base Salary Tables (Peer Group)

***$ in thousands***

| Title (Incumbent) | Base Salary | Base Salary Data Effective July 1, 2017 | | | | Approx. Market Position | Compa-Ratio | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | P25 | P50 | P75 | P90 | | P25 | P50 | P75 | P90 |
| Service Line Medical Admin (Surgery) (Brandt, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Specialty) (Patterson, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Oncology) (Li, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Trauma/Surgery) (Claridge, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Cardiology) (Lewis, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Obstetrics) (Bailit, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Rehab/Neuroscience) (Chae, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Other) (Teng, M.D.) | --- | | | | | --- | | | | |
| Service Line Medical Admin (Ambulatory) (Bruner, M.D.) (1) | --- | | | | | --- | | | | |
| Service Line Administrator (Oncology) (Rentschler) | $183.8 | | | | | 34 | | | | |
| Service Line Administrator (Cardiology) (Sukalac) | $180.0 | | | | | 42 | | | | |
| Service Line Administrator (Surgery) (Murphy) | $175.0 | | | | | 71 | | | | |
| Service Line Administrator (Ambulatory) (Yorko) | $155.0 | | | | | <25 | | | | |
| Service Line Administrator (Neuroscience) (Klinger) | $150.0 | | | | | 43 | | | | |
| Service Line Administrator/Business Development (Urgent Care) (Dunn) (1) | $150.0 | | | | | 37 | | | | |
| Sr Director Revenue Cycle (Graham) | $198.9 | | | | | 84 | | | | |
| Sr Director Of Access (Fragapane) (1) | $198.9 | | | | | 28 | | | | |
| Executive Director - Managed Care Program (Mego) | $193.8 | | | | | >90 (+3%) | | | | |
| CEO Aggregate (Peer Group): | | | | | | 29 | | | | |
| SVP/EVP Aggregate (Peer Group): | | | | | | 29 | | | | |
| VP Aggregate (Peer Group): | | | | | | 26 | | | | |
| Medical Administrator Aggregate (Peer Group): | | | | | | --- | | | | |
| Administrator Aggregate (Peer Group): | | | | | | 39 | | | | |
| Director Aggregate (Peer Group): | | | | | | 71 | | | | |

(1) National or general industry data used in the absence of peer group data.

# Total Cash Compensation Tables (Peer Group)

*$ in thousands*

| Title (Incumbent) | Base Salary | Total Cash Compensation* | | | | Total Cash Compensation Data Effective July 1, 2017 | | | | Approximate Market Position | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | No Incentive | Threshold | Target | Maximum | P25 | P50 | P75 | P90 | No Incentive | Threshold | Target | Maximum |
| President CEO (Boutros, M.D.) | $869.0 | $869.0 | $1,021.1 | $1,173.2 | $1,325.2 | | | | | <25 | 33 | 47 | 61 |
| EVP Chief Operating Officer (Lewis) | $450.0 | $450.0 | $506.3 | $562.5 | $618.8 | | | | | <25 | <25 | <25 | 28 |
| EVP Chief Clinical Officer (Boulanger, M.D.) | $450.0 | $450.0 | $506.3 | $562.5 | $618.8 | | | | | <25 | <25 | <25 | 35 |
| SVP Population Health (Chehade, M.D.) | $435.0 | $435.0 | $489.4 | $543.8 | $598.1 | | | | | 69 | 76 | 81 | 85 |
| SVP Chief Financial Officer (Richmond) | $420.0 | $420.0 | $472.5 | $525.0 | $577.5 | | | | | <25 | <25 | 30 | 40 |
| SVP Chief Quality Officer (Conners, M.D.) | $418.8 | $418.8 | $471.1 | $523.5 | $575.8 | | | | | 33 | 61 | 80 | >90 (+2%) |
| Chief Legal Officer (Phillips) | $360.0 | $360.0 | $405.0 | $450.0 | $495.0 | | | | | <25 | 31 | 45 | 56 |
| SVP Chief Of Staff (Stern) | $345.0 | $345.0 | $388.1 | $431.3 | $474.4 | | | | | <25 | <25 | <25 | 33 |
| SVP Campus Transformation (Jones) | $280.0 | $280.0 | $315.0 | $350.0 | $385.0 | | | | | 65 | 81 | 90 | >90 (+10%) |
| SVP External Affairs (Allen) | $247.5 | $247.5 | $278.5 | $309.4 | $340.3 | | | | | <25 | 25 | 35 | 45 |
| Chief Development Officer & President MH Foundation (Brown) | $225.0 | $225.0 | $253.1 | $281.3 | $309.4 | | | | | <25 | 30 | 42 | 53 |
| VP Care Delivery/Exec Dir MH Select (Perzy, M.D.) | --- | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| VP Chief Experience Officer (Laskey, M.D.) | --- | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| VP Chief Strategy Officer/SI Administration (Botros) | $320.0 | $320.0 | $344.0 | $368.0 | $392.0 | | | | | <25 | <25 | <25 | 25 |
| Chief Medical Informatics Officer (Kaelber) | $318.0 | $318.0 | $341.9 | $365.7 | $389.6 | | | | | 46 | 57 | 66 | 76 |
| VP Research (Sedor, M.D.) | $312.8 | $312.8 | $336.3 | $359.8 | $383.2 | | | | | 32 | 37 | 42 | 46 |
| VP Human Resources (Warman) | $285.0 | $285.0 | $306.4 | $327.8 | $349.1 | | | | | <25 | <25 | <25 | <25 |
| VP Chief Information Officer (Reichert) | $260.0 | $260.0 | $279.5 | $299.0 | $318.5 | | | | | <25 | <25 | <25 | <25 |
| VP Chief Nursing Officer (Kline) | $255.0 | $255.0 | $274.1 | $293.3 | $312.4 | | | | | <25 | <25 | <25 | <25 |
| Associate General Counsel (Rajki) | $220.4 | $220.4 | $236.9 | $253.5 | $270.0 | | | | | 33 | 42 | 50 | 58 |
| Exec Dir, Pop'n Health & Care Coordination (Delp) | $220.0 | $220.0 | $236.5 | $253.0 | $269.5 | | | | | 29 | 37 | 44 | 51 |
| VP Finance (Himes) | $216.0 | $216.0 | $232.2 | $248.4 | $264.6 | | | | | <25 | <25 | <25 | <25 |
| Exeutive Director, Ambulatory Network Operations (Jacono) | $195.0 | $195.0 | $209.6 | $224.3 | $238.9 | | | | | >90 (+1%) | >90 (+9%) | >90 (+16%) | >90 (+24%) |
| Associate CNO – Ambulatory Nursing Operations (Carney) | $165.4 | $165.4 | $177.9 | $190.3 | $202.7 | | | | | 62 | 75 | 78 | 81 |
| Assoc CNO (Hannu) | $150.0 | $150.0 | $161.3 | $172.5 | $183.8 | | | | | 42 | 58 | 70 | 77 |
| Assistant To The CEO - Special Projects (Platten) (1) | $150.0 | $150.0 | $161.3 | $172.5 | $183.8 | | | | | --- | --- | --- | --- |

# Total Cash Compensation Tables (Peer Group)

*$ in thousands*

| Title (Incumbent) | Base Salary | Total Cash Compensation* | | | | Total Cash Compensation Data Effective July 1, 2017 | | | | Approximate Market Position | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | No Incentive | Threshold | Target | Maximum | P25 | P50 | P75 | P90 | No Incentive | Threshold | Target | Maximum |
| Service Line Medical Admin (Surgery) (Brandt, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Specialty) (Patterson, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Oncology) (Li, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Trauma/Surgery) (Claridge, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Cardiology) (Lewis, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Obstetrics) (Bailit, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Rehab/Neuroscience) (Chae, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Other) (Teng, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Medical Admin (Ambulatory) (Bruner, M.D.) | — | — | — | — | — | | | | | — | — | — | — |
| Service Line Administrator (Oncology) (Rentschler) | $183.8 | $183.8 | $197.6 | $211.3 | $225.1 | | | | | 27 | 41 | 61 | 85 |
| Service Line Administrator (Cardiology) (Sukalac) | $180.0 | $180.0 | $193.5 | $207.0 | $220.5 | | | | | <25 | 50 | 67 | 81 |
| Service Line Administrator (Surgery) (Murphy) | $175.0 | $175.0 | $188.1 | $201.3 | $214.4 | | | | | 44 | 56 | 66 | 76 |
| Service Line Administrator (Ambulatory) (Yorko) | $155.0 | $155.0 | $166.6 | $178.3 | $189.9 | | | | | <25 | <25 | <25 | 57 |
| Service Line Administrator (Neuroscience) (Klinger) | $150.0 | $150.0 | $161.3 | $172.5 | $183.8 | | | | | 35 | 50 | 78 | 86 |
| Service Line Administrator/Business Development (Urgent Care) (Dunn) (1) | $150.0 | $150.0 | $161.3 | $172.5 | $183.8 | | | | | 35 | 40 | 45 | 51 |
| Sr Director Revenue Cycle (Graham) | $198.9 | $198.9 | $206.9 | $214.8 | $222.8 | | | | | 79 | 83 | 87 | 90 |
| Sr Director Of Access (Fragapane) (1) | $198.9 | $198.9 | $206.9 | $214.8 | $222.8 | | | | | <25 | 26 | 27 | 29 |
| Executive Director - Managed Care Program (Mego) | $193.8 | $193.8 | $201.6 | $209.3 | $217.1 | | | | | 87 | >90 (+2%) | >90 (+6%) | >90 (+10%) |
| CEO Aggregate (Peer Group): | | | | | | | | | | <25 | 33 | 47 | 61 |
| SVP/EVP Aggregate (Peer Group): | | | | | | | | | | <25 | 30 | 45 | 58 |
| VP Aggregate (Peer Group): | | | | | | | | | | <25 | 25 | 33 | 41 |
| Medical Administrator Aggregate (Peer Group): | | | | | | | | | | — | — | — | — |
| Administrator Aggregate (Peer Group): | | | | | | | | | | <25 | <25 | <25 | <25 |
| Director Aggregate (Peer Group): | | | | | | | | | | 42 | 45 | 49 | 53 |

* TCC based on the following annual incentive opportunity levels (Th/T/M): CEO: 17.5%; 35.0%; 52.5%; EVPs/SVPs: 12.5%; 25.0%; 37.5%; VPs: 7.5%; 15.0%; 22.5%; Service Line (Medical) Administrators: 7.5%; 15.0%; 22.5%; Directors: 4.0%; 8.0%; 12.0%
(1) National or general industry data used in the absence of peer group data.

# Total Compensation Tables (Peer Group)

*$ in thousands*

| Title (Incumbent) | Total Compensation with FY2016 Incentive Awards at: | | | | Total Compensation Data Effective July 1, 2017 | | | | Approximate Market Position | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No Incentive | Threshold | Target | Maximum | P25 | P50 | P75 | P90 | No Incentive | Threshold | Target | Maximum |
| President CEO (Boutros, M.D.) | $1,181.0 | $1,298.0 | $1,480.5 | $1,663.0 | | | | | 25 | 35 | 51 | 66 |
| EVP Chief Operating Officer (Lewis) | $571.9 | $622.3 | $684.2 | $746.1 | | | | | <25 | <25 | <25 | 30 |
| EVP Chief Clinical Officer (Boulanger, M.D.) | $558.0 | $619.8 | $681.7 | $743.6 | | | | | <25 | <25 | <25 | 36 |
| SVP Population Health (Chehade, M.D.) | $560.7 | $620.5 | $680.3 | $740.1 | | | | | 73 | 78 | 83 | 87 |
| SVP Chief Financial Officer (Richmond) | $535.4 | $581.9 | $639.7 | $697.4 | | | | | <25 | <25 | 31 | 41 |
| SVP Chief Quality Officer (Conners, M.D.) | $551.3 | $598.3 | $655.9 | $713.5 | | | | | 55 | 69 | 82 | >90 (+3%) |
| Chief Legal Officer (Phillips) (1) | $360.0 | $445.5 | $495.0 | $544.5 | | | | | — | — | — | — |
| SVP Chief Of Staff (Stern) | $441.9 | $486.8 | $534.3 | $581.7 | | | | | <25 | <25 | <25 | 36 |
| SVP Campus Transformation (Jones) | $370.0 | $408.5 | $447.0 | $485.5 | | | | | 76 | 85 | >90 (+4%) | >90 (+13%) |
| SVP External Affairs (Allen) | $323.3 | $353.1 | $387.1 | $421.2 | | | | | <25 | 27 | 37 | 47 |
| Chief Development Officer & President MH Foundation (Brown) | $289.9 | $318.5 | $349.4 | $380.4 | | | | | <25 | 30 | 42 | 53 |
| VP Care Delivery/Exec Dir MH Select (Perzy, M.D.) | — | — | — | — | | | | | — | — | — | — |
| VP Chief Experience Officer (Laskey, M.D.) | — | — | — | — | | | | | — | — | — | — |
| VP Chief Strategy Officer/SI Administration (Botros) | $363.7 | $387.7 | $411.7 | $435.7 | | | | | <25 | <25 | <25 | <25 |
| Chief Medical Informatics Officer (Kaelber) | $374.4 | $398.2 | $422.1 | $445.9 | | | | | 40 | 51 | 60 | 69 |
| VP Research (Sedor, M.D.) | $366.0 | $389.5 | $412.9 | $436.4 | | | | | 30 | 34 | 38 | 42 |
| VP Human Resources (Warman) | $335.4 | $356.7 | $378.1 | $399.5 | | | | | <25 | <25 | <25 | <25 |
| VP Chief Information Officer (Reichert) | $315.8 | $335.3 | $354.8 | $374.3 | | | | | <25 | <25 | <25 | <25 |
| VP Chief Nursing Officer (Kline) | $308.3 | $327.4 | $346.6 | $365.7 | | | | | <25 | <25 | <25 | <25 |
| Associate General Counsel (Rajki) | $265.4 | $281.9 | $298.5 | $315.0 | | | | | 29 | 37 | 45 | 52 |
| Exec Dir, Pop'n Health & Care Coordination (Delp) | $260.2 | $276.7 | $293.2 | $309.7 | | | | | <25 | 31 | 37 | 44 |
| VP Finance (Himes) | $269.1 | $285.3 | $301.5 | $317.7 | | | | | <25 | <25 | <25 | <25 |
| Exeutive Director, Ambulatory Network Operations (Jacono) | $223.6 | $238.2 | $252.8 | $267.4 | | | | | 64 | 76 | >90 (+3%) | >90 (+9%) |
| Associate CNO – Ambulatory Nursing Operations (Carney) | $200.3 | $212.7 | $225.1 | $237.6 | | | | | 52 | 63 | 75 | 78 |
| Assoc CNO (Hannu) | $184.6 | $195.9 | $207.1 | $218.4 | | | | | 27 | 45 | 58 | 68 |
| Assistant To The CEO - Special Projects (Platten) | $176.8 | $188.1 | $199.3 | $210.6 | | | | | — | — | — | — |

# Total Compensation Tables (Peer Group)

*$ in thousands*

| Title (Incumbent) | Total Compensation with FY2016 Incentive Awards at: | | | | Total Compensation Data Effective July 1, 2017 | | | | Approximate Market Position | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No Incentive | Threshold | Target | Maximum | P25 | P50 | P75 | P90 | No Incentive | Threshold | Target | Maximum |
| Service Line Medical Admin (Surgery) (Brandt, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Specialty) (Patterson, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Oncology) (Li, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Trauma/Surgery) (Claridge, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Cardiology) (Lewis, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Obstetrics) (Bailit, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Rehab/Neuroscience) (Chae, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Other) (Teng, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Medical Admin (Ambulatory) (Bruner, M.D.) | --- | --- | --- | --- | | | | | --- | --- | --- | --- |
| Service Line Administrator (Oncology) (Rentschler) | $225.0 | $238.8 | $252.6 | $266.4 | | | | | <25 | 32 | 46 | 69 |
| Service Line Administrator (Cardiology) (Sukalac) | $215.6 | $229.1 | $242.6 | $256.1 | | | | | <25 | <25 | 47 | 63 |
| Service Line Administrator (Surgery) (Murphy) | $212.9 | $226.1 | $239.2 | $252.3 | | | | | 33 | 48 | 58 | 68 |
| Service Line Administrator (Ambulatory) (Yorko) | $191.7 | $203.3 | $215.0 | $226.6 | | | | | <25 | <25 | <25 | <25 |
| Service Line Administrator (Neuroscience) (Klinger) | $182.3 | $193.6 | $204.8 | $216.1 | | | | | <25 | 34 | 48 | 75 |
| Service Line Administrator/Business Development (Urgent Care) (Dunn) | $173.3 | $184.6 | $195.8 | $207.1 | | | | | 27 | 31 | 36 | 40 |
| Sr Director Revenue Cycle (Graham) | $233.4 | $241.4 | $249.4 | $257.3 | | | | | 68 | 76 | 79 | 82 |
| Sr Director Of Access (Fragapane) | $233.4 | $241.3 | $249.3 | $257.2 | | | | | <25 | <25 | <25 | 26 |
| Executive Director - Managed Care Program (Mego) | $231.7 | $239.4 | $247.2 | $254.9 | | | | | 81 | 85 | 89 | >90 (+2%) |
| CEO Aggregate (Peer Group): | | | | | | | | | 25 | 35 | 51 | 66 |
| SVP/EVP Aggregate (Peer Group): | | | | | | | | | <25 | 32 | 47 | 59 |
| VP Aggregate (Peer Group): | | | | | | | | | <25 | <25 | 27 | 34 |
| Medical Administrator Aggregate (Peer Group): | | | | | | | | | --- | --- | --- | --- |
| Administrator Aggregate (Peer Group): | | | | | | | | | <25 | 29 | 41 | 55 |
| Director Aggregate (Peer Group): | | | | | | | | | 37 | 40 | 43 | 46 |

(1) Phillips is a contract employee and not eligible for benefits.

# Appendix E

## Incentive Prevalence Data

# Incentive Prevalence

| Cohort | STI Eligible | STI Target | STI Maximum | LTI Eligible | LTI Plan Total Years | LTI Target | LTI Maximum |
|---|---|---|---|---|---|---|---|
| Peer Group Incentive Prevalence (CEO): | | | | | | | |
| Metro Health CEO: | | | | | | | |
| **Delta (MetroHealth vs Peer Group):** | | | | | | | |
| Peer Group Incentive Prevalence (EVP/SVP level): | | | | | | | |
| MetroHealth EVP/SVPs: | | | | | | | |
| **Delta (MetroHealth vs Peer Group):** | | | | | | | |
| Peer Group Incentive Prevalence (VP level): | | | | | | | |
| MetroHealth VPs: | | | | | | | |
| **Delta (MetroHealth vs Peer Group):** | | | | | | | |
| Peer Group Incentive Prevalence (Administrators): | | | | | | | |
| MetroHealth Administrators: | | | | | | | |
| **Delta (MetroHealth vs Peer Group):** | | | | | | | |
| Peer Group Incentive Prevalence (Director level): | | | | | | | |
| MetroHealth Directors: | | | | | | | |
| **Delta (MetroHealth vs Peer Group):** | | | | | | | |

# Appendix F

## Benefits and Perquisite Assessment

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Medical/ Prescription Drugs** | • Two plans to choose from: MetroHealth Select Employee Plan and MetroHealth Select Employee Plus Plan.<br>• Cost-sharing applies.<br>• No special provisions for executives. | [redacted] | • Extending coverage to executives through the broad-based programs is consistent with market practice. |
| **Dental** | • Two plan to choose from: MetroHealth Dental Plan and Cigna PPO Plan.<br>• Cost-sharing applies.<br>• No special provisions for executives. | | |
| **Vision** | • One option: Eyemed Vision Care Plan.<br>• Cost-sharing applies (included in dental rate).<br>• No special provisions for executives. | | |
| **Employee Assistance Program (EAP)** | • Employer-paid.<br>• No special provisions for executives. | | |
| **Flexible Spending Accounts** | • Employee-paid.<br>• Health care ($2,600 maximum for 2017) and dependent care ($5,000 maximum for 2017) accounts.<br>• No special provisions for executives. | | |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Long-Term Care** | • No coverage provided. | [redacted] | • Not providing long-term care is consistent with market practice. |
| **Retiree Medical** | • Coverage provided via OPERS retirement plans.<br>• For Traditional Plan and Combined Plan, OPERS offers medical coverage to retirees and dependents with the monthly cost depending on Medicare status, years of service credit and date of retirement.<br>– Must be at least 60 years old with 20 years of service credit or any age with at least 30 years of service credit to be eligible.<br>• For the Member-Directed Plan, a portion of the employer contribution (4.0%) is made to a Retiree Medical Account (RMA), which can be used after retirement to pay qualifying medical expenses.<br>– Interest rate will be tied to the annual investment return of OPERS' pension assets:<br>• If returns are greater than zero, the RMA will be credited with 4% interest the following year.<br>• If returns are zero or negative, no interest will be credited to the RMA the following year.<br>– Graded vesting schedule at 10% per year starting at year 6 (100% vested after 15 years of service). | | • While retiree medical coverage is not a prevalent benefit for executives, extending coverage to executives through broad-based programs is consistent with market practice for organizations that provide such coverage.<br>• Having a retiree medical benefit automatically provided by OPERS in conjunction with retirement benefits is an uncommon arrangement in the market. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Basic Term Life Insurance and AD&D** | • Employer-paid.<br>• Basic Coverage of $50,000 for executives and physicians, 1.5x salary for others.<br>• $500,000 AD&D coverage for executives and physicians. | [redacted] | • Employer paid coverage is below market for any executive without GVUL coverage.<br>• Total employer-paid coverage of $500,000 provides 0.6x base pay coverage (for the CEO) to 3.33x base pay coverage.<br>– Higher paid executives receive below-median benefits relative to market.<br>• Total available coverage (employer plus employee paid) is consistent with the market. |
| **Supplemental Life Insurance** | • Executives provided $450,000 coverage (employer-paid).<br>– Additional amounts employee-paid.<br>• Provided through GVUL policies.<br>• Available coverage of 1x to 6x base pay, up to a maximum of $3,050,000 (including basic and supplemental coverage).<br>• May require health questionnaire or blood test for amounts in excess of guaranteed issue amount. | | |
| **Dependent Life Insurance** | • Employee-paid.<br>• 4 dependent life options for spouse and unmarried children at least 14 days of age to 26:<br>– Option 1: $5,000 spouse; $2,000 children.<br>– Option 2: $10,000 spouse; $4,000 children.<br>– Option 3: $20,000 spouse; $8,000 children.<br>– Option 4: $50,000 spouse; $20,000 children. | | |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Long-Term Disability** | • No employer-paid coverage provided.<br>• Two employee-paid options:<br>– Option A: 60% of base salary up to maximum monthly benefit of $10,000 (effectively caps pay at $200,000).<br>– Option B: 60% of base salary up to maximum monthly benefit of $15,000 (effectively caps pay at $300,000).<br>– All-source maximum of 70% of base pay for both options.<br>– 90 day elimination period for both options. | [redacted] | • It is uncommon in the market to offer no employer-provided long-term disability coverage.<br>• The voluntary coverage is consistent with market practice for employer-paid group coverage.<br>• Executives making more than $300,000 are further limited to the maximum monthly benefit, with seven executives eligible for less than 50% of base salary coverage. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Short-Term Disability** | • No employer-paid coverage provided.<br>• Two employee-paid options:<br>– Option 1: 60% of base salary up to a maximum weekly benefit of $2,500 (effectively caps pay at $216,667); 14 day elimination period; maximum benefit period of 11 weeks<br>– Option 2: 60% of base salary up to a maximum weekly benefit of $2,500 (effectively caps pay at $216,667); 29 day elimination period; maximum benefit period of 9 weeks<br>– Both options coordinate with the sick bank (i.e. if someone is receiving 60% STD pay, they can receive 40% sick pay from their sick bank, if time is available). | [redacted] | • Lack of employer provided short-tern disability, and the limits on the employee-purchased coverage, reflect a below-median market position.<br>• However, the chance to accrue significant sick leave helps offset the limited short-tern disability coverage, particularly for those with longer service and larger sick leave accruals. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Paid-Time Off** | • Holidays – 10 days.<br>• Vacation:<br>– CEO: 6 weeks (30 days)<br>– EVPs and SVPs: 5 weeks (25 days)<br>– Others receive 20 days per year if less than 23 years of service, 25 days after 23 years of service.<br>– Maximum accumulation of 1.5x annual accrual.<br>– Cash out of unused vacation at termination only.<br>• Sick leave:<br>– Sick hours are accrued at the rate of 4.6 hours for each 80 hours worked, up to a maximum of 15 days per calendar year.<br>– Sick leave can only be cashed out at retirement (need to immediately go into retirement status with OPERS) at 50% of accrual up to a max of 240 hours (800 hours if hired before January 1, 1994). | [redacted] | • Annual vacation accrual and holidays are consistent with market practice.<br>• The maximum accumulation for vacation available for cash out at termination is within typical market practice.<br>• However, it is uncommon to cash out sick leave. We note that MHS has limited the impact by:<br>– Cashing out at a 50% rate.<br>– Limiting the total number of hours that can be cashed out (240 or 800).<br>– Limiting cash out to retirement (i.e., not available for any termination). |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Qualified Retirement Plan** | **Ohio Public Employees Retirement System (OPERS)**<br>• Broad-based plan; MHS has opted out of Social Security.<br>• Contributions made on base pay, subject to IRS pay limits ($270,000 in 2017 for those hired after January 1, 1994, $400,000 in 2017 for those hired before January 1, 1994).<br>– Employer contributions of 14% of base pay.<br>– Mandatory employee contributions of 10% of base salary.<br>• Choice of three plans for those hired after January 1, 2003 (Traditional Plan for those hired prior to that date).<br>– Traditional Plan:<br>• Defined benefit pension plan providing 2.2% of final average salary for each year of service up to 30 years and either 2.5% or 2.2% of final average salary for each year of service over 30 years (depending on retirement group).<br>• Reduced for retirement prior to attaining 30 years of service or age 65.<br>– Combined Plan:<br>• Defined benefit pension plan providing 1% of final average salary for each year of service up to 30 years and 1.25% of final average salary for each year of service over 30 years.<br>PLUS<br>• The accumulated balance of employee contributions and earnings, with investment directed by the member.<br>– Member-Directed:<br>• The accumulated balance of a portion of the 14% employer contribution (reduced by plan-specified mitigating contribution of 1.00% and administrative expenses of 0.50%).<br>• A portion of the employer contributions (currently 4.0%) is set aside in a separate Retiree Medical Account, used to pay qualifying medical, dental, and vision expenses after retirement. | [redacted] | • It is consistent with market practice for executives to participate in the same program as other employees.<br>• Some provisions for MHS employees, like mandatory employee contributions, choice between DB and DC type benefits, and the lack of participation in Social Security, are uncommon in the not-for-profit market but much more prevalent in organizations with access to public retirement systems.<br>• Similarly, the 14% cost is high relative to not-for-profit competitors but is more in line with public retirement system costs. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Supplemental Retirement Plans** | **457(b) Plan**<br>• Broad-based defined contribution plan.<br>• Employee deferrals up to annual deferral limit ($18,000 in 2017), plus catch-up contributions.<br>**Section 457(f) SERP Plans**<br>• For CEO, EVPs and SVPs.<br>• Annual contributions, based on total cash compensation (base play plus PBVCP incentive):<br>– For the CEO: 20% (was 15% prior to 2015).<br>– For EVPs/SVPs: 10%<br>• Three-year "block" vesting.<br>– Vesting for the CEO is June 30, 2018 (initial vesting date was May 31, 2016).<br>– Vesting for original EVP/SVP participants is December 31, 2017.<br>– The intent is for there to be a new three-year vesting period after initial vesting is reached.<br>• Contributions also immediately vest upon death, disability, termination without cause, or termination for good reason.<br>• Vested contributions are paid in cash as soon as is practicable after amounts become taxable. | [redacted] | • Providing a 457(b) plan is consistent with market practice.<br>• Participation and contribution levels in the SERP plans are within typical market practice.<br>• The use of block vesting is less common than other forms of vesting, including class-year vesting, graded vesting based on years and/or service, and cliff vesting. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| Severance | • CEO: 18 months, extended to 24 months if suitable employment is not found. 12 months after the 4th year of employment.<br>• Other executives: 12 months continuation of base salary.<br>– After 6 months, payment is discontinued upon subsequent employment.<br>• Medical benefits continued for 6 months via employer payment of employer share of COBRA premium.<br>• Outplacement assistance available for 6 months.<br>• Subject to a release of claims by executive. | [redacted] | • The severance period for other executives is consistent with typical market practice.<br>• Other severance provisions are consistent with typical market practice. |

# Benefits and Perquisites Assessment

| Benefit | MetroHealth | Market Practice | Insights |
|---|---|---|---|
| **Perquisites** | • Not provided. | [redacted] | • Providing no perquisites is consistent with the trend in the market and limits the exposure for the organization. |

# Appendix G

## PBVC Principles Comparison

# THE METROHEALTH SYSTEM 2017 PBVC PROGRAM

## MANAGEMENT RECOMMENDATIONS - ADDENDUM

# THE METROHEALTH SYSTEM 2017 PBVC PROGRAM

## MANAGEMENT RECOMMENDATIONS – ADDENDUM

### CURRENT PROPOSAL

In mid-February 2017, management proposed several changes to the PBVC program for 2017. These changes to the program structure are delineated below.

1. **Metrics to focus on year-over-year improvements** – Progressive annual improvements are critical to institutionalizing a culture of performance. Continuity of the majority of metrics for several years, and focus on year-over-year improvement is more likely to create sustainable culture of performance.

2. **Expand the minimum to maximum range from 80-120% to 50-150%** – During the initial years of the program, concern was voiced for the efficacy of the program, and thus the range of performance was deliberately constrained. The past 4 years have unequivocally demonstrated that the program has become a very important driver to MetroHealth's success, as well as driving additional value to the community. Management recommends expanding the range of performance level to better correlate to actual achievement.

3. **Change from step-wise measurements to sliding scale** – 2013 through 2016, achievement was measured at threshold-value for each of the minimum, target, and maximum levels. For example if a goal was determined to be 500, 1,000, and 1,500 at minimum, target, and maximum levels, and actual performance was 950, then achievement is recognized at the minimum level. Management recommends using a sliding scale (e.g., achievement would be measures at 950/1,000, or 95%).

4. **Most senior executives (SVP, EVP, and CEO) would all use the same performance metrics for evaluation, but have different weights** – Previously, the SVP and EVP group performance was measured at 70% institutional metrics and 30% personal metrics. With the proposed change, the institutional goals would be equally weighed for the CEO, and would emphasize specific areas of responsibility for the CEO's direct reports. For example, quality metrics would account 40% for the Chief Quality Officer, while each remaining metrics weighted at 15%, each.

5. **Cap Executive Pay** - Previously, individual executive compensation was capped at 105% of the 75$^{th}$ percentile. Management proposes changing executive compensation cap to the 90$^{th}$ percentile of peer group.

## PROPOSED 2017 PBVC METRICS AND WEIGHTS

In addition, management proposed the following metrics for 2017.

1. **Financial (20%) – Adjusted EBIDA (Earnings Before Interest, Depreciation, and Amortization)** – We propose to move away from Adjusted Income to Adjusted EBIDA. This metric will assess the amount of funds available for debt payment, which is critically important relative to the MetroHealth Transformation.

   EBIDA performance would be adjusted to exclude:

   a. GASB 68 pension income / (expenses) which is recorded on an annual basis using the results from the OPERS actuary reports. In Ohio, employer contributions to the State's cost-sharing multi-employer retirement systems are established by statute. These contributions, are payable to the retirement systems one month in arrears and constitute the full legal claim on the System for pension funding. Although the liabilities recognized under GASB 68 meet the GASB's definition of a "liability" in its conceptual framework for accounting standards, they do not represent legal claims on the System's resources, and there are no cash flows associated with the recognition of net pension liabilities, deferrals and expense.

   b. Board-approved non-recurring charges including one-time investment and transitional costs relating to new services, programs, and initiatives.

   In recommending the various metrics, management has evaluated the levels of performance over the past 6 years. The table below reflects annual adjusted EBIDA and adjusted EBIDA margin for 2011 through 2016, and the average for the six years.

| Exclude GASB 68 Pension | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | Average |
|---|---|---|---|---|---|---|---|
| **Adjusted EBIDA** | [redacted] | | | | | | |
| **Adj. EBIDA Margin** | | | | | | | |

**For 2017, management recommends a [redacted] improvement over 2016 performance at the minimum, target, and maximum levels. This would equate to [redacted] in EBIDA at the minimum, target, and maximum levels, and [redacted] million in adjusted operating income at the minimum, target, and maximum levels.**

2. **STRATEGIC (20%) – Gain in Unique Patients (10%) and Gain in Unique Lives in Risk Contracts (10%)** – We propose to continue the focus on the number of patients served by MetroHealth during the calendar year (System Unique

Patients). This metric appropriately measures community reach and dependence on MetroHealth, especially in a county with a stable population.

In recommending the various metrics, management evaluated performance over the past 6 years. The table below reflects annual gains in the number of unique patients and the % Gain for 2011 through 2016, and the average for the six years.

| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | Average |
|---|---|---|---|---|---|---|---|
| Gain in Unique Patients | [redacted] | | | | | | |
| % Gain | | | | | | | |

**For 2017, management recommends [redacted] Gain in Unique Patients over 2016 performance at the minimum, target, and maximum levels. This would equate to [redacted] gain in unique patients served at the minimum, target, and maximum levels.**

The number of Unique Lives in Risk Contracts measures MetroHealth's progress in aligning reimbursement models with the population health commitment. This is a new performance measure. Management has evaluated the levels of performance in 2016, which includes Unique Lives in CMS MSSP program [redacted], CareSource Total Cost of Care Contract [redacted], MetroHealth Employee ACO [redacted] and Cle-Care [redacted]. Thus, the 2016 base is [redacted] Unique Lives in Risk Contracts.

**For 2017, management recommends [redacted] Gain in Unique Lives in Risk Contracts over 2016 performance at the minimum, target, and maximum levels. This would equate to [redacted] gain in attributed unique lives in risk contracts at the minimum, target, and maximum levels.**

3. **QUALITY (20%) – Improvement in CMS Star Rating (10%) and Improvement in Aggregate ACO Quality Score (10%)** – We propose to continue the focus on external benchmarking of overall quality using CMS Overall Hospital Quality Star Rating.

In recommending the various metrics, management has evaluated the levels of performance in 2016, which was the first year of the program. MetroHealth achieved a 1-Star rating, initially, and has received data which indicates that the improvements made should culminate in 2-Star rating.

**For 2017, management recommends an improvement of [redacted] CMS Overall Hospital Quality Star Rating over 2016 initial performance at the minimum, target, and maximum levels. This would equate to [redacted] achievement in CMS Overall Hospital Quality Star Rating during 2017.**

In addition, we are recommending continued focus on Aggregate ACO Quality Score, which represents 20 individual and composite quality measure targeted at population

health. In 2016, the initial year of measurement, MetroHealth achieved an Aggregate ACO Quality Score of [redacted] using the following table.

1. Population Health: All adult population primary care individual metric goals:

| Metric | Definition | 2016 Baseline | Minimum | Target | Maximum |
|---|---|---|---|---|---|
| [redacted] | | | | | |

Scoring: 1 point for Threshold
2 points for Target
3 points for Stretch

**For 2017, management recommends [redacted] improvement in Aggregate ACO Quality Score over 2016 at the minimum, target, and maximum levels. This would equate to a score of [redacted] in Aggregate ACO Quality Score for 2017.**

4. **COMMUNITY AND DIVERSITY (20%) – Diverse and Local Construction Spend (15%) and Community Engagement (5%)** – We propose to continue the focus on the percentage of design, engineering and construction aggregate spend for projects that originated in year or later to companies with diversity designation including: Minority business enterprise ( MBE), Small business enterprise (SBE), and Female business enterprise (FBE).

In recommending the various metrics, management has evaluated the levels of performance over the past 3 years. The table below reflects annual gains in the number of unique patients and the % Gain for 2011 through 2016, and the average for the six years.

| | 2014 | 2015 | 2016 | | Average |
|---|---|---|---|---|---|
| **Community Spend** | [redacted] | | | | |

**For 2017, management recommends [redacted] Diverse and Local Construction Spend performance at the minimum, target, and maximum levels. This is not a change from 2016 levels of performance, as current achievement in considered Best-in-Class.**

Management Proposes to introduce a Community Engagement goal to focus on working collaboratively with community groups to address issues that impact the well-being of those groups. With the creation of the Board Community Engagement Committee, three distinct projects, each building on the success of the proceeding were developed. The three projects are:

- Community Needs Assessment;
- Needs Gap Analysis;
- Identifying 5 Top Priorities for next 3 years

**For 2017, management recommends successful completion of [redacted] Community Engagement Projects as performance at the minimum, target, and maximum levels.**

5. **EFFICIENCY & PATIENT ENGAGEMENT (20%) – Call Center Service Level (10%) and Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) Score (10%)** – We propose to continue the focus the improving our service delivery efforts through our call center to facilitate and enhance consumer interactions with MetroHealth.

In recommending the various metrics, management has evaluated the levels of performance over the past year. The graph below demonstrates unacceptable service level performance from December 2015 through August 2016, which ranged between

[redacted] telephone answer rate within 60 seconds. During the last three months, MetroHealth has achieved a service rate of [redacted] telephone answer rate within 60 seconds.

[redacted]

As a result of this significant improvement, and in an effort to continue to elevate customer experience, management proposes to reset the service rate definition for telephone answering within 60 seconds to within 30 seconds. Analysis of our service level using this new definition during the fourth quarter of 2016 is [redacted]

**For 2017, management recommends [redacted] improvement of service performance at the minimum, target, and maximum levels. This would equate to [redacted] service performance at 30 seconds at the minimum, target, and maximum levels.**

Starting in 2014, MetroHealth has made accelerating progress towards population health as the cornerstone of its long term strategy for community and business success. The fundamental reinvention of care, is predicated on improving geographic access to care for patients, so as to diminish obstacles to care, such as transportation and unfamiliarity with neighborhood.

Since 2011, we have experienced a [redacted] increase in the total number of outpatient visits. The number of visits performed on the Main Campus has remained virtually unchanged, with 100% of the growth coming from outlying facilities. In 2017, we expect a [redacted] increase in outpatient visits over 2016, with the vast majority of this increase coming from outlying facilities. The graph below illustrates these changes.

It is clear that the patient experience is, therefore, shaped by the frequent interactions of the over [redacted] outpatient visits, rather than the [redacted] inpatient encounters. Accordingly, management proposes to focus on patient experience during these visits.

In 2011, CMS launched a Physician Compare website and currently provides a directory of providers in their communities and includes quality measures and patient experience measures for the physician office setting. Much like the Hospital Compare website, the Physician Compare website provides viewers with information to allow them to make informed decisions on where to receive care based on feedback strictly on physicians.

The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey is a standardized tool to measure patients' perception of care provided by physicians in an office setting. Another way to think of CGCAHPS is like a "sister" survey to the more well-known HCAHPS survey. The rating scale is still 0-10 where 9's and 10's will be evaluated in terms of a top box score.

The organization-wide CGCAHPS top-box score (9's and 10's make up the top box score) was [redacted] in 2016 for Recommend Provider.

**For 2017, management recommends [redacted] improvement organization-wide CGCAHPS top-box score compared to 2016 at the minimum, target, and maximum levels. This would equate to [redacted] Recommend Provider Top-box at the minimum, target, and maximum levels.**

| 2017 Goal / Measure | Weight | Performance Level | | | |
|---|---|---|---|---|---|
| | | Minimum (50%) | Target (100%) | Maximum (150%) | 2016 ACTUAL |
| **Financial (20%)** | | | | | |
| **1. Increase in Adjusted EBIDA[1] over 2016** ($ thousands) | 20% | | | | |
| **Strategic (20%)** | | | | | |
| **1. Gain Unique Patients** | 10% | | | | |
| **2 Gain in Unique Lives in Risk Contracts[2]** | 10% | | | | |
| **Quality (20%)** | | | | | |
| **1. Improve CMS Star Rating[3]** | 10% | | | | |
| **2 Improve Aggregate ACO Quality Score[4]** | 10% | | | | |
| **Community & Diversity (20%)** | | | | | |
| **1. Diverse & Local Construction Spend[5]** | 15% | | | | |
| **2. Complete Community Engagement[6]** | 5% | | | | |
| **Efficiency & Engagment (20%)** | | | | | |
| **1. Improve Call Center Service Level @ 30 seconds** | 10% | | | | |
| **2 Improve CGCAHPS Recommend Provider Top-box Sco** | 10% | | | | |

[redacted]

1 Plan includes a "trigger" equal to the minimum EBIDA improvement (after incentives). Adjusted EBIDA Excludes Board-approved non-recurring charges including one-time investment and transitional costs relating to new services, programs, and initiatives and the GASB 68 Pension

2 Includes all attributable lives under Risk arrangements, including Total Cost of Care and two-sided risk arrangements.

3 CMS Star Rating as published on medicare.gov/hospitalcompare website and updated quarterly during 2017.

4 All adult population primary care aggregate ACO metric ( [redacted] )

5 Aggregate design, engineering and construction spend that was originated in 2016 or later to companies with diversity designation including: Minority business enterprise ( MBE),Small business enterprise (SBE), and Female business enterprise (FBE).

6 Complete any number of the following projects: Community Needs Assessment; Needs Gap Analysis; Identifying 5 Top Priorities for next 3 years.

## SEPARATION OF FUNDING AND PERFORMANCE METRICS

Following discussion with several Board members since the issuance of management's proposed changes to the PBVC program for 2017 in mid-February, it became clear that there are two distinct elements of the program that when intermixed cause confusion.

For the sake of clarity, management proposes a separation of the funding and performance metrics. The **FUNDING METRIC** would determine the level of performance that management needs to meet its obligation to financial roadmap for organization success. This metric would serve as the on-off switch for the PBVC, as well as determine the amount available for distribution. The **PERFORMANCE METRICS,** as discussed in the preceding pages, would determine how the funds are distributed based on the achievements.

1. **Funding Metric** – Management proposes the funding metric used is Adjusted EBIDA. This metric will assess the amount of funds available for debt payment, which is critically important relative to the MetroHealth Transformation.

2. **Trigger for funding of PBVC program** – Management proposes that the PBVC program is funded ONLY after management has achieved the budgeted EBIDA of $66 million, which approximates investment grade EBIDA at BBB- rating and is $7 million improvement over 2016 EBIDA.

3. **Minimum funding of PBVC program** – Management proposes to fund the PBVC program at 50% share between $66 million to $70 million of EBIDA ($2 million in total PBVC awards).

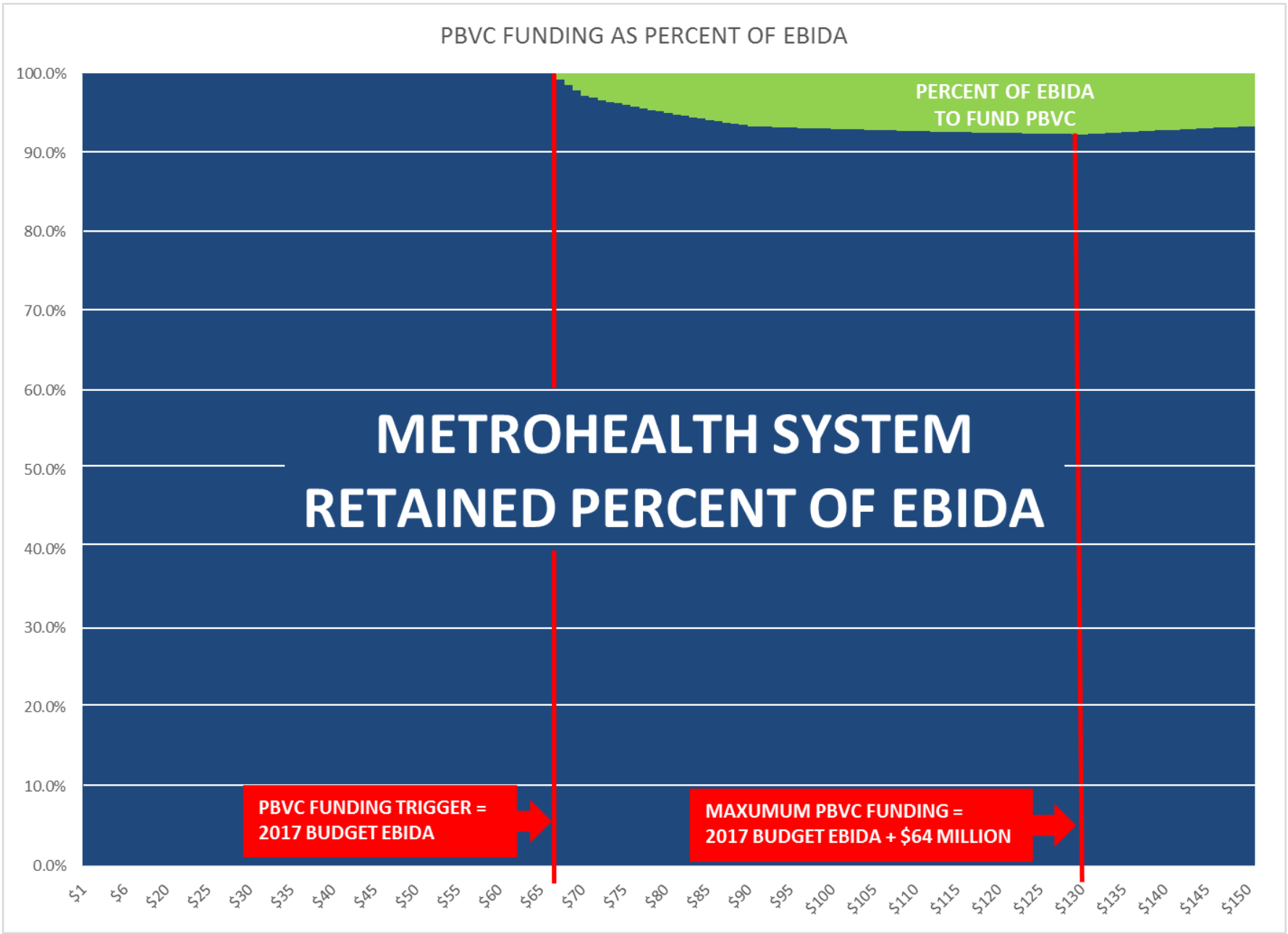
4. **Additional funding of PBVC program** – Management proposes to continue funding of the PBVC program at 20% share between $70 million to $100 million of EBIDA, and at 10% share between $100 million to $130 million of EBIDA

5. **Maximum funding of PBVC program** – Management proposes to cap funding of the PBVC program at $130 million of EBIDA, which approximates EBIDA at AA+ rating, with MetroHealth retaining 100% of EBIDA above $130 million.

See illustrative charts on next two pages. The first chart illustrates how the proposed model would impact the portion of EBIDA that is retained by MetroHealth vs. that used to fund the PBVC. It also indicates the threshold level of performance (trigger) and the maximum award. The second chart compares the current (2016 Design) and the proposed (2017 Design) funding, and benchmarks performance against S&P 2015 Medians* at various rating levels.

You will note that the funding in the proposed model begins once performance has reached investment grade achievement (BBB-) and increases along the benchmarks to a maximum is delayed, so that management has to achieve $10 million more in EBIDA to achieve the same level as the current design.

*EBIDA is calculated by using S&P 2015 Not-For-Profit Acute Stand-Alone Hospital Median Operating margin (%) + MH budgeted interest & deprecia ion ($50


PBVC FUNDING AS PERCENT OF EBIDA
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
PERCENT OF EBIDA
TO FUND PBVC
METROHEALTH SYSTEM
RETAINED PERCENT OF EBIDA
PBVC FUNDING TRIGGER =
2017 BUDGET EBIDA
MAXUMUM PBVC FUNDING =
2017 BUDGET EBIDA + $64 MILLION
$1
$6
$20
$25
$30
$35
$40
$45
$50
$55
$60
$65
$70
$75
$80
$85
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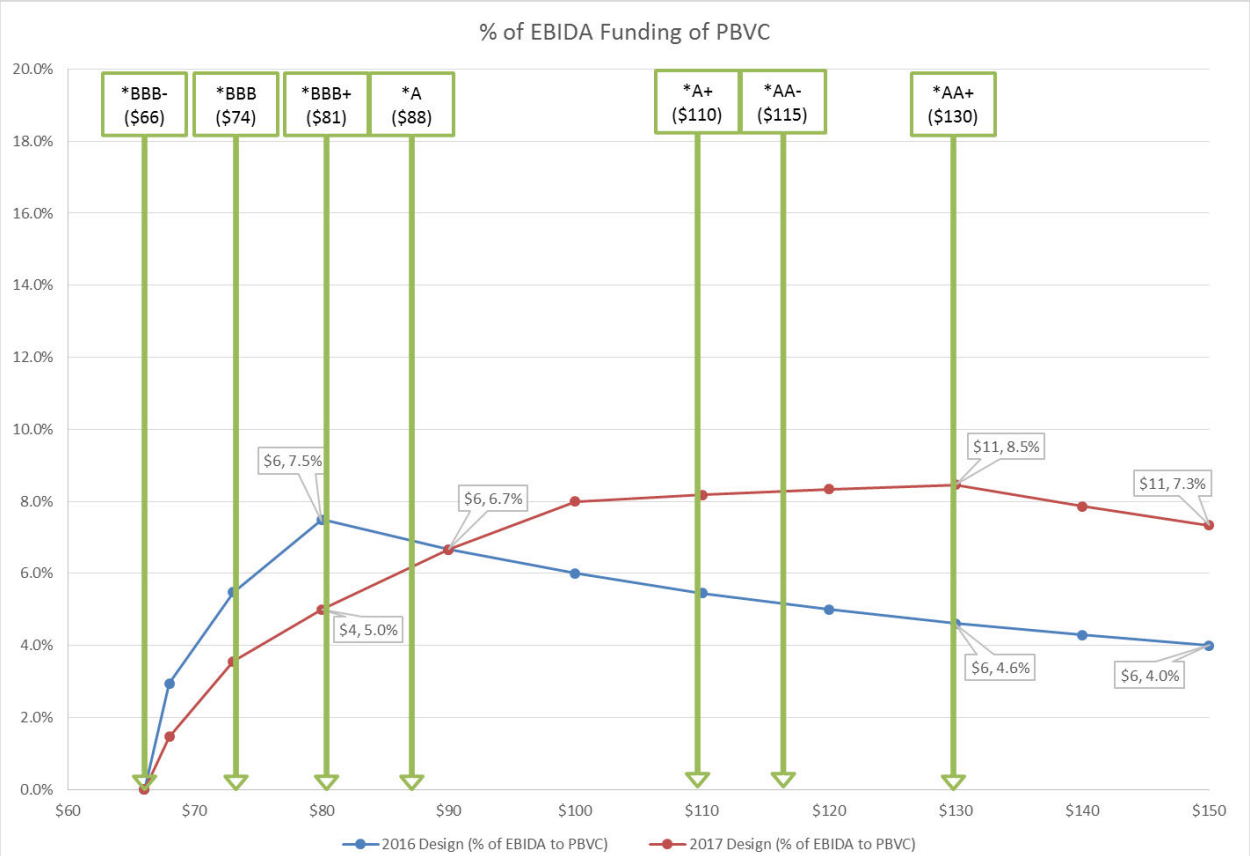
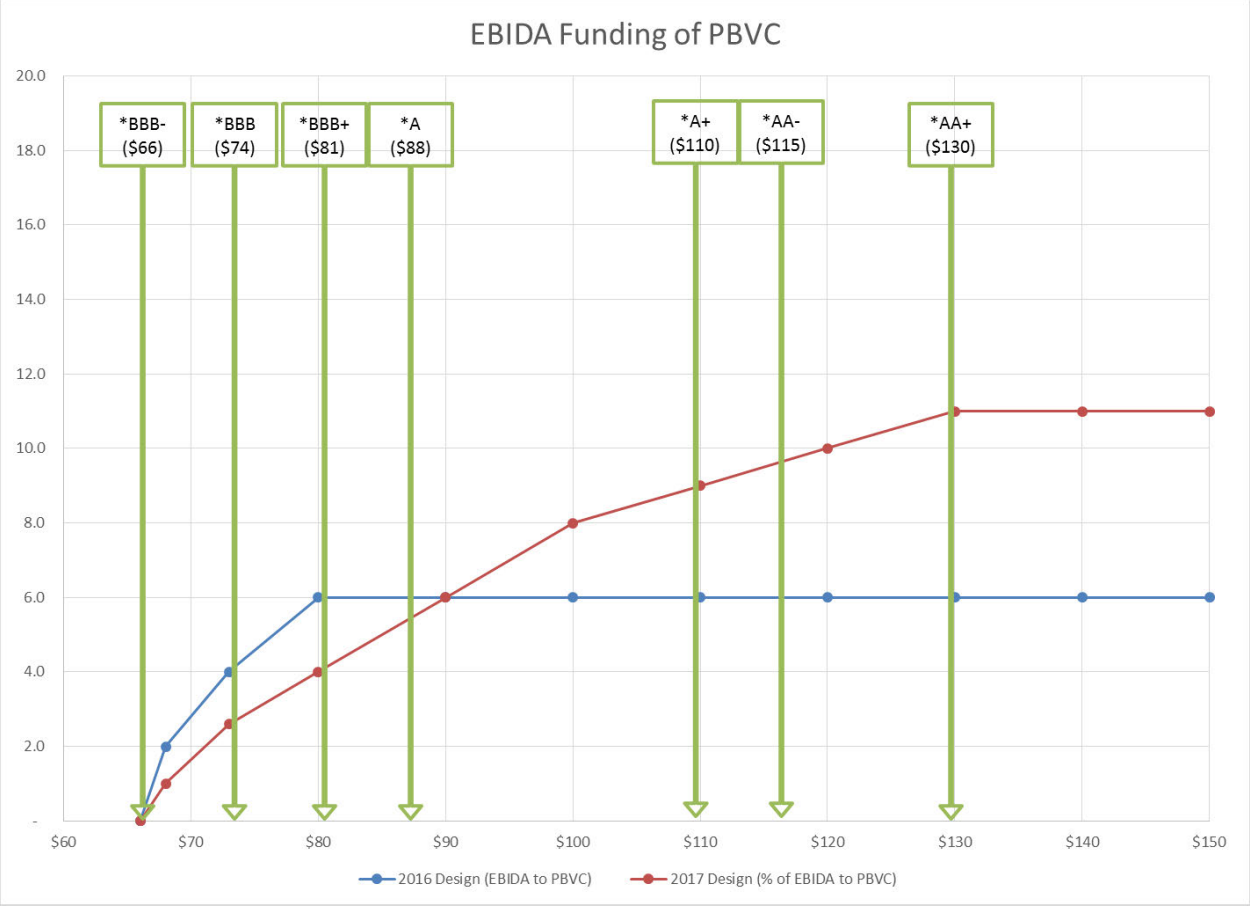
$105
$110
$115
$120
$125
$130
$135
$140
$145
$150




*EBIDA is calculated by using S&P 2015 Not-For-Profit Acute Stand-Alone Hospital Median Operating margin (%) + MH budgeted interest & depreciation ($50)



To further illustrate the difference and interplay between Funding Metrics and Achievement metrics, we have created the following examples.

**EXAMPLE 1**

Assumptions

- 2017 adjusted EBIDA is calculated at $80 million
- 2017 Achievement metrics composite equals 110% of target

Outcomes

- The PBVC is funded at $4 million which equals the maximum available distribution at 150% of target.
- Since achievement composite equals 110% of target, only $2.93 million is distributed by the program [$4 / 150% * 110% = $2.93].
- This results in an EBIDA retained by MetroHealth of $77.07 (96.3%) and the PBVC program is funded at $2.93 (3.7%).

**EXAMPLE 2**

Assumptions

- 2017 adjusted EBIDA is calculated at $100 million
- 2017 Achievement metrics composite equals 90% of target

Outcomes

- The PBVC is funded at $8 million which equals the maximum available distribution at 150% of target.
- Since achievement composite equals 90% of target, only $4.8 million is distributed by the program [$8 / 150% * 90% = $4.8].
- This results in an EBIDA retained by MetroHealth of $95.2 (95.2%) and the PBVC program is funded at $4.8 (4.8%).

**EXAMPLE 3**

Assumptions

- 2017 adjusted EBIDA is calculated at $140 million
- 2017 Achievement metrics composite equals 120% of target

Outcomes

- The PBVC is funded at the maximum of $11 million which equals the maximum available distribution at 150% of target.
- Since achievement composite equals 120% of target, only $8.8 million is distributed by the program [$11 / 150% * 120% = $8.8]
- This results in an EBIDA retained by MetroHealth of $131.2(93.9%) and the PBVC program is funded at $8.8 (6.1%).

| 2017 Proposed program | | | | |
|---|---|---|---|---|
| Adjusted EBIDA | EBIDA Retained by MH | EBIDA funding of PBVC | % of EBIDA Retained by MH | % of EBIDA funding of PBVC |
| $1 to $66 | $1 to $66 | $0.0 | 100.0% | 0.0% |
| $68.0 | $67.0 | $1.0 | 98.5% | 1.5% |
| $70.0 | $68.0 | $2.0 | 97.1% | 2.9% |
| $75.0 | $72.0 | $3.0 | 96.0% | 4.0% |
| $80.0 | $76.0 | $4.0 | 95.0% | 5.0% |
| $85.0 | $80.0 | $5.0 | 94.1% | 5.9% |
| $90.0 | $84.0 | $6.0 | 93.3% | 6.7% |
| $95.0 | $88.0 | $7.0 | 92.6% | 7.4% |
| $100.0 | $92.0 | $8.0 | 92.0% | 8.0% |
| $105.0 | $96.5 | $8.5 | 91.9% | 8.1% |
| $110.0 | $101.0 | $9.0 | 91.8% | 8.2% |
| $115.0 | $105.5 | $9.5 | 91.7% | 8.3% |
| $120.0 | $110.0 | $10.0 | 91.7% | 8.3% |
| $125.0 | $114.5 | $10.5 | 91.6% | 8.4% |
| $130.0 | $119.0 | $11.0 | 91.5% | 8.5% |
| $135.0 | $124.0 | $11.0 | 91.9% | 8.1% |
| $140.0 | $129.0 | $11.0 | 92.1% | 7.9% |
| $145.0 | $134.0 | $11.0 | 92.4% | 7.6% |
| $150.0 | $139.0 | $11.0 | 92.7% | 7.3% |

# The MetroHealth System

## EXECUTIVE COMPENSATION PRINCIPLES

| PRINCIPLE | CURRENT (2013) | PROPOSED (2017) |
|---|---|---|
| **Comparison Group** | Comparably-sized nonprofit and public hospital/health systems. | Comparably-sized nonprofit and public hospital/health systems, with average revenues at expected revenues for program duration of 3 years. |
| **Individual Base Salary** | Individual base salaries set at or below the 50th percentile of Total Cash Compensation for the Comparable Group.<br>For those executives whose current Base Salary is above this 50th percentile of Total Cash Compensation for the Comparable Group, their Base shall not be increased until such time that market conditions change and surpass their current base. | Individual base salaries will approximate the 50th percentiles of Base Salary of the Comparable Group. |
| **System Goals** | The Board of Trustees will annually establish goals that are metric-driven and provide a multidimensional approach to organizational success, including financial, strategic, quality and operational goals. | The Board of Trustees will annually establish goals that are metric-driven and balanced to achieve short and long term organizational success, including financial, strategic, quality, inclusion & diversity and operations/satisfaction goals. |
| **Financial Trigger for PBVC activation** | Financial trigger is set at the Threshold or Minimum Financial Goals, as annually set by the Board of Trustees. | Financial trigger will be a distinct funding metric annually set by the Board of Trustees.<br>Financial Trigger annually set to approximate investment grade EBIDA at BBB- rating of healthcare organizations as published annually by Standard & Poors. |
| **Executive Target as % of Base Salary** | CEO – 35%<br>EVP/SVP – 25%<br>Service Line Leader/Chair – 15%<br>Center Leader/Director – 8% | CEO – 35%<br>EVP/SVP – 25%<br>Service Line Leader/Chair – 15%<br>Center Leader/Director – 8% |
| **Institutional vs. Personal Goals** | CEO Institutional: Personal Goals – 100%:0%<br>EVP/SVP Institutional: Personal Goals – 70%:30%<br>SL Leader/Chair Institutional: Personal Goals – 50%:50%<br>Center /Director Institutional: Personal Goals – 30%:70% | CEO Institutional: Personal Goals – 100%:0%<br>EVP/SVP Institutional: Personal Goals – 100%:0% (with individually assigned weights for each executive)<br>SL Leader/Chair Institutional: Personal Goals – 50%:50%<br>Center /Director Institutional: Personal Goals – 30%:70% |

| PRINCIPLE | CURRENT (2013) | PROPOSED (2017) |
|---|---|---|
| **Range of PBVC performance** | Minimum – 80% of Target<br>Target – 100% of Target<br>Maximum – 120% of Target | Minimum – 50% of Target<br>Target – 100% of Target<br>Maximum – 150% of Target |
| **Progression of PBVC performance** | Stepwise progression – achievement at midpoints, will be assumed at the lower performance level.<br>System funds PBVC program at 100% after initial trigger is achieved. | Sliding scale progression - achievement at midpoints, will be calculated at % of Target performance.<br>System funds PBVC program at 50% share for first $4 million above EBIDA trigger.<br>System funds PBVC program at 20% share for next $30 million above EBIDA trigger (EBIDA Trigger + $4 million).<br>System funds PBVC program at 10% share for next $30 million above EBIDA trigger (EBIDA Trigger + $34 million). |
| **Maximum Individual Total Cash Compensation** | Total Cash Compensation will be Base Salary plus any Performance Based Variable Compensation earned for the year.<br>Total Cash Compensation for each executive will not exceed an amount equal to 105% of 75% Percentile of Total Cash Compensation of the Comparable Group. | Total Cash Compensation will be Base Salary plus any Performance Based Variable Compensation earned for the year.<br>Total Cash Compensation for each executive will not exceed an amount equal to the 90th percentiles of Total Cash Compensation of the Comparable Group.<br>Exceptions shall be specifically authorized by the Board of Trustees. |
| **Aggregate Base Salary of Executive Group (CEO, EVP, SVP, VP, SL Leader, Chairs)** | Aggregate base salaries will be between the 40th – 50th percentiles of Total Cash Compensation of the Comparable Group. | DELETED |
| **Aggregate Base Salary + Threshold PBVC Compensation of Executive Group (CEO, EVP, SVP, VP, SL Leader, Chairs)** | Aggregate base salaries will be between the 45th – 60th percentiles of Total Cash Compensation of the Comparable Group. | DELETED |
| **Aggregate Base Salary + Target PBVC Compensation of Executive Group (CEO, EVP, SVP, VP, SL Leader, Chairs)** | Aggregate base salaries will be between the 50th – 65th percentiles of Total Cash Compensation of the Comparable Group. | DELETED |
| **Aggregate Base Salary + Maximum PBVC Compensation of Executive Group (CEO, EVP, SVP, VP, SL Leader, Chairs)** | Aggregate base salaries will not exceed 105% of the 75th percentiles of Total Cash Compensation of the Comparable Group. | DELETED |