Pinnacle Hospital

A Recapitalization & Value-Creation Plan for a Moratorium-Protected, Physician-Owned Acute-Care Hospital

Crown Point, Indiana · Chicago Metropolitan Statistical Area / Northwest Indiana

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The Thesis in One Line

> Underwrite the normalized run-rate, not the trailing loss; own the real estate as the credit and recovery spine; and engineer every physician transition around the license rather than into it.

Pinnacle is a high-margin surgical platform sitting a single orthopedic recruitment away from break-even, wrapped around real estate worth roughly twice its mortgage, now made structurally cheaper to run by a newly won tax exemption.

- Enterprise Value: 2× RE debt + franchise

What This Plan Contains

01

Executive Summary

The opportunity, three pillars of value, and the recommended two-track path

02

The Asset, Market, & Its History

Legacy ownership and operating timeline of a protected franchise in a growing Chicagoland Market

03

Situation Assessment

Operations, capital structure, and the narrow gap to break-even

04

The Two Structural Catalysts

A recurring tax exemption and the real-estate equity beneath the enterprise

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Capital Structuring Strategies

Bridge, sale-leaseback, PE recapitalization, and health-system acquisition

01

Phased Physician Buyout

Redeeming legacy holders and rebuilding the cap table around active surgeons

02

Operational Expansion

Converting a single recruitment into durable, diversified surgical volume

03

Value-Based Care Overlay

A physician-enablement layer that compounds the franchise, license intact

04

Risks & Mitigants

Named plainly, each paired with a control

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The Ask & Next Steps

What we invite a capital partner to do

Three Pillars of Value

Protected Franchise

18

Licensed Beds

A grandfathered physician-owned hospital license under the federal moratorium — it cannot be replicated de novo.

Recurring Tax Relief

$1.3M

Annual Saving

A validated Indiana provider-fee (HAF) exemption — an annual, recurring cost now removed prospectively.

Hard-Asset Equity

$13.5M

Equity Above Mortgage

A 2023 appraisal concluded $28.1MM of real property against ~$14.6MM in RE-secured debt.

Ops Gap: 1 orthopedic surgeon 5–6 incremental monthly spine cases separate the platform from break-even.

An Acquirable, Financeable Turnaround

Pinnacle Hospital is a moratorium-protected, physician-owned acute-care hospital — 18 licensed beds, four operating rooms, and a cardiac catheterization lab, purpose-built in 2006–2007 and profitable through most of its operating life.

The honest starting point is a negative operating result, a senior lender in covenant default, and a stretched payables book. The opportunity is that each of those pressures is **separable, temporary, and — correctly structured — a source of value rather than a barrier to it.**

EXECUTIVE OVERVIEW

Transaction Summary

Facility Profile

Pinnacle Hospital is an 18-bed physician-owned acute care facility in Crown Point, Indiana, operating under a grandfathered state license that no longer permits new physician-owned hospitals. The hospital provides multi-specialty surgical services including orthopedics, spine, cardiology with cath lab, and advanced imaging.

Management has invested over $10M in recent facility upgrades and weathered a perfect storm of temporary headwinds—COVID disruptions, EHR conversion challenges, and provider volatility—while maintaining all debt service obligations.

Financing Request

Total Facility: $23.0M consolidated structure

- $18M first mortgage (3-year term + 2×1yr options, interest-only, ~6.5% target rate)
- $5M revolving A/R line (first lien on receivables)

Collateral: Real estate at 9301 Connecticut Drive, all equipment, and accounts receivable

Use of Proceeds: Refinance existing debt, normalize payables, provide working capital for stabilization phase

Existing Centier Note

~$15M

Unpaid Principle

10%

Interest Rate

March 2027

Loan Due

Crown Point, Indiana

Crown Point represents an exceptional demographic profile for sustainable healthcare demand. This Lake County suburb within the Chicago metropolitan area (9.5M population) combines strong growth fundamentals with high insurance coverage and substantial purchasing power.

The community's population has grown 3.5% since 2020 to approximately 35,100 residents. With median household income near $102K—substantially above the county average of $71K—and remarkably low poverty (6.8% vs. 13.3% countywide), the payer mix strongly favors commercial insurance and Medicare.

The senior population (age 65+) comprises 18–19% of residents, providing a significant high-acuity patient base. With 97%+ insurance coverage, 94% high school graduation rates, and 34.6% holding college degrees, Crown Point residents actively seek and can afford quality healthcare services.

Geography	Population	Median HH Income	Age ≥65
Crown Point, IN	35,097	$101,686	18.3%
Lake County, IN	498,700	$71,493	18.8%

The broader Northwest Indiana market encompasses approximately 500,000 Lake County residents plus spillover from adjacent Cook County. Major health systems are rapidly expanding to meet demand—UChicago Medicine's Crown Point facility projects 110,000 annual patient visits and is already adding ORs and imaging capacity. This validates the strong underlying demand that Pinnacle can capture as utilization normalizes.

SECTION 02

A Twenty-Year Franchise, Tested & Intact

Pinnacle's value is inseparable from its history. The license, contracting, physical plant, and physician relationships were built over two decades and cannot be assembled quickly by a new entrant.

1

Early 2000s

Founding: physician group establishes a purpose-built surgical platform before the federal moratorium closed the door to new entrants.

2

2006–2007

Opening: four ORs, focused inpatient/outpatient surgical program in orthopedics, spine, and cardiac cath.

3

2008–2010

Stabilization: long-tenured leadership resolves early physician disputes, contracting gaps, and governance complexity.

4

2010s

Peak performance: consistent profitability and roughly $37–38MM of owner distributions over the decade.

5

Ongoing

Reinvestment: ~$10MM+ into the plant — cardiac cath lab, women's imaging, and clinic access points.

The Perfect Storm & Inflection

1

2020–2023

COVID elective-surgery pauses, a ~$2MM EHR-conversion billing disruption, a post-COVID anesthesia-subsidy shock (~$2MM/yr), adverse spine reimbursement, and physician loss compress margins.

2

2023

Utilization shock: a key orthopedic group withdraws cases and seeks a discounted acquisition; the board declines, preserving enterprise value over a distressed sale.

3

2024–2025

Trough and inflection: results turn negative, then brush break-even YTD in late 2025 as expense discipline and recruitment take hold; debt service maintained without drawing the revolver.

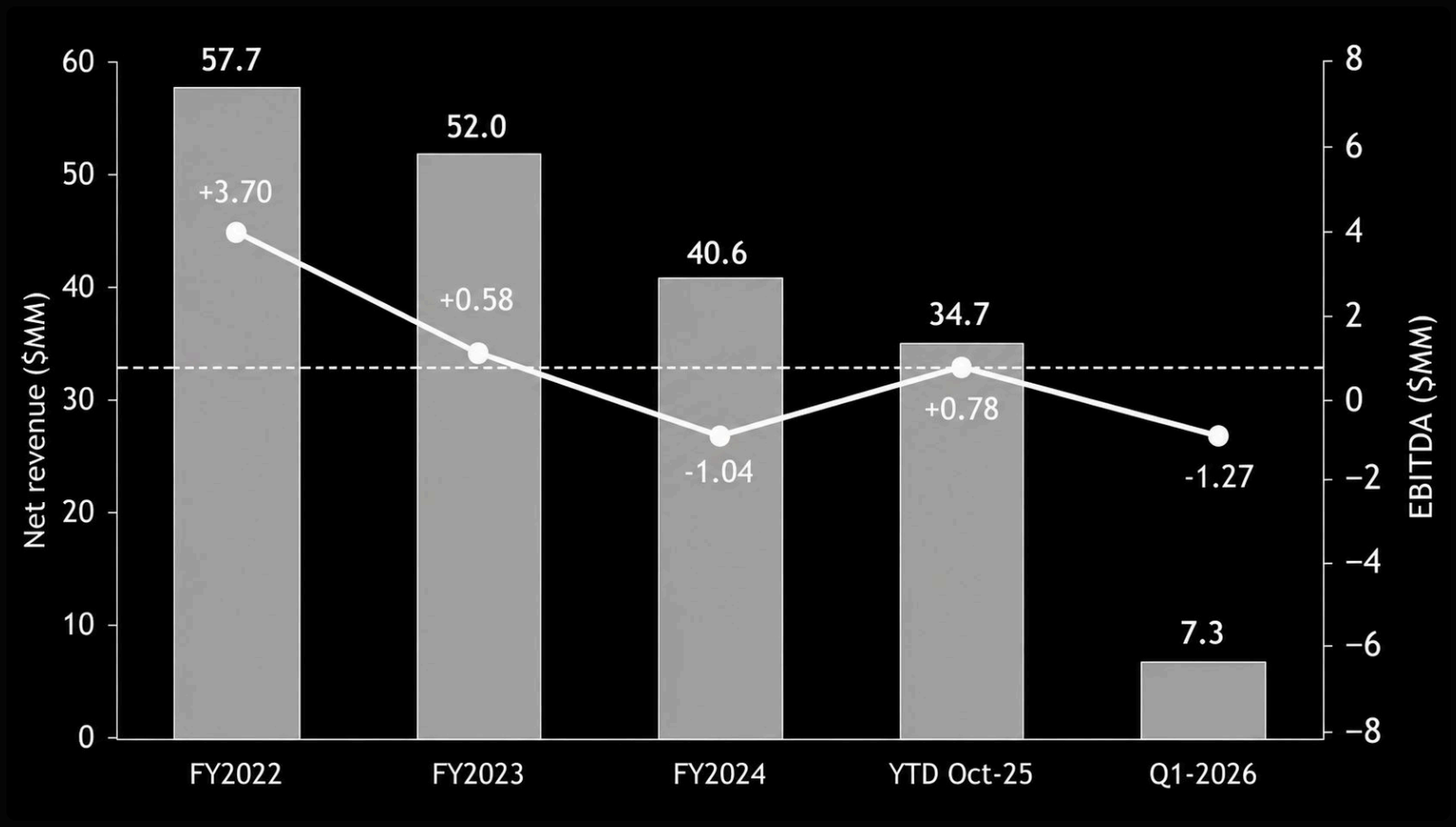
4

2026

Late-stage turnaround: seven surgeons from the departed group agree to return cases; clean-claim collections run 90–95%; the tax exemption is won.

The downturn was a **utilization disruption layered on temporary external shocks**, not a structural decline in demand, facility condition, or collections.

Financial Trajectory: Revenue & EBITDA



The consolidated record shows a business solidly profitable through 2021, eroding through 2023, turning negative in 2024, brushing break-even in late 2025, and relapsing in Q1-2026 on a seasonally soft, sub-scale volume base. Annualizing Q1 implies run-rate revenue near $29MM and an EBITDA loss around $5MM — before the catalysts that follow.

$57.7M

FY2022 Revenue

EBITDA: +$3.70MM

$52.0M

FY2023 Revenue

EBITDA: +$0.58MM

$40.6M

FY2024 Revenue

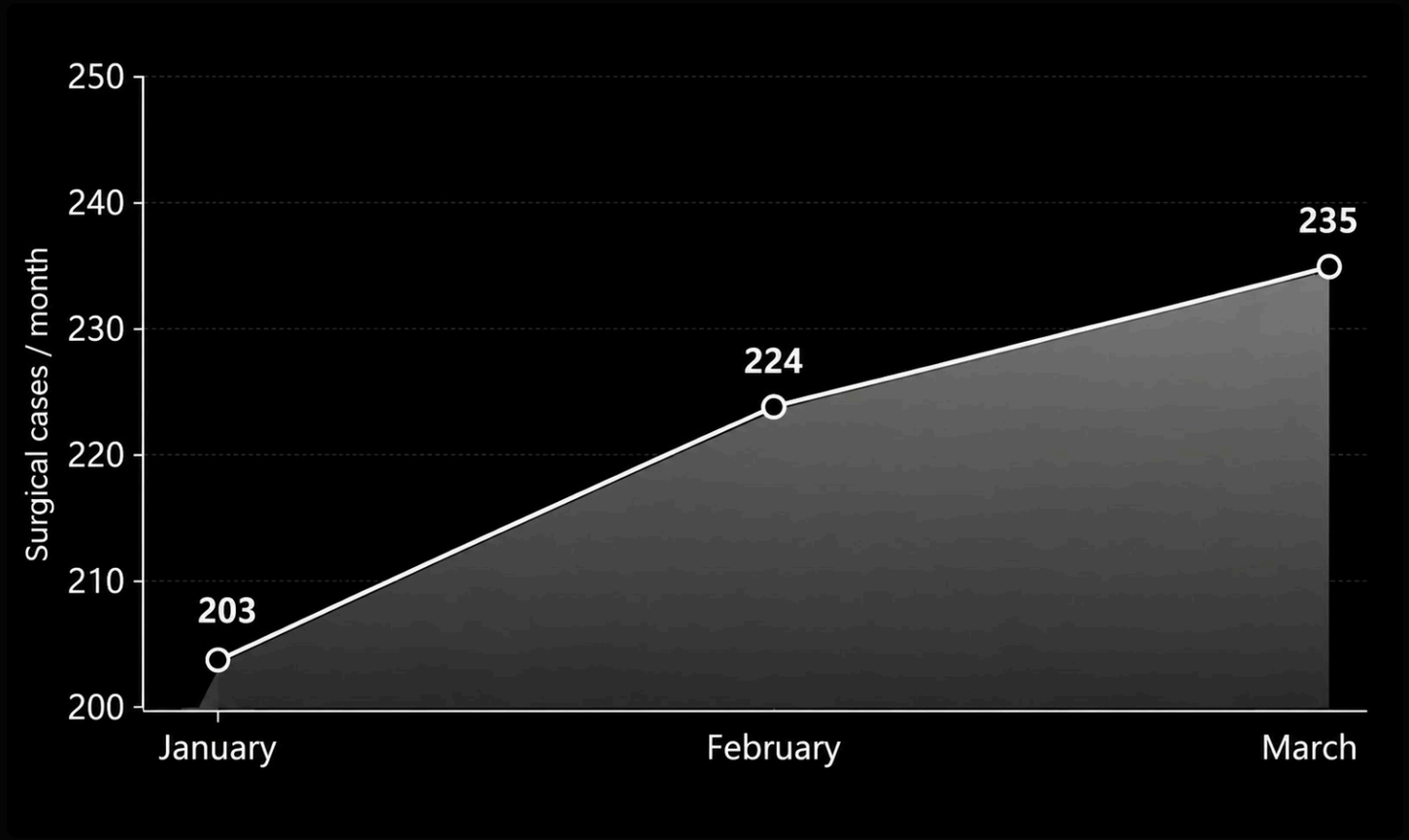
EBITDA: -$1.04MM

$7.3M

Q1-2026 Revenue

EBITDA: -$1.27MM

Volume Is the Swing Variable



First-quarter surgical volume rose month over month — 203 cases in January, 224 in February, 235 in March. Management attributes the shortfall almost entirely to the near-total loss of orthopedics.

- Reinstating a single orthopedic surgeon with 5–6 incremental monthly spine cases converts the current monthly operating loss into profitability — given the fixed-cost base already in place.

SECTION 07

Operational Expansion: One Recruitment, Four Vectors

The platform requires roughly an **18–22% utilization improvement** to restore strong cash flow — not a reinvention. The expansion runs along four vectors.

Reinstate Orthopedics

Returning surgeons re-establishing case flow with existing implant and instrumentation readiness — not a relationship rebuilt from scratch.

Deepen Spine

5–6 incremental monthly spine cases, at high implant and facility economics, carry outsized operating leverage against the covered fixed-cost base.

Diversify Producer Base

Newer, younger shareholder-physicians across ENT, orthopedics, and spine are already placing cases, reducing single-group dependence.

Refresh Governance

Board composition updated to add producing physicians, aligning governance with the clinical pipeline that drives the recovery.

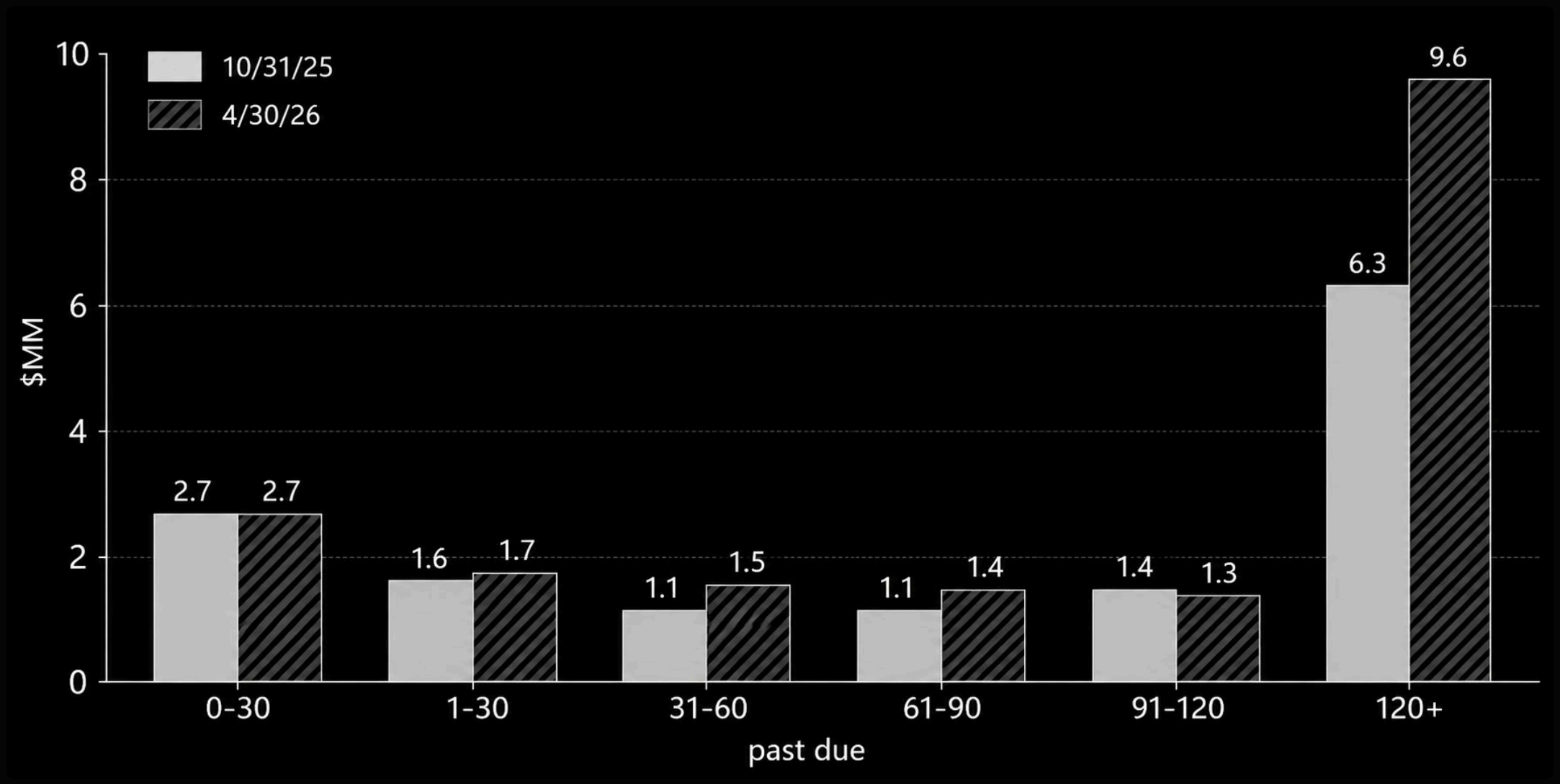
SECTION 03

Capital Structure & the Incumbent Lender

Total funded debt stood near **$18.55MM** at March 31, 2026. The relationship is carried on short-term renewals while in covenant default; a renewal decision is expected mid-year. The receivership the bank itself wishes to avoid is leverage for a credible take-out.

Obligation (3/31/26)	Balance	Status
Note payable (property entity)	$7,391,093	Covenant default
Refinancing loan (hospital entity)	$7,243,255	Real estate secured
Line of credit	$1,807,771	Working capital
Current portion, notes payable	$1,237,164	Various
ROU finance leases (equipment)	$871,795	Equipment
Total funded debt	**$18,550,978**	—

Trade Payables: Large on the Surface, Stale Underneath



The face payables balance overstates the cash required to normalize. More than half the book is aged beyond 120 days, where a meaningful share resolves at a deep discount as vendors are acquired, wind down, or cease active collection.

- Treated as a counsel-supervised, negotiated compromise, the economically necessary cure is materially smaller than the face figure — converting a large stated liability into a much smaller funded need.

SECTION 04

Structural Catalyst #1: The HAF Tax Exemption

Indiana has exempted physician-owned hospitals from the provider assessment Pinnacle had paid for years — a recurring seven-figure annual cost that management associates with a meaningful share of recent losses.

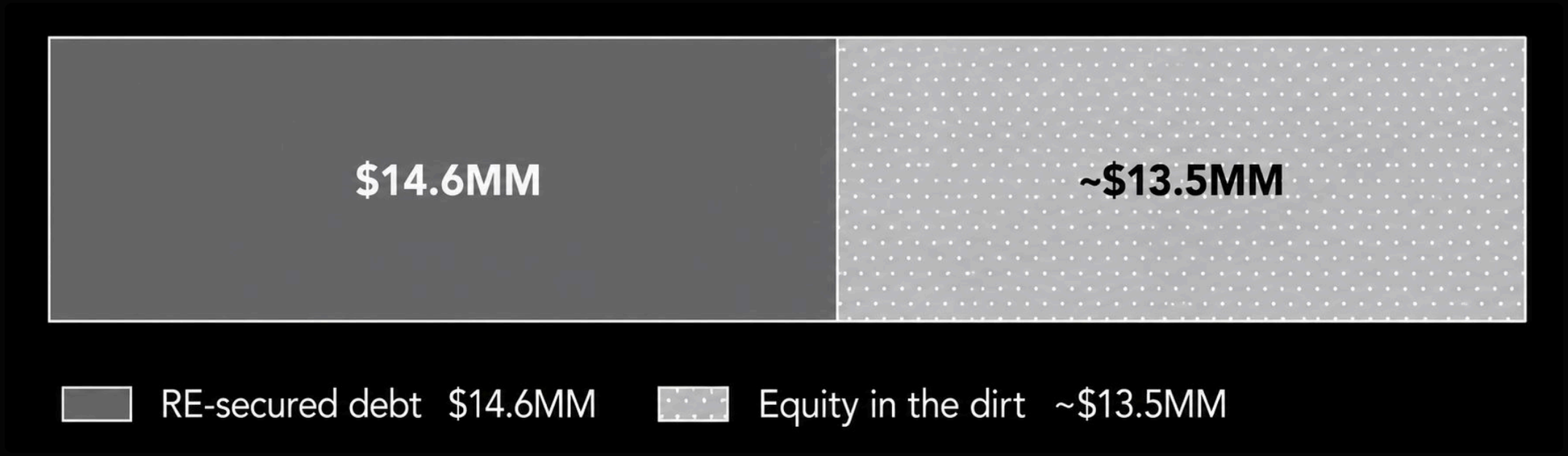
Prospective Saving

~$1.3MM annually, now taken prospectively with related accruals reversed. A central pillar of the go-forward story.

Retroactive Recovery

A separate, more speculative effort to recover prior payments is a potential upside — but should **not** be underwritten.

Structural Catalyst #2: Real-Estate Equity

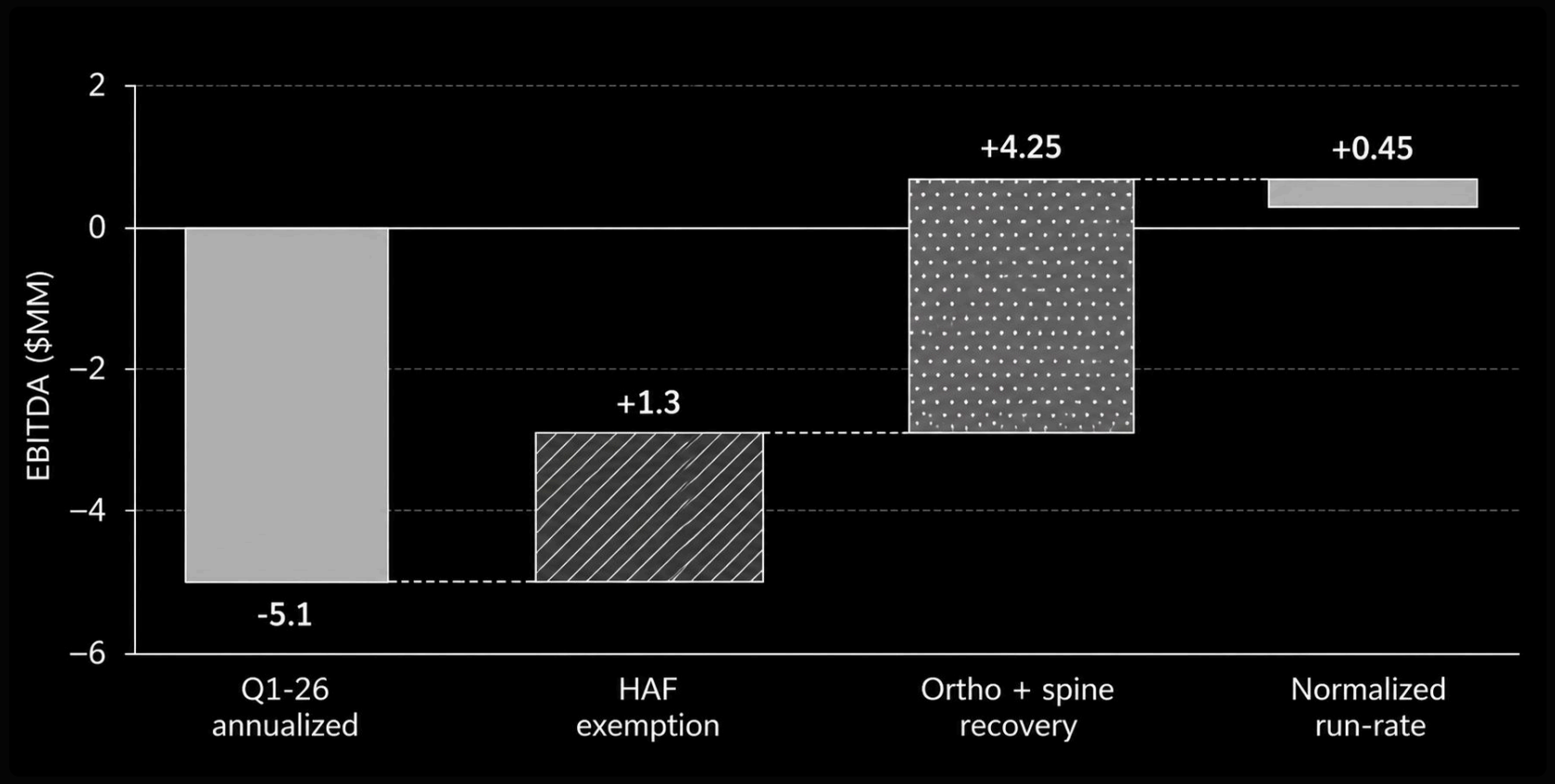


The property is held in an affiliated entity and carries RE-secured debt near **$14.6MM** against a **2023 appraisal of $28.1MM**, implying on the order of **~$13.5MM of equity** above the mortgage.

That equity is the single most reliable source of recovery in every scenario. Its separability from the operating company is what makes a real-estate-led recapitalization — and a clean phase-out of legacy physician real-estate ownership — achievable.

- ~$13.5MM of equity supports a conservatively levered, near-non-recourse senior tranche.

The EBITDA Bridge to Break-Even



Combining the catalysts with the operating thesis yields the following directional bridge. It is illustrative and rests on estimates that require validation; it frames the underwrite, it is not a forecast.

1

Q1-26 Annualized

-$5.1MM EBITDA baseline

2

HAF Exemption

+$1.3MM recurring annual saving

3

Ortho + Spine Recovery

+$4.25MM from surgical volume restoration

4

Normalized Run-Rate

+$0.45MM — approximately break-even

Structure A: Bridge to Break-Even

A short, 12–24-month senior facility retires the incumbent lender and funds the operating gap and a partial payables cure. It underwrites to a normalized rather than trailing EBITDA, using the real estate as the credit spine, with a higher-yielding piece carrying the operational risk.

Execution Options

Can be executed as a conventional refinance or, where the bank prefers an exit, behind an acquired note position.

Binding Constraint

Underwrites to a normalized run-rate; requires validation of the tax exemption and the volume recovery.

SECTION 05

A Menu of Capital Structures

The strategies below are not mutually exclusive; the strongest outcomes pair a near-term financing with a medium-term recapitalization. Each is framed with the value it unlocks and the single constraint that governs it.

Structure	Essence	Binding Constraint	License
Bridge	Retire the incumbent; fund the gap	Normalized-EBITDA underwrite	Preserved
Sale-Leaseback	Monetize RE; redeem RE equity	EBITDAR lease coverage	Preserved
PE Recap	Redeem legacy holders; refresh surgeons	Majority-physician fork	Preserved
Health-System JV	Strategic minority + building	Majority-physician ownership	Preserved
ASC Conversion	Sell RE; re-syndicate as an ASC	Surrenders the license	Forfeited

Sale-Leaseback & PE Recapitalization

Real-Estate Sale-Leaseback

Monetizes the ~$13.5MM equity above the mortgage, retires RE debt, and delivers cash to redeem legacy physician real-estate holders — all while the operating company continues under a market lease.

Binding constraint: Lease coverage must be supportable on normalized EBITDAR; time the monetization to follow EBITDA restoration.

Private-Equity Recapitalization

A sponsor redeems disengaged legacy holders and refreshes the surgeon base. The sponsor concentrates control off the operating-company cap table: acquires the real estate entirely, takes a minority operating stake with a management agreement, board governance rights, and a preferred return.

Binding constraint: Majority physician ownership must be preserved — confirmed by healthcare regulatory counsel before any offer.

Health-System JV or ASC Conversion

Joint-Venture Path (Higher Value)

A strategic health-system partner takes a minority operating position and acquires the building, with physicians retaining the majority required to hold the license. Preserves the moratorium-protected franchise and the tax exemption. A strategic partner can also supply the scarce input the balance sheet cannot: surgeon recruitment.

ASC Conversion Path

Acquires the real estate and re-syndicates operations into an ambulatory surgery center. Trades the franchise for simplicity and must be priced accordingly — it forfeits the license and the exemption.

A Note on the Note

> Where the incumbent lender prefers to exit rather than renew, its position can be acquired at a negotiated basis — a note purchase — and financed with note-on-note leverage from a senior provider.

Note-on-Note Financing

The capital stack behind acquiring the paper — a senior provider finances the note purchaser's position.

Loan-to-Own Strategy

Converting that paper into control of the collateral — complementary to note-on-note leverage.

The Opportunity

Either route keeps a bank exit an opportunity rather than a crisis, using the bank's desire to avoid receivership as negotiating leverage.

The Counsel Gate & Physician Alignment

The Counsel Gate

Every phase-out mechanic intersects the physician-ownership tests for the hospital license, the provider-fee exemption, and the federal physician-owned-hospital rules. The majority-ownership representation, permissibility of the redemption sequence, and treatment of the real-estate carve-out must all be confirmed by healthcare regulatory counsel before any offer is made.

> The plan is engineered around the license constraint, not into it.

Physician Alignment Is Evidenced

Owners remained invested and practicing through multiple years of suppressed distributions rather than exiting — behavior that signals a shared objective: restore EBITDA and participate in a monetization.

Having stayed through the hardest period, the aligned owners are incentivized to remain through the final stage. The redemption program is aimed at the disengaged minority, not the producing core.

SECTION 06

The Phased Physician Buyout

The objective is a sponsor-led recapitalization that phases legacy physicians out of both the operating company and the collateral real estate, while preserving the majority-physician ownership the license and tax exemption require.

Phase 1: Redeem Class B

Non-voting, non-guarantor Class B units redeemed at a negotiated value. Simplest to execute; no governance or license implications.

Phase 2: Redeem Disengaged Class A

Target Class A holders declining capital calls and contributing no clinical volume. Concentrates the surviving block among aligned owners.

Phase 3: Carve Out the Real Estate

Redeem legacy physician real-estate interests through the sale or sale-leaseback of the property entity — without touching the operating license.

Phase 4: Reconstitute Around Active Surgeons

Rebuild the majority-physician block around active, case-contributing surgeons while the sponsor holds the real estate, cash-flow priority, and operating control.

The Leverage

One surgeon. One platform. Break-even.

A single orthopedic recruitment, on a platform whose fixed costs are already covered, converts a monthly operating loss into profitability — then compounds as the diversified producer base matures.

SECTION 08

Value-Based Care Overlay

A sale-leaseback resolves the balance sheet; a value-based-care overlay resolves the income statement's next chapter. A physician-enablement model — of the kind operated by groups such as Privia — is uniquely compatible with Pinnacle's binding constraint: it preserves physician ownership while layering scale, contracting, and analytics on top.

Preserves the Majority

Enablement partners work with physicians rather than employing them — satisfying the license and exemption tests.

Bends the Payer Mix

Methodical transition toward outcomes-based contracting rewards high-acuity surgical care without abandoning commercial contracting.

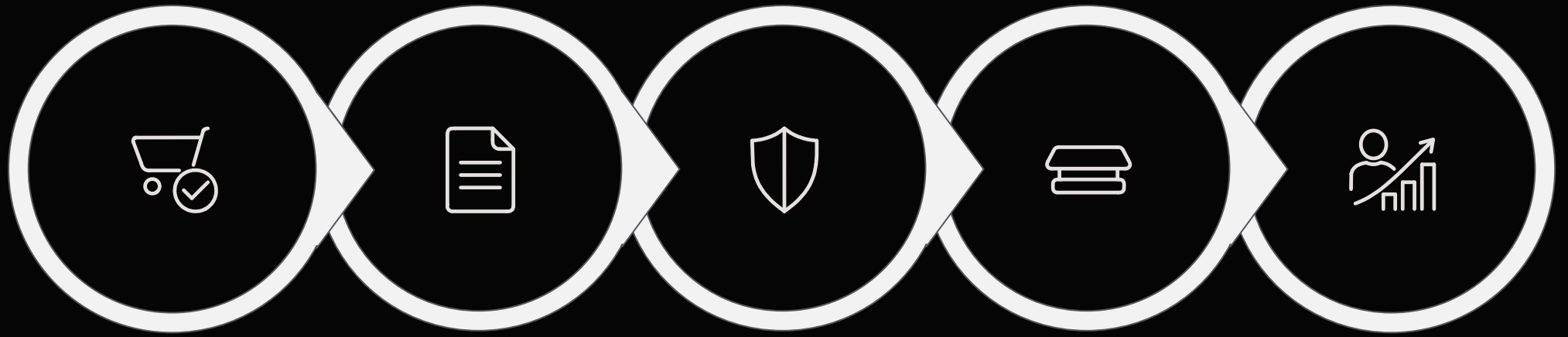
Industrializes Back Office

Centralized RCM, payer contracting, and population-health analytics reduce direct expense and stabilize collections.

Widens the Front Door

Expanded access and proactive engagement grow patient volume and reduce avoidable episodes, reinforcing the utilization recovery.

Sequencing the Overlay with The Sale-Leaseback



Sale-Leaseback

Repair Balance Sheet

De-risk Credit

Enable VBC Platform

Compound Margin

The two moves are complementary: one addresses the capital structure, the other the operating model — and neither disturbs the license that anchors the enterprise's scarcity value.

SECTION 09

Additional Strategic Levers

→ Two-Step Sequencing

Place a milestone-based bridge now to remove the incumbent lender and fund recruitment, then execute the control recapitalization once break-even is demonstrated. Converts a distressed underwrite into a stabilized one within a quarter or two.

→ Payables Compromise

A counsel-supervised, negotiated compromise — executed with attention to creditor-litigation, preference, and disclosure considerations — converts a large stated liability into a modest funded need.

→ Manufacture the Underwrite Explicitly

Present a normalized EBITDA bridge isolating the recurring tax saving and payables compromise as defined, validated add-backs — so a credit committee sees the path from trailing loss to a financeable run-rate.

→ Court-Supervised Backstop

If member dissent threatens consent or payables cannot be compromised consensually, a court-supervised process can deliver clean title and bind dissenting holders — disciplining every consensual negotiation.

SECTION 10

Risks & Mitigants

Risk	Mitigant
Bank calls the loan	Place a credible bridge or note-purchase alternative before the decision; use receivership cost as negotiating leverage.
Below-breakeven trailing EBITDA	Underwrite the normalized run-rate; isolate the tax exemption and surgical recovery as validated add-backs; lean on real-estate coverage.
Tax-exemption benefit overstated	Reconcile magnitude and timing to the general ledger before it anchors the underwrite; do not underwrite the retroactive recovery.
Stale trade payables	Counsel-supervised compromise; segment the book into must-pay, negotiable, and likely-stale tranches; estimate the realistic funded cure.
Member / board consent	Class-graduated redemption; supermajority-friendly structuring; a court-supervised backstop that can bind dissenters.
License or exemption lost in phase-out	License-preserving architecture; healthcare regulatory counsel sign-off before any offer is circulated.
Surgeon recruitment slips	Operator-investor partner that supplies recruitment; milestone-based funding tied to case-flow evidence.

SECTION 11

The Ask & Next Steps

Treme-Parker invites capital providers and healthcare private-equity groups to engage on a two-track basis: a near-term senior bridge or note-level solution that retires the incumbent lender and funds the runway, and a medium-term recapitalization that monetizes the real estate, resolves legacy ownership around the license, and positions the platform for a value-based-care overlay.

1

Confirm Interest & Structure Preference

Across the bridge, sale-leaseback, recapitalization, and joint-venture paths.

2

Open Diligence Under NDA

On the financials, the 2023 appraisal, the tax-exemption support, the payables book, and the ownership schedules.

3

Validate the Underwrite

Reconcile the exemption to the general ledger and test contribution margin by service line.

4

Negotiate a Term Sheet

For the senior facility and, where pursued, the note-on-note or note-purchase counterparty.

The Gating Step & The Reward

The Gating Step

A full diligence review — validating the tax exemption, the real-estate appraisal, the payables book, and the normalized EBITDA bridge.

The Reward

A scarce, moratorium-protected franchise acquired at a distressed basis, with a clear, evidenced path to stabilization — and a real-estate equity cushion of ~$13.5MM providing recovery in every scenario.

> This is a financeable and acquirable distressed-turnaround situation, provided the underwrite is built on the normalized run-rate, the real estate is used as the credit and recovery spine, the payables are compromised professionally, and any physician transition is engineered around the license.

Protected Franchise

18-bed moratorium-protected license — irreplaceable.

$1.3MM Annual Saving

Validated HAF exemption, recurring and prospective.

$13.5MM RE Equity

The credit and recovery spine in every scenario.

1 Surgeon to Break-Even

The narrowest operational gap in the turnaround.

Treme-Parker

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Joffre-Charles Colbert — Founder & CEO

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