AGREEMENT FOR
INTERIM MANAGEMENT SERVICES

THIS AGREEMENT FOR INTERIM MANAGEMENT SERVICES ("**Agreement**") is made and entered into as of April 17, 2015, to be effective April 21, 2015 ("**Effective Date**"), by and between Paladin-Howard Management, LLC ("**PHM**"), and FTI Consulting, Inc., a Maryland corporation ("**FTI**").

WHEREAS, PHM provides management services to Howard University Hospital ("**HUH**") under that certain Management Services Agreement among Howard University on behalf of Howard University Hospital, Paladin-Howard Management, LLLC, and Paladin Healthcare Management, LLC dated October 1, 2014 ("**PHM-HUH Management Agreement**"); and,

WHEREAS, FTI is a corporation with the capability to provide interim management services to PHM in partial fulfillment of its obligations to HUH under the PHM-HUH Management Agreement; and

WHEREAS, PHM desires to engage FTI to arrange and provide for interim management services pursuant to the terms of this Agreement, and FTI and PHM desire that FTI arrange for the provision of such services to PHM for HUH;

NOW, THEREFORE, in consideration of the mutual covenants set out in this Agreement and other forms of consideration, the adequacy and receipt of which are forever acknowledged, the parties, intending to be legally bound, agree as follows:

Article I
AUTHORITY AND RELATIONSHIP OF THE PARTIES

1.1 Relation of Agreement to PHM-HUH Management Agreement. The parties acknowledge that PHM is bound by the terms of the PHM-HUH Management Agreement and agree that FTI will abide by the terms of the PHM-HUH Management Agreement, as applicable to the services provided by FTI under this Agreement. A copy of the PHM-HUH Management Agreement is attached hereto and incorporated herein by this reference as Exhibit A. Where there is a conflict between the terms of the PHM-HUH Management Agreement and this Agreement regarding the services provided by FTI under this Agreement, the provisions of the PHM-HUH Management Agreement shall control. Further, FTI acknowledges that for purposes of this Agreement, FTI is bound to the fullest extent by law by the PHM-HUH Management Agreement and the Interim Strategic Plan and any and all amendments thereto, including but not limited the February 2015 Revised Strategic Plan and Financial Forecast which is attached hereto and incorporated herein by this reference as Exhibit B, and as amended from time to time (collectively the "Strategic Plan"). FTI

1.2 Relationship of the Parties. The parties intend by this Agreement solely to effect the provision of interim management services to HUH through PHM. This Agreement is not intended to extend to or involve any other activities of either FTI, HUH, or PHM. The relationship between PHM and FTI created by this Agreement is one of principal and agent. Notwithstanding the above, the duties to which Paladin is obligated under the PHM-HUH Management Agreement shall apply to FTI, including, but not limited to, any fiduciary duties thereunder, as set forth in this Agreement and in the PHM-HUH Management Agreement. With the exception of the forgoing, no other relationship is intended to be created among the parties, and nothing in this Agreement shall be construed as to make any party the employer or employee of any other (except for the Special Employees (as defined below) who function as borrowed employees at HUH and owe certain duties and obligations as set forth in the PHM-HUH Management Agreement), the joint venturer or partner of the other, or have the right to control or conduct the other's business in any manner, other than as explicitly provided in this Agreement and the PHM-HUH Management Agreement. FTI has no right or obligation to direct HUH or HUH's employees in the performance of their professional medical judgments or duties.

1.2.1 Anything to the contrary in this Agreement notwithstanding, FTI shall not have any claim against PHM or HUH for seniority, vacation time, vacation pay, sick leave, personal time off, overtime, health insurance, medical care, retirement benefits, Social Security, Workers' Compensation, disability or unemployment insurance benefits, or employee benefits of any kind. FTI agrees to comply with all applicable laws pertaining to taxes and employee benefits in relation to its employees and contractors. FTI shall be solely liable for and obligated to pay directly all applicable taxes, including, but not limited to, federal and state income taxes and Social Security taxes, and, in connection therewith, FTI shall indemnify and hold PHM and HUH harmless from any and all liability which PHM may incur because of FTI's failure to pay such taxes or to provide any employee benefits.

Article II
SPECIAL EMPLOYEES

2.1 Special Employees. FTI shall provide PHM the full-time (at least 40 hours per week), on-site services of Richard Wier Jones ("**Jones**") to serve as HUH' Interim Chief Financial Officer ("**CFO**") (Jones, together with any other persons subsequently provided by FTI to PHM for service at HUH, "**Special Employees**").

The Special Employees shall be bound by all terms and conditions of the PHM-HUH Management Agreement, including, but not limited to, Section 5 of the PHM-HUH Management Agreement as it applies to any Special Employees in their respective capacities. The Special Employees shall each be a "borrowed employee" as applicable to the roles and responsibilities pursuant to the PHM-HUH Management Agreement, and shall at all times while serving HUH be under the direction, control, and supervision of PHM and shall be acceptable to PHM on a continuing basis. The parties intend that, except in those areas listed in section 1.2.1, the Special Employees, when acting in the course and scope of performing services accordance with this Agreement, shall be afforded all the protections of PHM as set forth in the PHM-HUH Management Agreement, as well as any obligations of PHM as set forth in Section 7 below.

FTI recognizes that, as professionals, the Special Employees are accustomed to working more than would be required of hourly employees and will dedicate that time consistent with industry norms. Absent unusual circumstances, however, the Special Employees will not work weekends or legal holidays. That portion of the Fee attributable to the services of the Special Employees ("**Special Employees Fee**") will not be pro-rated for FTI holidays or for such other times, in amounts of time reasonable to PHM, that any of the Special Employees are on leave under the FTI paid time-off policy. For contract periods of less than one calendar month, the Special Employees Fee will be prorated by multiplying the Special Employees Fee times the ratio of the total weekdays (Monday through Friday including holidays) for which the contract is in effect for that month to the total weekdays (Monday through Friday including holidays) in that month.

2.2 Duties of the CFO; Special Employees.

2.2.1 CFO Duties. The CFO shall, at the direction of PHM or its designee, be responsible for the tasks now assigned to the CFO as set forth in the PHM-HUH Management Agreement, including but not limited to the duties and obligations set forth in Section 5 and the Strategic Plan, as well as any additional duties and obligations assigned by PHM pursuant to this Agreement.

2.3 Limitation of Duties of Special Employees. At no point in time pursuant to this Agreement shall the authority of the Special Employees exceed that of PHM as set forth in the PHM-HUH Management Agreement, and in particular Special Employees shall not have the authority to:

2.3.1 Enter into or terminate contracts with physicians on behalf of HUH, but the Special Employees shall have the authority on behalf of PHM to negotiate and administer such contracts.

2.3.2 Enter into or terminate contracts with outside consultants, attorneys, accountants, and/or other service providers on behalf of HUH, but the Special Employees shall have the authority on behalf of HUH to negotiate and administer such contracts.

2.3.3 Purchase capital assets without the prior written approval of the CEO.

2.3.4 Enter into any leases of capital assets that, if purchased, would be described in section 2.3.3, without the prior written approval of the CEO.

2.3.5 Enter into any leases without the prior written approval of the CEO, unless such approval is deemed granted as part of an approved annual budget.

2.3.6 Negotiate or enter into collective bargaining agreements covering or purporting to cover employees of HUH.

2.3.7 Manage any of the clinical operations of HUH.

2.3.8 Incur debt, outside the ordinary course of business, on behalf of HUH.

2.3.9 Prepare or sign any Medicare or Medicaid cost reports.

2.4 Covenant Not to Hire. The parties agree, that neither party will, directly or indirectly, through an affiliate or separate employee leasing or staffing company or otherwise, employ or solicit for employment any member of the other party's project team or any other employees of the other party, independent contractors, or consultants providing services related to this engagement until one year following the termination or expiration of this Agreement unless (i) such employee or consultant was an employee of the other party immediately prior to their becoming a FTI or PHM employee or consultant; or (ii) each party gives its written consent thereto. The parties recognize and agree that monetary damages are not an adequate remedy for a breach by the other party of this covenant not to hire. The parties agree that irreparable damage will result to a party and its business from a breach of this covenant, and that, in the event of a breach or a threatened breach of this covenant, in addition to monetary damages, the non-breaching party shall be entitled to an injunction enjoining the other party from violating this covenant. The restrictions under this section shall not prohibit either party from hiring a person (a) who submits an unsolicited application or (b) who responds to a solicitation done by means of a general advertisement that is not directed to employees of the other party, its subsidiaries, or affiliates.

Article III
SUPPORT SERVICES

3.1 General Responsibilities and Services. FTI shall perform those services set forth in this Agreement, subject to the supervision and direction of PHM and HUH, the policies and directives dictated HUH, the financial resources available to HUH, the competitive marketplace in which HUH is located, and Medicare reimbursement and other laws. FTI shall abide by all policies and procedures reasonably established by PHM and HUH. FTI may rely on the recommendations of the medical staff of HUH (and their respective designated committees and department chairmen) (collectively, "**Medical Staff**") relative to the quality of professional services provided by individuals with clinical privileges, and on the Board and the Medical Staff, or any jointly appointed or Board appointed committee or representative, as to the adequacy and proper state of repair of all medical equipment and the professional competency, training, and requisite supervision of nurses, medical technicians, and other allied health professionals and Medical Staff.

3.1.1 Reporting Relationships. Richard Jones will initially be the CFO, who will report to Jim Edwards, CEO, and then to Joel Freeman, President, PHM. A copy of Jones' curriculum vitae is attached hereto and incorporated by this reference as Exhibit C.

3.2 Additional Services. If additional assistance is requested by PHM in areas outside of the scope identified in this Agreement, it may be necessary to amend the scope of services and terms of this Agreement with terms and conditions agreeable to both parties. FTI may identify areas that would benefit from assessment and/or concurrent implementation. If such occurs, FTI will bring its recommendations to PHM and/or HUH, as applicable, for consideration and action.

3.2.1 Supply Chain and Revenue Cycle Assessment. During the first 45 days of the Term (as defined in section 8.1, below), FTI shall conduct a high-level assessment of HUH's supply chain and revenue cycle functions ("**Assessment Services**"). The results of and recommendations arising from our Assessment Services will be presented to PHM in PowerPoint format ("Assessment Report"). Any particular conclusion in the Assessment Report, while it may indicate a potential avenue for improvement, will not be actionable without further study. In particular, conclusions will not be detailed enough for the purposes of budget projections, reductions in force, or similar purposes and should not be used for such purposes.

3.3 Compliance Programs. PHM shall provide FTI with true and correct copies of any compliance programs, privacy policies and procedures, Corporate Integrity Agreements or similar programs, policies, or agreements binding upon HUH. FTI agrees to comply with the requirements the PHM-HUH Management Agreement, including but not limited to Section 5, as well as any such programs, policies, and agreements as are provided to FTI in writing (whether now implemented or adopted later), in carrying out its duties under this Agreement. FTI will bring items of potential noncompliance to the attention of PHM, as applicable, when discovered by FTI and, at the direction of PHM, take corrective action prescribed by PHM once any item of noncompliance is identified; provided that all costs (including, without limitation, legal and consulting fees and expenses incurred in undertaking any corrective action) required to develop, implement, update, and maintain these programs, policies, and procedures or to take approved corrective actions shall be the responsibility of PHM.

3.4 Limitations on FTI's Duties and Authorities. FTI's duties and authorities with respect to PHM and HUH are limited to those expressly set forth in this Agreement. Absent a specific written agreement to the contrary, FTI's services shall not include such items as the functions of a certified public accounting firm; legal services; audit services; expert witness services; cost report preparation services; data processing or information technology services; architectural services; engineering services; MSO development or management services; facility planning services; feasibility studies or certificate of need applications related to major capital projects; development or management of a home health agency, an emergency medical or ambulance service, a nursing home or a rehabilitation unit; and similar services.

Article IV
[Intentionally omitted]

Article V
COMPENSATION FOR SERVICES

5.1 Fee. In consideration of the services to be provided by FTI to PHM pursuant to this Agreement, PHM shall pay FTI the following (collectively "**Fees**"):

5.1.1 CFO Fee. In consideration of the services of the CFO, PHM will pay FTI a monthly fee of $65,000.00 ("**CFO Fee**"). The CFO Fee shall be considered a Special Employees Fee, as that term is defined in section 2.1.

5.1.2 Assessment Services Fee. The Assessment Services will be provided by FTI without a separate Fee. However, direct expenses associated with the provision of the Assessment Services will be reimbursed in accordance with section 5.2, below, but in no event shall exceed $5,000.

5.2 Reimbursement of Expenses. In addition to the payment of the Fees, PHM will reimburse FTI for FTI's reasonable actual costs for all travel, lodging, and other out-of-pocket expenses incurred by FTI personnel in the course of providing services to PHM, an amount which shall not exceed $6,500.00 each month (excluding any expenses associated with the Assessment Services, as set out in section 5.1.2) without express written authorization of PHM. FTI will furnish reasonable documentation supporting all reimbursement requests. FTI will use all reasonable efforts to control expenses, such as the use of coach airfare, and the purchase of airline tickets in advance as much as possible. FTI shall invoice PHM monthly for such expenses and reimbursement of such expenses will be due and payable within 14 days of the date of invoice. Notwithstanding the above, the Parties agree that in the first 30 days of the Agreement, the additional fees contemplated in this section 5.2 shall not exceed $10,000, and the Parties agree to meet in good faith in the next 30 days to determine the propriety of the monthly amount of $6,500 that shall be in effect as of the second month of this Agreement.

5.3 Payment Terms. The prorated payment for the Fees attributable to the period from the Effective Date to April 30, 2015, shall be due and payable upon execution of this Agreement. Payments for subsequent periods shall be due the first day of each month, in advance, during the term of this Agreement. FTI shall submit to PHM every month an invoice for the applicable Fees.

5.4 Late Payments. PHM shall pay FTI interest on all payments that are not paid when due. Interest shall accrue from the date the original payment was due at a rate of one percent (1%) per month until the payment is made in full. PHM shall bear the costs of any legal or collection fees and expenses incurred by FTI in attempting to enforce PHM's payment obligations.

5.5 Document Production and Testimony. In the event FTI is requested pursuant to a subpoena or other legal process to produce any documents or to provide testimony relating to this engagement in any judicial or administrative proceedings to which FTI is not a party, PHM shall reimburse FTI at its then standard billing rates for its professional time and expenses, including reasonable attorneys' fees, incurred in preparing for and responding to requests for documents and providing testimony.

Article VI
OWNERSHIP OF INFORMATION; CONFIDENTIALITY

6.1 Ownership of Information. FTI shall not be entitled to any property interest, real, personal or intellectual property, as it relates to any and all operating procedures, protocols, and other non-public proprietary business or information relating to performance pursuant to this Agreement (the "**PHM Proprietary Information**"). Notwithstanding the above, to the extent FTI utilizes an item not directly or indirectly pertaining to PHM and/or the PHM-HUH

Management Agreement (collectively, "**FTI Proprietary Information**") that are or were created or developed by FTI or obtained by FTI from sources other than PHM and/or the PHM-HUH Management Agreement and not in connection with this Agreement, it shall be the exclusive property of FTI. Nothing contained in this Agreement shall be construed as a license or transfer of the PHM Proprietary information or the FTI Proprietary Information or any portion of it, either during the Term or thereafter, to the other Party. Upon the termination or expiration of this Agreement, the Parties shall have the right to retain all such PHM and PTI Proprietary Information, and any party, upon request, shall return to the other all PHM or FTI Proprietary Information in its possession, as applicable. Notwithstanding the foregoing, the receiving party (a) shall be entitled to retain a copy of its work papers, including work papers containing or reflecting the other party's Proprietary Information, in accordance with its professional standards and subject to the obligations of confidentiality set forth herein; and (b) will not be obligated to return or destroy the other party's Proprietary Information that is temporarily contained on a computer system backup in accordance with its security and/or disaster recovery procedures.

6.2 Confidentiality. The Parties agree to be bound by the confidentiality and non-disclosure agreement attached hereto and incorporated herein by this reference as Exhibit D.

6.3 Injunctive Relief. The parties agree that violations of this Article VI would result in irreparable harm and that, in addition to any other rights and remedies provided by law, a party shall be entitled to injunctive relief to enforce the other party's obligations under this Article VI.

Article VII
INDEMNIFICATION, LIMITATION OF LIABILITY, AND INSURANCE

7.1 Indemnification by PHM. PHM shall indemnify, defend, save and hold harmless FTI and its Special Employees, including but not limited to as set forth in Section 11 of the PHM-HUH Management Agreement, and in particular Section 11.4 ("**FTI Indemnified Parties**"), from and against any and all judgments, losses, claims, damages, liabilities, costs, and expenses (including reasonable attorneys' fees and expenses paid or incurred by a FTI Indemnified Party), joint or several, which may be asserted against any FTI Indemnified Party arising out of the activities or operations as set forth in this Agreement and in the PHM-HUH Management Agreement ("**FTI Claim**").

7.2 Indemnification by FTI. FTI shall indemnify, defend, save and hold harmless PHM as it relates to its performance under this Agreement, including but not limited to those items set forth in Section 11 of the PHM-HUH Management Agreement, and in particular Section 11.4 ("**PHM Indemnified Parties**") from and against any and all judgments, losses, claims, damages, liabilities, costs, and expenses (including reasonable attorneys' fees and expenses paid or incurred by a PHM Indemnified Party), joint or several, which may be asserted against any PHM Indemnified Party arising out of the activities or operations as set forth in this Agreement and in the PHM-HUH Management Agreement ("**PHM Claim**").

7.3 Conditions on Indemnification. The obligations of an indemnifying party ("**Indemnitor**"), as set forth in this Agreement, are conditioned upon (i) the indemnified party

("**Indemnitee**") promptly notifying the Indemnitor of any claim, demand, or action, or any incident of which the Indemnitee has actual or constructive knowledge, which may reasonably result in a claim, demand, or action, and for which the Indemnitee will look to Indemnitor for indemnification under this Agreement; (ii) Indemnitee, its directors, officers, employees, and agents, cooperating fully with Indemnitor in Indemnitor's investigation and review of any such claim, demand, action, or incident; and, (iii) Indemnitee not entering into any admissions, agreements, or settlements which may affect the rights of Indemnitee or Indemnitor without the prior written consent and approval of Indemnitor.

7.4 **Exclusions of Protection from Indemnification**. Notwithstanding anything in this Agreement to the contrary, any PHM Claim or FTI Claim arising out of the negligence, gross negligence, recklessness or willful misconduct as it relates to this Agreement and the PHM-HUH Management Agreement, and in particular Section 11.1 of the PHM-HUH Management Agreement, shall have the same limitations as set forth therein.

7.5 **Defense Costs.** The Indemnitor shall have the obligation to assume the defense of Indemnitee, with counsel reasonably satisfactory to Indemnitee, including but not limited to the obligations set forth in the PHM-HUH Management Agreement

7.6 **Limitation of Liability.** Except as set forth in this Section 7, FTI, its employees (including, without limitation, the Special Employees), agents, and representatives shall have no liability to PHM for any indirect, consequential, incidental, exemplary, special, or punitive damages or costs including, without limitation, lost profits or loss of goodwill, even if such party has been advised, knew, or should have known of the possibility thereof. The cumulative liability of FTI, its employees (including, without limitation, the Special Employees), agents, and representatives to PHM for any and all claims, regardless of the form of action, arising out of or relating in any way to this Agreement, shall not exceed the total of all fees paid by PHM to FTI during the three month period immediately preceding the date on which such claim arose.

7.7 **Insurance.** PHM has and shall maintain at its own cost and expense throughout the Term insurance coverage, or in the alternative, funded self-insurance in the amounts noted:

Worker's Compensation	Statutory Amount
Employer's Liability	$100,000
Comprehensive General Liability	$1,000,000
Professional Liability	$1,000,000
Automobile Liability	$1,000,000
Directors' and Officers' Liability	$10,000,000
Employment Practice	$1,000,000
Property Insurance	Insurable Value

The Special Employees will receive the benefit of the indemnification and advancement provisions provided by PHM to any equivalently placed employees, whether under PHM's charter or by-laws, by contract or otherwise, including that provided under Section 11 of the PHM-HUH Management Agreement. Notwithstanding anything to the contrary, PHM's insurance coverage for the indemnitees shall be specifically primary to (and without allocation

against) any other valid and collectible insurance coverage that may apply to the indemnitees (whether provided by FTI or otherwise). A copy of PHM's Certificate of Liability Insurance is attached hereto and incorporated herein by this reference as Exhibit E.

Article VIII
TERM AND TERMINATION

8.1 Term. The term of this Agreement ("**Term**") shall begin on the Effective Date and terminate, as to any Special Employee, upon the dated stated in a notice of termination from one party to the other party ("**Termination Notice**"); provided that the termination date shall be at least 30 days after the giving of the Termination Notice. The Term of this Agreement shall terminate upon the termination of the last Special Employee. Notwithstanding anything to the contrary as set forth in this Section 8.1, FTI shall not be entitled to terminate this Agreement without providing the necessary transition services as set forth in Section 19 of the PHM-HUH Management Agreement.

8.2 Termination for Cause.

8.2.1 Bankruptcy. Either party may terminate this Agreement immediately in the event the other party: files a petition commencing a voluntary case under the U.S. Bankruptcy Code; makes a general assignment for the benefit of its creditors; becomes insolvent; becomes unable to pay its debts as they become due; files a petition or answer in any proceeding seeking for itself or consenting to, or acquiescing in, any insolvency, receivership, composition, readjustment, liquidation, dissolution, or similar relief under any present or future statute, law, or regulation, or files an answer or other pleading admitting or failing to deny or to contest the material allegations of the petition filed against it in any such proceeding; seeks or consents to, or acquiesces in, the appointment of any trustee, receiver of it or any material part of its property; or, has commenced against it any involuntary case under the U.S. Bankruptcy Code, or a proceeding under any receivership, composition, readjustment, liquidation, insolvency, dissolution, or like law or statute, which case or proceeding is not dismissed or vacated within sixty (60) days from commencement.

8.2.2 Nonpayment. If PHM fails to make any payment to FTI within ten days following FTI's notice to PHM of nonpayment, FTI, among other rights and remedies pursuant to this Agreement or otherwise available at law or in equity, shall have the right to terminate this Agreement upon written notice of such termination to PHM and in accordance with Section 8.1 above; provided, however, that, in the case of termination by FTI under this section 8.2.2, the transition provisions set forth in the last sentence of section 8.1 shall not apply.

8.2.3 Default. Except as otherwise provided in sections 8.2.1 and 8.2.2, if a party fails substantially to perform any of its material obligations under this Agreement ("**Defaulting Party**"), the other party ("**Non-Defaulting Party**") may give the Defaulting Party a "**Notice of Default**." The Notice of Default shall set forth the nature of the obligation that the Defaulting Party has not performed ("**Default**") and shall be in writing. The Defaulting Party shall have thirty (30) days to cure the Default or object in writing to the Notice of Default ("**Cure Period**"). If the Defaulting Party does not object to the Notice of Default or cure the

Default within the Cure Period, the Non-Defaulting Party shall have the right to terminate this Agreement upon no less than thirty days' notice; provided that notice of termination must be given no later than thirty days after the expiration of the Cure Period and be consistent with Section 8.1 above. To the extent the Defaulting Party provides the Non-Defaulting Party with an objection to the Notice of Default, the Parties shall resolve this dispute and there shall be no Default pursuant to this Agreement. Failure to terminate this Agreement as set forth in this Section 8.2.3 shall not waive that Default or any other breach of this Agreement. A waiver of any Default or other breach of this Agreement shall not constitute a waiver of any future Defaults or other breaches of this Agreement, whether of a similar or dissimilar nature.

8.3 Rights Upon Termination. In the event of the termination of this Agreement for reasons other than cause as set forth in Section 8.2, FTI shall immediately be paid all fees and payments earned and reimbursed for all expenses incurred through the effective date of the termination. The right to terminate this Agreement and to receive payment of any amounts owing as of the effective date of termination shall be in addition to any other remedy available at law or in equity. The termination of this Agreement for any reason shall be without prejudice to any payments or obligations which may have accrued or become due prior to the date of termination or which may become due after such termination.

ARTICLE IX
MISCELLANEOUS

9.1 Duty to Cooperate. The parties acknowledge that their mutual cooperation is critical to FTI's ability to perform its duties hereunder successfully and efficiently. Accordingly, each party agrees to cooperate with the other fully in formulating and implementing the goals and objectives that are in PHM's best interest. Both parties also understand and agree that flexibility regarding scheduling and use of FTI resources will especially be required at the initial part of the engagement and thereafter on an ongoing basis.

9.2 Further Documents. The parties covenant and agree that they and their successors and assigns will execute any and all instruments, releases, assignments, and consents which may reasonably be required of them in order to carry out the provisions of this Agreement.

9.3 Effect on Successors; Survival; Third Party Beneficiaries. This Agreement shall be binding upon, enforceable by, and inure to the benefit of, the parties and their successors and assigns. Notwithstanding anything herein to the contrary, the provisions of Articles VI, VII, and IX shall survive the expiration or earlier termination of this Agreement. Except as otherwise explicitly stated in this Agreement, there shall be no third party beneficiaries to this Agreement.

9.4 Entire Agreement. This Agreement contains the entire agreement among the parties relating to the subject matter of this Agreement. Except as otherwise provided herein, the terms of this Agreement may be modified or amended only by written agreement of the parties.

9.5 Governing Law. This Agreement shall be governed by and construed, interpreted, and enforced pursuant to the laws of the District of Columbia, excluding its conflict of laws provisions.

9.6 Waiver of Jury Trial. PHM AND FTI IRREVOCABLY AND UNCONDITIONALLY AGREE TO WAIVE A TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT.

9.7 Notices. All notices under this Agreement by any party to the other shall be in writing. All notices, demands, and requests shall be deemed given when mailed, postage prepaid, registered or certified mail, return receipt requested, or sent by prepaid express delivery service:

To FTI: FTI Consulting, Inc.
105 Westwood Place
Suite 250
Brentwood, Tennessee 37027
Attn.: Senior Managing Director

To PHM: Paladin-Howard Management, LLC
2121 Rosecrans Avenue, Suite 2320
El Segundo, CA 90245
Attn.: President

9.8 No Waiver. The failure of any party to exercise any right or enforce any remedy contained in this Agreement shall not operate as or be construed to be a waiver or relinquishment of the exercise of such right or remedy, or of any other right or remedy contained in this Agreement.

9.9 Enforceability; Severability. The invalidity or unenforceability of any term or provision of this Agreement shall not, unless otherwise specified, affect the validity or enforceability of any other term or provision, which shall remain in full force and effect.

9.10 Confidentiality. Each party covenants and agrees that it shall not disclose the terms of this Agreement or any agreement supplementing this Agreement to third parties without the consent of the other party, except to the extent disclosure is required by court or administrative order or by applicable law or regulation, or required for the performance of its obligations under this Agreement, or as necessary or appropriate in dealing with the accountants, attorneys, and other representatives of the respective parties.

9.11 Headings; Gender; Interpretation. The headings and other captions contained in this Agreement are for convenience of reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement. Whenever the context requires, the gender of all words used herein shall include the masculine, feminine and neuter, and the number of all words shall include the singular and plural. This Agreement has been prepared through the efforts of all the parties and shall not be construed against any party as the draftsman.

9.12 Access to Books and Records. Until the expiration of six years after the furnishing of services pursuant to this Agreement, the parties shall, upon written request, make available to the Secretary of Health and Human Services or the Comptroller General or their duly authorized representative the contract, books, documents, and records necessary to verify the nature and extent of the cost of such services. If any party carries out any of its obligations under this Agreement by means of a subcontract with a value of $10,000 or more, that party agrees to include this requirement in any such subcontract.

9.13 Counterpart Signature. This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each of which shall be deemed an original agreement and all of which shall constitute but one agreement.

9.14 Compliance with Laws. In performing their respective duties hereunder, FTI and PHM shall conduct themselves in full accordance with all applicable state, federal and local laws and regulations, including, without limitation, the federal physician self referral law (commonly known as the Stark II Law, 42 U.S.C. §1395nn et seq.) and the anti-fraud and abuse provisions of the Social Security Act (42 U.S.C. § 1320a-7 et seq.). Nothing in this Agreement shall require either party to arrange for or send patients to the other party. FTI shall observe and comply with all applicable laws, ordinances, codes and regulations of governmental agencies, including federal, state, municipal, and local governing bodies, having jurisdiction over the scope of services, including the Joint Commission standards for compliance and accreditation. FTI shall furnish services that comply with all applicable Centers for Medicare and Medicaid Services conditions of participation and standards of contracted services.

9.15 Time of Essence. Time is of the essence in each and all the provisions of this Agreement.

9.16 Absence of Sanctions. FTI represents that neither FTI nor any of its employees, owners, or agents have been sanctioned by or excluded from participation in any federal or state health care program, including Medicare and Medicaid. FTI agrees that if it or any such individual associated with it should be sanctioned by or excluded from participation in any federal or state health care program, including Medicare and Medicaid, it shall immediately notify PHM of such event.

[SIGNATURES CONTINUED ON NEXT PAGE]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

PALADIN-HOWARD MANAGEMENT, LLC

_____
Joel Freedman
President

FTI CONSULTING, INC.

_____
Jeffrey Benton
Senior Managing Director

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Joel Freedman
President

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Jeffrey Benton
Senior Managing Director

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PALADIN-HOWARD MANAGEMENT, LLC

_____

Joel Freedman
President

FTI CONSULTING, INC.

_____

Jeffrey Benton
Senior Managing Director

EXHIBIT A

Execution Version

MANAGEMENT SERVICES AGREEMENT

AMONG

HOWARD UNIVERSITY

ON BEHALF OF

HOWARD UNIVERSITY HOSPITAL,

PALADIN-HOWARD MANAGEMENT, LLC,

AND

PALADIN HEALTHCARE MANAGEMENT, LLC

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Exhibits

MANAGEMENT SERVICES AGREEMENT

THIS MANAGEMENT SERVICES AGREEMENT (this "**Agreement**") is entered into as of the 1st day of October, 2014, by and among Howard University ("**Howard**"), a District of Columbia non-profit tax-exempt corporation created by congressional enactment, on behalf of its operating division known as Howard University Hospital ("**HUH**"), and Paladin-Howard Management, LLC, a Delaware limited liability company ("**Manager**"). Howard and Manager are sometimes referred to herein individually as a "**Party**" or collectively as the "**Parties**." Paladin Healthcare Management, LLC is a Party to and is bound by this Agreement solely for purposes of Section 21.21.

WITNESSETH:

WHEREAS, Howard owns and operates an acute general medical/surgical adult hospital (the "**HUH Facilities**") located on the medical campus with a principal address of 2041 Georgia Avenue, Washington, D.C. 20060;

WHEREAS, Manager is a wholly owned subsidiary of Paladin Healthcare Management, LLC ("**Paladin**");

WHEREAS, Paladin has demonstrated expertise and a track record of successfully managing and improving the performance of hospitals serving diverse, urban communities;

WHEREAS, Howard desires that Manager provide services to administer, supervise, and manage, and Manager desires to administer, supervise, and manage, the operations of the HUH Facilities on behalf of Howard commencing on October 1, 2014 (the "**Effective Date**") on the terms and conditions set forth hereinafter, in furtherance of and consistent with Howard's Section 501(c)(3) tax-exempt charitable and educational purposes; and

WHEREAS, since the HUH Facilities are financed in part with tax-exempt bonds, the Parties intend that the terms of this Agreement be consistent with the provisions of the Internal Revenue Service's Revenue Procedure 97-13 to avoid any part of the compensation paid to Manager under this Agreement resulting in private business use of the HUH Facilities.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements, covenants and promises hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties hereto agree as follows:

1. Retention of Manager. Subject to the terms and conditions of this Agreement, as of the Effective Date, Howard hereby retains Manager to manage the HUH Facilities on behalf of Howard. During the Term hereof, Manager shall be the exclusive provider of such services as are described in Section 5 as Management Services; provided, that Howard retains the authority to obtain any services, systems, equipment or other items within or outside of the scope of the Management Services provided hereunder by Manager, as may be necessary to comply with law or lawful obligations, or to fulfill the fiduciary obligations of its Board of Trustees as the Governing Body of the HUH Facilities; provided that, to the extent allowed by law, Howard shall provide Manager written notice of any such additional services it believes must be provided

and offer Manager an opportunity to provide such services. In the event that Manager does not confirm in writing within thirty (30) days (or such shorter period as is reasonably possible) of receipt of such notice that it will provide such services, Howard may obtain such services from a third party. Manager accepts such appointment and agrees to manage the HUH Facilities in a reasonably economical and in an ethical manner and to devote sufficient time and efforts thereto, in accordance with the terms and conditions of this Agreement.

2. Strategic Plan and Budget.

2.1 Strategic Plan and Budget. Manager and Howard, shall develop and agree on an annual plan setting forth details regarding the strategic, operational and capital activities that Manager shall undertake and oversee on behalf of Howard and the budgets regarding such activities (as amended from time to time, the "**Strategic Plan and Budget**"), which shall include, among other matters:

(a) strategic, programmatic and service line initiatives (including their operating and capital requirements) for the HUH Facilities;

(b) performance improvement initiatives, business development objectives, cost reduction plans, synergistic opportunities and efficiency improvements;

(c) an annual operating budget setting forth an estimate of operating revenues and expenses for the next year, which operating budget shall be in reasonable detail and shall contain an explanation of anticipated changes in utilization, patient charges, payroll, and other factors;

(d) an annual capital expenditures budget outlining a program of capital expenditures for the next fiscal year, which budget shall designate expenditure items as either "routine capital" or "enhancement capital" and estimate where possible their return on investment and other impact on operations, market position, etc.; and

(e) an annual projection of cash receipts and disbursements based upon the proposed capital expenditures and operating budgets, which projection shall contain recommendations concerning use of excess cash flow, if any.

2.2 Development; Modifications. An initial Strategic Plan and Budget shall be developed and agreed to by Manager and Howard within ninety (90) days following the Effective Date. During such initial ninety (90) day period, an interim Strategic Plan attached hereto as **Exhibit A** (the "**Interim Strategic Plan**") shall be in effect for purposes of this Agreement and shall serve as the Strategic Plan and Budget for all purposes hereunder during such period (unless modified by agreement of the Parties). The Parties will consult with each other on an ongoing basis throughout the Term to identify and agree on any proposed modifications to the Strategic Plan and Budget required to enhance the quality and economic viability of HUH while continuing to further Howard's charitable and educational mission. Manager shall be responsible for developing proposed additions, modifications and improvements to the Strategic Plan and Budget and shall propose such changes to Howard from time to time but no less than annually in accordance with Section 6.2. Howard, through its Governing Body (as defined below) or the President (or his designee specified in writing) shall

promptly review all proposed modifications or additions to the Strategic Plan and Budget and the written consent of the Governing Body (or its designee specified in writing, such as the Management Committee) shall be required for any change to the Strategic Plan and Budget. In the event proposed revisions to the Strategic Plan and Budget are not approved, the most recently approved Strategic Plan and Budget shall continue in full force and effect until further modified or until this Agreement expires or is terminated.

As soon as feasible but no later than thirty (30) days after the effective date hereof, the Parties will adopt decision making guidelines (the "**Decision Making Guidelines**") that set forth actions specified to be taken by Manager in the Strategic Plan and Budget (i) that shall not require any further consent or approval of the Management Committee, Howard or its Governing Body, except as required by law or accreditation standards, (ii) that shall require consent or approval of the Management Committee, but not the Governing Body, and (iii) that shall require consent or approval of the Governing Body. The Decision Making Guidelines may be modified by mutual agreement of the Parties. In addition, the Strategic Plan and Budget may be modified unilaterally by the Governing Body if required in order to maintain tax-exempt status, avoid default under its long-term debt, or comply with laws or accreditation standards and notwithstanding anything to the contrary herein, the Governing Body retains the ultimate authority and obligation to adjust to changing circumstances and to make changes to the Strategic Plan and Budget; provided that Manager shall be consulted in advance concerning any such change to the Strategic Plan and Budget.

2.3 Revenues. To the extent revenues of the HUH Facilities are not sufficient to support expenditures contemplated by the Strategic Plan and Budget, Howard will be solely responsible for its cost of operation. If requested by Howard, Manager will use commercially reasonable efforts to assist Howard in obtaining financing to fund such cost of operation. Manager shall use commercially reasonable efforts to achieve the revenue targets and other goals consistent with the Strategic Plan and Budget and Performance Targets.

3. Management Committee. Manager and Howard shall establish a Management Committee (the "**Management Committee**") comprised of two (2) appointees of Manager and two (2) appointees of Howard that shall be responsible for executing certain functions and powers delegated from time to time by the Governing Body. The Management Committee shall meet (in person or by telephone) at least once a month to review the most recent monthly financial statements and the most recent Data Deck (as defined below) for the HUH Facilities, shall work with Manager to ensure the effective and efficient management of the HUH Facilities in accordance with this Agreement and shall have such other responsibilities as are approved by the Governing Body and Manager from time to time. The presence at any meeting of at least a majority of the Management Committee shall constitute a quorum for the taking of actions by the Management Committee (except to adjourn which shall only require the affirmative vote of the majority of members in attendance). Additionally, the Management Committee (subject to ratification by the Governing Body), shall agree from time to time on guidelines with respect to various operational activities contemplated by this Agreement (e.g., bank account signatory authority, commencement of lawsuits, etc.). The Management Committee shall make decisions by majority vote and may act by unanimous written consent. If less than all members are present, any decision of the Management Committee requires the approval of at least one Howard appointee and one Manager appointee. A written proxy may be given by a member of

the Management Committee to any other member of the Management Committee. In addition to the four (4) appointees of Manager and Howard, Howard may appoint up to two (2) ex officio members of the Management Committee. In the event voting on an action by the Management Committee results in a tie, one of Howard's ex officio members shall cast his or her vote for or opposed to such action and such vote will be counted for purposes of approving or disapproving such action; provided, that, in the event any action approved by such tie-breaking method is reasonably likely to have a negative effect on Manager's ability to achieve any of the Performance Targets hereunder, the Parties agree to mutually adjust such Performance Targets commensurately to take into account such potential negative effect. The ex officio members of the Management Committee shall otherwise have no voting rights. The Management Committee may from time to time request and permit additional Manager or Howard management personnel to attend Management Committee meetings to assist the Committee or its work, but such persons shall have no vote.

4. Control By Howard. Notwithstanding anything contained anywhere to the contrary, the governing body of Howard (i.e., its Board of Trustees) shall be the governing body of the HUH Facilities (the "**Governing Body**") and, shall possess ultimate authority and control over the operations of, and shall be responsible for the approval of policies with respect to, the HUH Facilities (not inconsistent with the Strategic Plan and Budget). The Governing Body will exercise all functions that by law, payer/program agreements, Conditions of Participation, Howard's long-term debt covenants or accreditation standards must be exercised by the Governing Body. Notwithstanding the authority granted to Manager herein, Manager and Howard agree that Howard, through the Governing Body, shall at all times exercise ultimate control over the affairs of the HUH Facilities and shall approve general operating policies to be carried out by Manager under this Agreement. The Governing Body shall delegate sufficient authority to Manager (subject to ultimate oversight by the Governing Body) to enable Manager effectively to perform its functions hereunder. By entering into this Agreement, Howard does not, and shall not in the future, delegate to Manager any of the powers, duties, and responsibilities vested in the Governing Body by law or by Howard's governing documents.

5. Operational Services. Manager shall use commercially reasonable efforts to oversee the efficient and orderly operation of the HUH Facilities and shall provide the following services in accordance to the terms hereof, or if not herein specified then at least at the level of prevailing industry practices (the "**Management Services**"), specifically including the following (compensation for which, unless otherwise specifically set forth herein, shall be included within the Management Fee payable to Manager described in Section 13 hereof):

5.1 Key Hospital Services. Manager shall (a) use commercially reasonable efforts to perform all services consistent with the specific standards herein, (b) use commercially reasonable efforts otherwise to oversee the implementation of processes and systems at the HUH Facilities consistent with the Strategic Plan and Budget and Howard's charitable and educational mission, and (c) refrain from intentionally taking any actions that are in material violation of applicable laws in its activities pursuant to this Agreement. Manager's objectives in performing the Management Services shall include the following:

(a) Improving Emergency Department responsiveness to patients, reducing wait times and left-without-being-seen metrics;

(b) Improving clinical service quality and documentation through sophisticated hospitalist and case management programs and quality of services;

(c) Decreasing supply chain costs and quality of services by standardizing purchasing activities and establishing cost-effective purchasing and usage protocols;

(d) Managing labor costs through disciplined staffing policies, while strengthening employee retention and recruitment activities;

(e) Improving the clinical documentation, coding and billing procedures of the HUH Facilities, and compliance with government programs and private payor requirements, so as to increase proper fee realization in accordance with applicable contracts and law;

(f) Improving other revenue cycle functions;

(g) Developing new recurring revenue streams and increasing inpatient volumes by expanding and refining managed care activities;

(h) Realigning administrative infrastructure to better capitalize on system scale and to standardize best practices;

(i) Improving marketing, advertising and positioning of HUH within the local market;

(j) Improving care protocols and management of patient care flow, bed availability and turnover, and length of stay;

(k) Augmenting initiatives in payer relations and contracting;

(l) Enhancing the effective linkage of the clinical enterprise with support of Howard's teaching and research activities; and

(m) Implementing the services described in the remainder of Article 5 hereof.

(n) Advising the Governing Body of any material actions that Manager recommends be taken to avoid material non-compliance with law or deficiencies in services.

5.2 Staffing.

(a) During the Term, Manager shall contract with and provide, and at its sole expense pay all compensation and benefits due to, a team of senior c-suite executives comprising a Chief Executive Officer, Chief Financial Officer, Chief Operating Officer and Chief Nursing Officer (the "**Senior Executives**") who shall provide such executive management services to HUH on a full-time basis. Each such Senior Executive, and any future replacement thereof, shall be subject to reasonable advance approval by the Governing Body, which shall not be unreasonably withheld or delayed. When so approved by the

Governing Body and in the performance of their duties hereunder, such Senior Executives shall be subject to and shall comply with all Howard policies and requirements applicable to their respective positions and duties, subject to the Senior Executives being advised thereof in writing in advance. In the event that any Senior Executive is unavoidably unavailable or otherwise ceases to perform his or her duties hereunder for more than thirty (30) days in a calendar year, and the Parties are unable to reasonably agree on a suitable replacement for such Senior Executive or Manager is not able to make other reasonably acceptable arrangements for such Senior Executive's services such that substantially equivalent services are provided during such absence, then the Parties agree mutually to adjust the Base Fee to take into account the period of unavailability of such Senior Executive and the extent to which such services were not provided. In addition, at Manager's sole cost and expense, Manager may make available certain of its principals, advisors and other personnel (the "**Senior Advisors**") from time to time to consult with, visit and perform on site periodic reviews and evaluations, and advise Howard regarding the operations and business of the HUH Facilities in order to ensure effective management of the HUH Facilities. During each year of the Term (and during the first six months of the Term), the Senior Advisors shall collectively provide an average of no less than eighty (80) hours per month of such advisory services to HUH. The Parties acknowledge and agree that the composition of such advisory services at any given time may vary depending on the needs of the business of HUH, in Manager's reasonable discretion and/or at Howard's reasonable request and Manager's agreement thereto.

(b) Subject to the Strategic Plan and Budget, Manager, in consultation with the President of Howard (or his or her designees) will determine necessary and appropriate staffing levels of the HUH Facilities, and Manager shall oversee and administer the recruitment and hiring in the name of and on behalf of Howard such physicians, nurses, technicians, administrative, and other staff as are determined to be necessary or appropriate for the operation of the HUH Facilities. Manager shall recommend to Howard as appropriate any employee hirings, terminations, or other actions. Manager shall oversee and administer all payroll functions for the HUH Facilities including payroll payments, appropriate payroll withholding, and payroll accounting therefor.

(c) All personnel required to be employed directly by Howard under applicable licensure and reimbursement laws, regulations, and related requirements shall be employees or contractors of Howard ("**Howard Personnel**") and not Manager, and shall be subject to Howard's personnel policies. All wages, benefits and other payroll expenses related to Howard Personnel shall be included as part of Expenses (as defined in Section 5.17). For the avoidance of doubt, the term Howard Personnel does not include any Senior Executives or any personnel of Manager.

(d) Manager shall administer and oversee the enforcement of personnel policies established in accordance with Howard's contractual obligations, employment policies and the Strategic Plan and Budget in connection with hiring, managing, and discharging Howard Personnel.

(e) Subject to the terms of any applicable labor agreements binding Howard or the HUH Facilities, including, without limitation, any collective bargaining

agreements, Manager, as the authorized agent of Howard, shall (i) recommend the number and qualifications of Howard Personnel required for the efficient and effective operation of HUH Facilities operations, and, (ii) in accordance with the Strategic Plan and Budget, implement wage scales, employee benefit packages, in-service training programs, staffing schedules, and job descriptions for Howard Personnel, all in order to accomplish the policies established by of Howard.

5.3 Training. Manager, in collaboration with Howard, shall assist in educational training programs for Howard Personnel designed to improve inpatient and case management, clinical documentation, departmental operations and such other matters as Manager may determine to be beneficial to the efficient operation of the HUH Facilities.

5.4 Contracts. Subject to the conditions and limitations in Section 10, Manager shall assist the Senior Executives in negotiating and consummating agreements and contracts for and on behalf of the HUH Facilities in the name of Howard in the usual course of business, all in accordance with the Strategic Plan and Budget.

5.5 Laws; Accreditations. Manager shall provide assistance in obtaining and maintaining, in Howard's name, all licenses, permits, approvals and certificates of accreditation required for the operation of the HUH Facilities.

5.6 Medical Records. Manager shall administer and oversee systems for the timely, accurate and efficient creation, filing, security, sharing among care givers and other lawful persons, and retrieval at the HUH Facilities, of all medical records, charts, and files, all in accordance with applicable law, the requirements of payors, the needs of effective risk management and compliance systems, and other best practices.

5.7 HIPAA and Business Associate Agreement. The Parties hereby acknowledge and agree to enter into and comply with the Business Associate Addendum attached hereto as **Exhibit D**, to evidence their compliance with privacy standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. Parts 160 and 164, subparts A, D and E, the security standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. Parts 160, 162 and 164, subpart C , and the requirements of Title XIII, Subtitle D of the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and all its implementing regulations, when and as each is effective and compliance is required, as well as any applicable state confidentiality laws.

5.8 Support Services. Manager shall administer and oversee customary hospital support services, including, but not limited to, housekeeping, maintenance (including repair and maintenance of the interior and exterior of the HUH Facilities building, and grounds), janitorial, security and food services, other than those which Howard advises Manager that Howard elects to provide to HUH through other divisions of Howard or its affiliates or which may be provided by Howard to HUH from time to time pursuant to the Strategic Plan and Budget, which services shall be administered and overseen solely by Howard and its affiliates.

5.9 Information Technology Systems and Records. Manager shall administer and oversee the maintenance and operation of accounting, auditing, budgeting, reimbursement, revenue cycle, payor reporting and reconciliation, electronic health record, computerized physician order entry, and other clinical service records and other information technology systems required for the efficient management of the HUH Facilities' affairs and compliance with payor program requirements and/or contracts. Manager shall administer and oversee the preparation and maintenance of all books and records regarding operations and financial transactions pertaining to the HUH Facilities and shall ensure copies of such books and records are made available to the Governing Body or its designee upon request.

5.10 Establishment of Operational Policies. Manager shall develop and recommend to Howard policies, procedures, and standards of operation, maintenance, pricing, and other matters affecting the HUH Facilities and the operation thereof, consistent with the Strategic Plan and Budget.

5.11 Acquisition of Property. Manager shall be responsible for the oversight of acquisition of all personal property, equipment, supplies, and inventory as may be necessary to operate the HUH Facilities in accordance with (i) this Agreement, (ii) the Strategic Plan and Budget, (iii) applicable laws, rules, and regulations, and (iv) applicable standards and guidelines on accreditation promulgated by the Joint Commission or any other applicable accreditation organization. Manager shall have the right to utilize such personal property, equipment, supplies, and inventory at the HUH Facilities as Manager reasonably deems necessary and appropriate to fulfill its obligations hereunder.

5.12 Howard Missions. Manager shall assist Howard in:

(a) Managing the linkage between the clinical programs and student and resident academic training programs; and

(b) Enhancing the HUH Facilities' community service mission and engagement in community activities that educate, inspire, and improve the quality of life and overall health outcomes of the patient populations served by HUH.

5.13 Public Relations. Manager shall implement such advertising, marketing and other activities as may be conducive to the efficient operation of the HUH Facilities, subject to the prior approval of the Management Committee for all new materials. Subject to the foregoing, from time to time, Manager shall engage in reasonable and lawful marketing and public relations activities designed to enhance the HUH Facilities' image and reputation and to secure and maintain patients at the HUH Facilities.

5.14 Liability Insurance. Manager shall obtain and/or maintain in effect, on Howard's behalf and at Howard's sole expense, throughout the term of this Agreement, such policies (or programs) of property/casualty coverage, public liability, professional liability and hazard insurance and other customary insurance coverages in commercially reasonable amounts for and on behalf of the HUH Facilities as are designated by Howard and consistent with the Strategic Plan and Budget or, in the absence of such a specification, as Manager considers reasonable and prudent based on criteria generally used by Manager with respect to other

hospitals owned or managed by Manager, subject to approval of the Management Committee. Howard, Manager and the Senior Executives shall be covered under all such applicable policies (or programs). Additionally, Manager and the Senior Executives shall be named as additional insureds under Howard's Directors' and Officers' liability, Errors and Omissions liability, professional liability and other insurance policies and the Senior Executives shall be insured under any such policies to the same extent as Howard's other officers and directors. Throughout the Term, Paladin Healthcare Management, LLC and Manager shall each themselves maintain their own policies of Directors' and Officers' liability, Errors and Omissions liability, professional liability and other insurance policies covering their respective operations, officers, directors, employees and agents, as is customary in the hospital management industry, all with commercially reasonable amounts and terms.

5.15 Indigent Care. Manager shall assure access to medical care for indigent persons at the HUH Facilities in accordance with Howard's mission, Section 501(c)(3) tax-exempt status, the Strategic Plan and Budget and applicable law. Manager and Howard shall ensure that charity care at HUH Facilities is provided in a manner consistent with Howard's policies in effect from time to time. Manager shall implement and administer on behalf of Howard appropriate agreements with governmental authorities concerning reimbursement for services provided to indigent and uninsured persons.

5.16 Charges.

(a) Manager shall administer and oversee the billing for services rendered by the HUH Facilities and the collection of all accounts due to the HUH Facilities in accordance with lawful chargemaster and collection policies developed by Manager pursuant to the Strategic Plan and Budget and each applicable third party payor program or contract. Manager shall be entitled to obtain, on behalf of, and at the expense of, Howard, the assistance of one or more collection agencies who shall be required to act in accordance with law and generally recognized practices for non-profit hospitals (such as the AHA Guidelines.) Manager shall exercise commercially reasonable care in managing the accounts and hold in trust available cash of Howard in accordance with the Strategic Plan and Budget, shall maintain accounts and/or certificates of deposit with a financial institution or institutions designated by Howard, and shall inform the Governing Body or its designee of the availability of any excess cash from time to time.

(b) Howard shall maintain bank accounts ("**Howard Accounts**") necessary for operations of the HUH Facilities and Manager shall cause to be deposited therein all receipts and money arising from operations of the HUH Facilities. It is anticipated that the Senior Executives appointed as Chief Executive Officer and Chief Financial Officer of HUH, and such other individuals as are approved by the Governing Body from time to time, shall have the right to authorize disbursements from Howard Accounts on behalf of HUH in such amounts and at such times as the same are required, as addressed further below.

5.17 Payment of Expenses. Except as otherwise specifically provided in this Agreement, and subject to authorization policies adopted by the Governing Body and applicable Howard financial controls, Manager shall timely and accurately pay on behalf of Howard, from funds generated by the HUH Facilities in the Howard Accounts, where and as due, and without

delinquency or default, all proper debts, liabilities, costs, and expenses ("**Expenses**") related to the ownership, management and operation of the HUH Facilities, including any taxes and all bills for goods delivered or services rendered to the HUH Facilities and all personal property, supplies, inventory and all other items necessary for operation of the HUH Facilities and to provide the Management Services described herein. Manager shall contest by appropriate and legal means, (but may not bring any lawsuit without complying with such guidelines and policies as are established from time to time by the Governing Body or the Management Committee) on behalf of Howard, any claims for payment asserted with respect to the HUH Facilities that Manager, in good faith, considers erroneous or improper.

5.18 Agency. Within the scope of functions delegated to Manager hereunder and subject to other conditions set forth herein (including Section 10), Manager shall have the right to act and shall assist Howard as the agent and attorney-in-fact of Howard in the procuring of licenses, permits and other approvals, the payment and collection of accounts, and in all other activities necessary, appropriate, or useful to Manager in the carrying out of its duties as specified in the preceding paragraphs of this Section 5. In performing such services, Manager shall comply with all applicable laws, regulations and requirements of governmental bodies.

5.19 Elective Corporate-Based Consulting Services. If requested by Howard and agreed by Manager, Manager or its designees may provide as added elective consulting services (not included with Management Fees but paid instead under mutually agreed separate written agreements), corporate-based consulting services that are outside of the scope of the Management Services provided under this Agreement ("**Consulting Services**"). Manager will provide any such Consulting Services at market rates or such rates as may be mutually agreed to by the Parties, which rates shall be determined at the time such Consulting Services are requested.

5.20 Compliance with Law and Professional Standards. In performing its services hereunder, and in all conduct related to this Agreement, Manager will comply with all applicable laws and with generally recognized professional standards for similar services within the hospital management industry.

6. Reports to Howard. For the purpose of keeping informed with respect to the operation of the HUH Facilities and Manager's performance hereunder, Manager shall arrange for the preparation and delivery to the Governing Body or its designee the following:

6.1 Financial Statements.

(a) Within twenty-one (21) days after the close of each calendar month, monthly unaudited financial statements of the HUH Facilities, containing a balance sheet and a statement of income, prepared in reasonable detail and in accordance with generally accepted accounting principles (which shall also be provided to the Management Committee); and

(b) Annually, within one hundred twenty (120) days after the end of each fiscal year of the HUH Facilities, audited financial statements of the HUH Facilities ("**Audited Financial Statements**"), including a balance sheet, statement of income, and

statement of changes in financial position, prepared in reasonable detail and in accordance with generally accepted accounting principles and accompanied by a report of the independent auditor of the HUH Facilities (selected by the Governing Body) which shall also be provided to the Management Committee.

6.2 Strategic Plan and Budget. An annual updated Strategic Plan and Budget, to be delivered at least thirty (30) days prior to the beginning of each HUH Fiscal Year during the Term of this Agreement.

6.3 Annual Report. An annual report to Howard describing the operations of the HUH Facilities, its services provided to the community its support of Howard's education and research missions, and any significant problems encountered or pending with respect to the HUH Facilities, such report to be delivered within sixty (60) days of the end of each HUH Fiscal Year; provided, that, the Parties acknowledge that such report may be subject to adjustment following delivery of the Audited Financial Statements with respect to such HUH Fiscal Year.

6.4 Data Deck. Commencing on the ninetieth (90th) day after the Effective Date, and monthly thereafter, financial and operating reports regarding the services, operations and financial results of the HUH Facilities during the previous period in a form substantially similar to the Data Deck attached hereto as **Exhibit B** (as it may be amended from time to time by agreement of the Parties) which shall be deliverable within twenty-one (21) days after the end of each month of the term of this Agreement.

All reports deliverable hereunder shall be generated by Manager using the then-existing systems of Howard and delivery of such reports is conditioned upon the capability, availability, cooperation and access to, such Howard systems and personnel for Manager. Manager shall hold annual meetings with the Governing Body or its designee specified in writing to discuss the reports required by this Agreement.

7. Access to Records. Each Party agrees to provide the other, promptly when received, with access to all material reports, other filings, and communications from governmental authorities or agencies having jurisdiction over the HUH Facilities.

8. Medical Staff, Quality of Care.

8.1 Cooperation with Medical Staff. Manager shall reasonably cooperate and maintain liaisons with the medical staff of the HUH Facilities (collectively, the "**Medical Staff**") and shall advise and assist the Medical Staff concerning procedural matters and standards and guidelines on accreditation promulgated by The Joint Commission or any other applicable accreditation organization. However, all medical, ethical, and professional matters, including control of and questions relating to the composition, qualifications, and responsibilities of the Medical Staff, shall be the responsibility of the Governing Body, the Credentialing Committee, and the Medical Staff of the HUH Facilities.

8.2 Cooperation with Howard University College of Medicine and Health Sciences Program. Manager shall reasonably cooperate and maintain liaisons with the executive office of Howard University College of Medicine and its Health Sciences Program, including with respect to any academic affiliation arrangements in effect from time to time between HUH

and Howard University College of Medicine and/or the Health Sciences Program. Manager shall use commercially reasonable efforts to cooperate with the College of Medicine and its Health Sciences Program with the goal that the HUH Facilities are supportive of continued excellence in such academic programs and their ability to recruit talented students and residents.

8.3 Quality Assurance Program. Manager shall review and make recommendations regarding Howard's existing Quality Assurance Program and shall assist Howard with the implementation and administration of its Quality Assurance Program in accordance with applicable law.

8.4 Medical Affairs Committee. In order to provide a forum for communication among representatives of the Medical Staff and to ensure compliance with Howard's Quality Assurance Program, Manager shall assist Howard in the implementation and administration of a Medical Affairs Committee that shall consist of a designated senior officer of Howard, physicians appointed by the Medical Staff, persons designated by the Governing Body or its designee, and one additional person designated by Manager. The Medical Affairs Committee, if and when implemented, would meet quarterly, or as needed, keep minutes of its meetings, and have the following suggested duties:

(a) to ensure that acceptable medical, ethical, and professional standards are attained within the HUH Facilities;

(b) to assist in implementation of the Quality Assurance Program so that the quality of health care provided at the HUH Facilities may be measured objectively;

(c) to ensure that all patients admitted to the HUH Facilities or treated as outpatients receive quality patient care;

(d) to provide a forum for discussion of problems of a medical-administrative nature;

(e) to assist the Governing Body and Manager in ensuring compliance with federal, state, and local requirements; and

(f) to act in an advisory capacity in the implementation of quality of care policies adopted by the Governing Body or the Medical Staff.

9. Laws; Licenses; Reimbursement Programs; Accreditation.

9.1 Compliance with Law. In performing services hereunder and in all other actions related to this Agreement, Manager and all personnel of Manager shall comply with applicable federal, state, and local laws, rules, and regulations relating to the HUH Facilities or Manager's Management Services, including without limitation all agencies having jurisdiction over health care services, billing, labor/employment, taxation, environmental compliance, antitrust, or physical facility compliance. Manager shall assist Howard to operate the HUH Facilities so that it maintains all necessary licenses, permits, consents, and approvals from all governmental agencies that have jurisdiction over the operation of the HUH Facilities. Manager shall not be obligated to Howard for failure of the HUH Facilities to comply with any such laws,

rules, and regulations or for failure of the HUH Facilities to maintain any such licenses, permits, consents, and approvals, to the extent that the failure is due to financial limitations of the HUH Facilities or to the design or construction of the HUH Facilities, or is attributable to acts or omissions of Howard or its agents (other than Manager or Manager's employees or contractors).

9.2 Charges for Services. Manager shall comply with all laws, regulations and payer contract or program requirements concerning coding, billing, charging, collecting and reporting on fees received for services of or provided in the HUH Facilities.

9.3 Accreditation. Manager shall use its commercially reasonable efforts to manage the HUH Facilities in the manner necessary to maintain accreditation by The Joint Commission or any other similar applicable accreditation organization.

9.4 No Violation. Neither Howard nor Manager shall knowingly cause or permit any action that shall (i) cause any governmental authority having jurisdiction over the operation of the HUH Facilities to institute any proceeding for the rescission, suspension, or revocation of any license, permit, consent, or approval; (ii) cause the Joint Commission or any other similar applicable accreditation organization to institute any proceeding or action to revoke its accreditation of the HUH Facilities; (iii) cause a termination of, or adversely affect, Howard's participation in Medicare, Medicaid, Blue Cross, or any other public or private medical payment program; or (iv) cause Howard to violate or default under any of its legal obligations under debt financings.

10. Limitations on Manager's Exercise of Duties.

10.1 Limitations on Manager's Exercise of Duties.

(a) Except as contemplated by the Strategic Plan and Budget or as the Governing Body or its designee (such as the Management Committee) may specifically authorize in writing from time to time, Manager shall not have the authority to undertake the following, on Howard's behalf, without the advance written consent of the Governing Body (or its designee authorized in writing):

(1) Enter into, modify or terminate contracts or agreements with physicians and medical groups or other HUH Facilities personnel on behalf of Howard (but Manager shall have the authority on behalf of Howard to assist in negotiating and administering such contracts, at all times in accordance with applicable laws and regulations and Governing Body policy);

(2) Enter into, modify, or terminate contracts or agreements with third parties on behalf of Howard (but Manager shall have the authority on behalf of Howard to assist in negotiating and administering such contracts);

(3) Purchase capital assets or incur expenses (other than consistent with the Strategic Plan and Budget) in excess of $50,000 or such higher amount as may be authorized pursuant to policies established by the Management Committee provided, however, in the event of an Emergency, subject to at least eight (8) hours, or that amount of time which is medically appropriate given the

conditions of any given patient, prior written notice in reasonable detail to the Management Committee, the above restriction shall not apply to restrict Manager's right to purchase, on behalf of Howard, any equipment or capital assets that are reasonably required to remedy any failure of existing equipment or other emergency materially affecting patient care, and not exceeding $100,000. For purposes of this Agreement, "**Emergency**" means any circumstance or situation which, if left unattended until such time as prior approval from the Governing Body or its designee can be obtained, presents an imminent risk to the health and safety of one or more Howard patients

(4) Other than as consistent with the Strategic Plan and Budget, enter into, modify or terminate any leases of capital assets which, if purchased, would be described in Section 10.1(a)(3) of this Agreement;

(5) Negotiate, enter into, modify or terminate collective bargaining agreements covering or purporting to cover Howard personnel;

(6) Undertake or permit any material changes in the scope of services offered by Howard;

(7) Incur debt on behalf of Howard;

(8) Encumber Howard property, or sell or dispose of any material assets having a value in excess of $25,000;

(9) Approve or undertake any other matters required by law to be approved by Howard's Governing Body;

(10) Negotiate, enter into, modify or terminate benefit plans for Howard employees;

(11) File or settle litigation;

(12) Other than in accordance with the policies developed pursuant to the Strategic Plan and Budget, hire, suspend, terminate or otherwise discharge, modify responsibilities or compensation of, any present or future employee of Howard;

(13) Grant any person any rights with respect to ownership of, or limiting the activities of, the HUH Facilities; or

(14) Negotiate any legally binding affiliation, joint venture or joint enterprise involving Howard, HUH or the HUH Facilities; provided, that, in the case of the activities described in this Section 10.1(a)(14), the Parties agree that the Governing Body's final approval right is delegated to the General Counsel of Howard University who shall be required to review, consider and approve, disapprove or require further review of such proposed activity under this Section 10.1(a)(14) within ten (10) business days of receiving such request; provided,

further, that Howard, through the General Counsel of Howard University, will determine the matter in a reasonably prompt manner given all the circumstances.

(15) Appear in relation to Howard before any governmental body (except as may be required by law), or issue any public statement concerning Howard or the HUH Facilities, in each case unless approved in advance by Howard.

(b) Notwithstanding any term herein to the contrary, if Howard undertakes any material budgetary or operating decision or action that is solely within its discretion hereunder or including without limitation any major actions or decisions of the type listed in Section 10.1(a), which was against the advice of Manager as set forth in a written notice to Howard, prior to or promptly after such unilateral decision or action by Howard, Howard agrees to provide Manager with reasonable advance written notice of any scheduled meeting of the Governing Body or its designee (including the Management Committee) and afford Manager an opportunity to submit materials and to address such action and any related matters at the meeting of such body.

(c) Except as set forth in the Strategic Plan and Budget, Howard shall have the ultimate authority to decide, in its sole and absolute discretion, whether to approve, disapprove or undertake any of the above listed items or actions in Section 10.1(a). However, Howard agrees to consult and cooperate with Manager in good faith concerning any decisions related to the above listed items.

10.2 Non-Recurring Actions. In the event Manager desires to take any non-recurring or one-time actions that are not contemplated by the Strategic Plan and Budget or that otherwise require the advance written consent or approval of the Governing Body (or its designee) or the Management Committee pursuant to this Agreement or the Decision Making Guidelines but which do not require a formal modification to the Strategic Plan and Budget, the following provisions shall apply:

(a) a request for consent or approval of the applicable entity with approval rights (the "Approving Party") shall be provided to such Party by Manager. Such request shall include a reasonably detailed description of the act or event for which consent is sought, and shall be delivered to the official designated by Howard at the designated address via hand delivery or certified U.S. Mail or by facsimile or email;

(b) the Approving Party shall review, consider and approve, or require further review of, such proposed act or event within ten (10) business days of receiving such request; provided, that, such period shall be reasonably extended to provide the Approving Party with additional opportunities to review or consider any such acts or events if requested in writing accompanied by a reasonably detailed explanation of the reasons for delay and a commitment to provide a final decision within a stated period of time not to exceed thirty (30) days from the date of the initial request or such longer period as is reasonable given the circumstances;

(c) for all matters determined in Manager's reasonable discretion to constitute an Emergency, Manager shall, in its written request for consent to the Approving Party, state the nature of the Emergency, and the Approving Party shall have a reasonable opportunity given the circumstances in which to respond in writing to Manager's request for consent. However, in the event of an Emergency (or the failure of the Approving Party timely to respond), Manager, with the approval of the Howard President, may take reasonable actions that involve temporary solutions in order to resolve such Emergencies.

10.3 Manager's and Paladin's Conduct. In addition to due performance of the obligations as specified herein, it shall be a material component of Manager's obligations that it, and its ultimate parent Paladin Healthcare Management, LLC, not be found by any court or other governmental body to have engaged in substantial unlawful, immoral or disgraceful conduct that reasonably could cause an impairment of the reputation of Howard, unless such effect is promptly avoided or resolved.

11. Defense of Claims; Exculpation.

11.1 Howard.

(a) Howard agrees to indemnify, defend and hold harmless Manager, including its "advisors" (selected by Manager and accepted by Howard), affiliates, subsidiaries, successors and assigns, and any employee, agent, officer, director, manager, representative, attorney, or independent contractors, including but not limited to Senior Executives and their employer and its affiliates (together, the "**SE Employer**"), and direct or indirect equity holder of Manager, and any person who controls Manager (any or all of the foregoing hereinafter a "**Manager Indemnified Person**"), from and against any losses, damages, liabilities, deficiencies, claims, actions, suits, proceedings, judgments, settlements, interest, awards, penalties, fines, costs, or expenses (including reasonable attorneys' fees and costs of defense), joint or several, of any kind or nature whatsoever (collectively, "**Claims**") that may be incurred by or asserted against Manager or a Manager Indemnified Person (whether or not Manager or a Manager Indemnified Person is party to such Claims) to the extent they result from, arise out of, or are in any way related to, the following, in each case as finally determined by an arbitrator under Section 16.4:

(1) the breach or non-fulfillment by Howard or any of its Representatives of any of the covenants, duties, obligations, representations or warranties of Howard set forth in this Agreement;

(2) any actions or omissions of Howard or its affiliates, subsidiaries, successors, assigns, employees, agents, officers, directors, managers, advisors, representatives, attorneys, independent contractors (respectively, "**Representatives**," but for the avoidance of doubt specifically excluding Manager, SE Employer and Manager Indemnified Persons), including without limitation actions or omissions arising out of the negligence, gross negligence, recklessness, or willful misconduct of Howard or its Representatives related to this Agreement;

(3) any failure by Howard or any of its Representatives to comply with any applicable federal, state or local laws, regulations or codes in the performance of its obligations under this Agreement;

(4) Manager's or any Manager Indemnified Person's involvement in, in any manner including without limitation the management of, oversight of or operation of, the HUH Facilities or any other actions or omissions of Manager or any Manager Indemnified Person;

(5) any claim which is brought or asserted by third parties against Manager or any Manager Indemnified Person relating to this Agreement or Howard's ownership or operation of the HUH Facilities, including without limitation the use of any real or tangible property in connection with the HUH Facilities; or

(6) any bodily injury, death of any person or damage to real or tangible property caused by the acts or omissions of Howard or any of its Representatives, subject to Section 11.1(c) below.

(b) Furthermore, Howard agrees to reimburse Manager, as incurred and upon demand by Manager, for legal or other expenses reasonably incurred by Manager or a Manager Indemnified Person in connection with investigating, defending or preparing to defend any such Claims (including without limitation in connection with the enforcement of the indemnification obligations set forth herein), whether or not Manager or any Manager Indemnified Person is a party to any Claims out of which any such expenses arise and whether or not such Claims are brought by Howard, its Representatives or any other person or entity.

(c) However, Howard shall not be obligated under the foregoing indemnity agreement in respect to any Claims (a) to the extent such Claims resulted in whole or in part from the gross negligence, willful misconduct or fraud of Manager or a Manager Indemnified Person; (b) by one Manager Indemnified Person against another relating to activities of such parties pursuant to the Agreement; or (c) arising from (i) felony criminal activity that any Senior Executive or Manager Indemnified Person directly participated in or (ii) other acts indemnifiable by Manager under Section 11.2, in each such case (other than with respect to felony criminal acts), as finally determined by an arbitrator under Section 16.4.

(d) The reimbursement and indemnity obligations of Howard under this Section 11.1 shall be in addition to any liability Howard may otherwise have; shall extend upon the same terms and conditions to the Manager Indemnified Persons, and shall be binding upon and inure to the benefit of any successors, assigns, heirs, and personal representatives of Howard, or of Manager or any Manager Indemnified Persons.

11.2 Manager. Manager shall indemnify, defend, and hold harmless Howard including its affiliates, subcontractors, successors and assigns and any employee, agent , officer, director, manager, representative, attorney or independent contractor ("**Howard Indemnified Persons**") against any Claims (including reasonable attorneys' fees and costs of defense) to the extent that they result from the felony criminal acts that Manager Indemnified Persons directly

participated in, willful misconduct, gross negligence or fraud of Manager, in each such case (other than with respect to felony criminal acts which shall require final judgment by a court of competent jurisdiction (not subject to further appeal)), as finally determined by an arbitrator under Section 16.4. A Manager Indemnified Person shall not be liable for any act or omission of any other Manager Indemnified Person other than its own officers, directors, employees and subcontractors. In addition, Manager shall not be obligated under the foregoing indemnity agreement in respect to any Claims (a) to the extent such Claims resulted in whole or in part from the gross negligence, willful misconduct or fraud of Howard or a Howard Indemnified Person (b) by one Howard Indemnified Person against another relating to activities of such parties pursuant to the Agreement; or (c) arising from (i) felony criminal activity that any Howard Indemnified Person directly participated in or (ii) other acts indemnifiable by Howard under Section 11.1, in each such case (other than with respect to felony criminal acts) as finally determined by an arbitrator under Section 16.4. The Manager Indemnified Persons shall not be liable for any act or omission taken at the specific direction or with the express approval of the Management Committee or the Governing Body.

11.3 Procedure.

(a) In the event that any Party hereunder shall receive any notice of any claim or proceeding against said Party in respect to which indemnity may be sought under Section 11 of this Agreement, the said Party ("**Indemnitee**") shall give the Party upon whom a claim could be made under this Section 11 ("**Indemnitor**") written notice of such loss, liability, claim, damage, or expense and the Indemnitor shall have the right to contest and defend any action brought against the Indemnitee based thereon, and shall have the right to contest and defend any such action in the name of the Indemnitee at the Indemnitor's own expense; provided, however, that if the Indemnitor shall fail to assume the defense and notify the Indemnitee of the assumption of the defense of any such action within ten (10) days of the giving of such notice by the Indemnitee, then the Indemnitee shall have the right to take any such action as it reasonably deems appropriate to defend, contest, settle, or compromise any such action or assessment and claim indemnification as provided herein; provided, however, that no Party shall settle any such action without the consent of the other applicable Party (which consent shall not be unreasonably withheld) unless such settlement involves only the payment of money and the claimant provides the Indemnitee a release from all liability in respect of such claim. If the Indemnitor defends any action for which indemnification is claimed, the Indemnitee shall be entitled to participate at its own expense in the defense of such action; and further, provided, however, that the Indemnitor shall bear the fees and expense of the Indemnitee's counsel only if (i) the engagement of such counsel is specifically authorized in writing by the Indemnitor, (ii) the Indemnitor is not adequately prosecuting the defense in good faith, or (iii) the named parties to such action include both the Indemnitor and the Indemnitee and there exists a conflict or divergence of interest between such parties which renders it inappropriate for counsel selected by the Indemnitor to represent both of such parties. The Indemnitor shall not be liable for any settlement of any claim, action, or proceeding effected without its written consent, except as provided in this Section 11.3. No Party shall recover an amount in excess of the actual damages incurred.

(b) Notice of all claims as required by Section 11 shall be promptly provided as to (i) the nature of any claim; or (ii) the commencement of any suit or proceeding

brought to enforce any claim. In the event of failure to provide such notice or in the event that Indemnitee shall fail to cooperate fully with Indemnitor in the Indemnitor's defense of any suit or proceeding, the Indemnitor shall be released from some or all of its obligations with respect to that suit or proceeding to the extent that the failure of notice or cooperation actually and materially adversely affected the Indemnitor's defense of such claims.

11.4 Indemnification of Senior Executives. In addition to, and without limiting the indemnification described above, Howard shall indemnify the Senior Executives who will be acting as officers of HUH to the same extent and subject to the same conditions as the most favorable indemnification it extends to its officers or directors, whether under Howard's charter, bylaws, by contract or otherwise.

11.5 Exculpation of Senior Executives and SE Employer. Though the Senior Executives may continue to be employed by and associated with the SE Employer and its affiliates while providing services described hereunder, with respect to HUH and Howard, the Senior Executives shall serve at the pleasure and direction of the Manager, the Management Committee and/or Governing Body and neither the SE Employer, any Senior Executive nor any of their respective affiliates shall have any liability to Howard or HUH for any acts or omissions of the Senior Executives, notwithstanding that SE Employer may receive compensation from Manager for making the Senior Executives available to serve in such capacity (and Howard and HUH expressly waive and agree not to assert any claim of respondeat superior or similar legal theory which might otherwise hold SE Employer or its affiliates liable for the acts or omissions of the Senior Executives), except to the extent that any such Claims result primarily and directly from such Senior Executive's felony criminal acts, willful misconduct, gross negligence or fraud in each such case (other than with respect to felony criminal acts which shall require final judgment by a court of competent jurisdiction (not subject to further appeal)), as finally determined by an arbitrator under Section 16.4.

12. Access to Records.

12.1 Access to Records.

(a) Manager shall provide to the Governing Body, Howard's auditors and accountants, Howard's fiscal intermediaries, and accountants and agents for the Medicare and Medicaid programs or any other governmental authority exercising legal and appropriate authority, access to all lawfully required records for a period of four (4) years after the furnishing of services under this Agreement.

(b) Until the expiration of four (4) years after the furnishing of Management Services pursuant to this Agreement, the Parties shall, upon written request, make available to the Secretary of Health and Human Services (the "**Secretary**") or the Comptroller General, or their duly authorized representative(s), contract, books, documents, and records related to this Agreement and necessary to verify the nature and extent of the cost of such Management Services. If any Party carries out any of its obligations under this Agreement by means of a subcontract with a value of $10,000 or more, that Party agrees to include this requirement in any such subcontract. The availability of books, documents, and records shall be subject at all times to all applicable legal requirements, including without

limitation such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary by regulation. Neither Party shall be construed to have waived any applicable attorney-client privilege by virtue of this Section 12.

12.2 Exercise of Right of Access. The foregoing rights of access shall be exercisable through a written request, upon which Manager and its subcontractors shall give access to the above contracts, books, documents, and records from time to time during reasonable business hours.

13. Management Fee.

13.1 Management Fees. In consideration for the Management Services provided by Manager as described in Section 5, the reports to Howard described in Section 6, the Medical Staff functions described in Section 8, and the other functions of Manager described herein (but excluding corporate Consulting Services described in Section 5.19), Howard shall pay Manager as follows (collectively, the "**Management Fees**"):

(a) An annual base fee (the "**Base Fee**") equal to $5,400,000 increased at the end of each twelve (12) month period during the Term by 3%**;** plus

(b) An annual incentive fee (the "**Incentive Fee**") of up to $1,350,000 depending on achievement of the four (4) annual performance targets set forth on Schedule 13.1(b) (the "**Performance Targets**"); plus

(c) A one-time (not annual) success fee (the "**Success Fee**") calculated as follows:

For each contract year that any Performance Targets were achieved a multiplier (the "Multiplier") shall be determined as follows:

(1) Achievement of 1 Performance Target during such contract year = 20% Multiplier;

(2) Achievement of 2 Performance Targets during such contract year = 40% Multiplier;

(3) Achievement of 3 Performance Targets during such contract year = 70% Multiplier; and

(4) Achievement of 4 Performance Targets during such contract year = 100% Multiplier.

The Multiplier for each contract year then shall be multiplied by $2,250,000 to produce each contract year's portion of the Success Fee which shall all be added together to produce the Success Fee payable to Manager.

For illustrative purposes only, if the Term is five years and Manager achieved three Performance Targets in years one through three and four Performance Targets in years four

and five, then Manager would receive a Success Fee equal to $9,225,000, calculated as follows: for years one through three Manager would earn $1,575,000 and for years four and five Manager would earn $2,250,000. The Success Fee shall become due and payable in the event of (x) a change of control of HUH as described in Section 17.6, (y) the termination of this Agreement for any reason other than valid termination by Howard for material breach in accordance with Section 17.1 (in which event any Success Fee that may be earned and shall be reduced by the proven damages to Howard directly resulting from Manager's material breach), or (z) the expiration of this Agreement (each, a "**Success Fee Triggering Event**"), and shall be paid in a lump sum in accordance with Section 13.2 below.

13.2 Timing of Payments.

(b) Manager shall bill Howard monthly in advance for one twelfth (1/12) of the annual Base Fee and Howard shall pay such monthly amount no later than the end of the applicable calendar month, throughout the Term.

(c) Any earned Incentive Fee shall be paid as follows:

(1) Seventy percent (70%) shall be paid promptly (but in any event not later than forty-five (45) days after the end of the applicable HUH Fiscal Year) and determination of achievement of the Performance Targets, which determination shall be based on Manager providing the required information, and on the unaudited financial statements of HUH for the applicable HUH Fiscal Year; and

(2) Any remaining earned but unpaid Incentive Fee shall be paid promptly (but in any event not later than one hundred fifty (150) days after the end of the applicable HUH Fiscal Year) after determination of achievement of the Performance Targets, which determination shall be updated based on the Audited Financial Statements for the applicable HUH Fiscal Year. Any final adjustment in the initial Incentive Fee payment that results from the Audited Financial Statements shall then be made.

In the event this Agreement is terminated prior to the end of any HUH Fiscal Year for any reason, the measurement period for the year of termination shall be automatically adjusted with no further action by either party to begin on the date that the applicable HUH Fiscal Year commences and end on the date of termination of this Agreement, and the earned Incentive Fees, if any, for such partial year shall be (i) determined on a pro-rata basis based on such partial HUH Fiscal Year, and (ii) paid within thirty (30) days after termination of this Agreement.

(d) Any Success Fee shall be paid within forty-five (45) days after the earliest occurring Success Fee Triggering Event.

13.3 Arm's Length Transaction. The Parties have negotiated the Management Fees at arm's length, assisted by professional financial advisers. They believe that the management fees are consistent with fair market value and comply with law.

13.4 Adjustments to Performance Targets. In the event Howard unilaterally modifies the Strategic Plan and Budget or otherwise takes any action or omits to take any action relating to the operation of HUH in contravention of Manager's advice or without Manager's input (including, but not limited to, election to provide support services through divisions of HUH under Section 5.8 or determinations of the Management Committee achieved with a tie-breaking vote under Section 3) that are reasonably likely to have a significant negative effect on Manager's ability to achieve any of the Performance Targets hereunder such that adherence to the original Performance Targets would be unfair, the Parties agree to mutually adjust such Performance Targets commensurately to take into account such potential unfair negative effect(s).

14. Breach. In the event of a breach of any obligation or covenant under this Agreement, other than the obligation to pay money (which shall have a thirty (30) day cure period), the non-breaching Party may give the breaching Party written notice of the specifics of the breach, and the breaching Party shall have sixty (60) days (the "**Cure Period**") in which to cure the breach; provided, that for any non-monetary defaults reasonably requiring greater than ninety (90) days to cure, the breaching Party shall not be in default so long as the breaching Party commences to cure such default within the required sixty (60) days and diligently prosecutes such cure to completion thereafter. Only if the breach is not cured within said Cure Period shall the non-breaching Party be entitled to pursue any remedies it may have by reason of the breach. A waiver of any breach of this Agreement shall not constitute a waiver of any future breaches of this Agreement, whether of a similar or dissimilar nature.

15. Term. The term of this Agreement ("**Term**") shall commence and be deemed effective as of the Effective Date, and continue for an initial five (5) year period, and shall automatically renew for one (1) additional five (5) year period unless a Party provides at least one hundred eighty (180) days prior written notice of nonrenewal to the other party. Thereafter, this Agreement may be renewed upon prior written agreement of the Parties. Any renewal periods shall be deemed a part of the Term.

16. Dispute Resolution and Remedies.

16.1 Resolution by Management. The Parties' respective management teams shall attempt, in good faith, to privately and confidentially resolve any dispute, controversy or claim arising under this Agreement (a "**Dispute**"). In the event the Parties are unable to resolve the Dispute after negotiating in good faith for thirty (30) days following written notice of the Dispute served on a Party, either Party may refer such Dispute to the President of Howard and the CEO of Paladin for resolution.

16.2 Resolution by Board Chairs. If the President and CEO are unable to resolve the Dispute within twenty (20) days of meeting, then such Dispute shall be submitted in writing to the Chairpersons of Howard's Board of Trustees and Paladin's Boards of Directors, respectively, for resolution. The Chairpersons shall meet as soon as reasonably practicable, but in no event later than thirty (30) days of the written request referring the matter to them, and attempt in good faith to resolve the Dispute.

16.3 Resolution by Consultant. If the Chairs are unable to resolve the Dispute within twenty (20) days of meeting, then the Dispute shall be referred for resolution to a third Party consultant with expertise in the field of the Dispute (the "**Consultant**"), the identity of such Consultant to be mutually agreed upon by the parties in good faith.

16.4 Arbitration. If the agreed-upon Consultant is unable to resolve, or propose a correction plan that resolves, the Dispute, in either case to the mutual satisfaction of the Parties, within twenty (20) days after the referral, or the Parties cannot agree on a consultant within twenty (20) days after a request by a Party, then the Dispute shall be settled by binding arbitration, in the District of Columbia, before a single, mutually agreeable arbitrator from Judicial Arbiter Group, Inc., in accordance with the JAMS expedited arbitration rules. Each Party covenants to use its commercially reasonable efforts to conclude any arbitration proceeding as expeditiously as reasonably feasible. Each Party shall be responsible for one-half of all costs resulting from initiation of the arbitration procedure set forth herein, (but each Party shall be responsible for its own attorneys' fees, legal fees and costs for expert and other witnesses); provided, that the arbitrator may award reasonable costs and attorneys' fees to the prevailing Party or Parties or a claim or counterclaim.

16.5 Remedies. The arbitrator under Section 16.4 may grant as remedies in connection with an outstanding Dispute: (a) a required Corrective Action Plan for Manager's performance of the Management Services, (b) specific performance of this Agreement, (c) a reduction in the Management Fees payable to Manager, (d) full payment by Howard to Manager in accordance with the terms hereof, (e) a modification to the Performance Targets; (f) monetary indemnification in accordance with the terms hereof, and/or (g) any other lawful and appropriate remedy, including termination of this Agreement.

16.6 Exclusive Process. Except as otherwise set forth herein, the procedure set forth in this Section 16 shall be the Parties' exclusive process for resolution of all Disputes; provided, that any Party may seek from any court of competent jurisdiction (a) temporary injunctive relief (but not monetary damages) to prevent imminent harm or danger to the Party or its patients or employees pending final resolution as described herein, (b) specific performance of a Party's indemnification obligations, or (c) judicial entry of any arbitral award.

17. Termination. This Agreement may be terminated prior to the expiration of the Term only as follows, and any such termination shall not affect any rights or obligations arising prior to the effective date of termination:

17.1 Termination for Material Breach.

(a) In the event of a material breach of this Agreement which is not cured within the Cure Period set forth in Section 14 of this Agreement, the non-breaching Party may terminate this Agreement upon no less than sixty (60) days' advance written notice to the other Party unless the breaching Party has diligently commenced to cure, and has cured the breach, within the prescribed Cure Period; provided, that, in the event the material breach is related to an obligation to pay money, no such advanced written notice period shall be required in the event such breach is not cured within the thirty (30) day Cure Period provided

in Section 14. This remedy shall be in addition to any other remedy available at law or in equity. Failure to terminate this Agreement shall not waive any breach of this Agreement.

(b) Notwithstanding any provision contained herein, however, Manager shall not be liable to Howard and shall not be deemed to be in breach of this Agreement for the failure to perform any or all obligations to be performed by Manager pursuant to this Agreement, to the extent such failure results from (i) governmental intervention, (ii) labor dispute, (iii) law, regulations, rules or reimbursement rules or policies that actually prevent such performance, (iv) any other action or event which is beyond the reasonable control of Manager, or (v) any failure by Howard to perform or meet any of Howard's obligations hereunder; and provided that Manager shall nevertheless be obligated duly to perform hereunder to the extent such performance remains feasible.

17.2 Bankruptcy Insolvency. Manager may terminate this Agreement upon ten (10) days written notice to Howard in the event Howard (or Howard's sponsoring entity) becomes insolvent or fails to pay, or admits in writing its inability to pay, its debts as they mature; or a trustee, receiver or other custodian is appointed for such other party for all or a substantial part of such person's property and is not discharged within sixty (60) days of appointment; or any bankruptcy reorganization, debt, arrangement, or other proceeding under any bankruptcy or insolvency law or any dissolution or liquidation proceeding is instituted by or against such person and if instituted against such person's is consented to or acquiesced in by such person or remains undismissed for sixty (60) days following the original filing; or any warrant or attachment is issued against any substantial portion of the property of such person which is not released within sixty (60) days of service; and Howard may likewise terminate if any of the foregoing occurs with regard to Manager or Paladin Healthcare Management, LLC and this substantially impairs Manager's ability to perform its obligations under this Agreement.

17.3 Legal Event; Notice to Amend; Termination. Notwithstanding any other provision of this Agreement, provided that this Agreement is not terminated by Manager or Howard pursuant to any other provision of this Agreement, if the governmental agencies that administer the Medicare, Medicaid, or other federally funded programs (or their representatives or agents), or any other federal, state or local governmental or non-governmental agency, or any court or administrative tribunal pass, issue, or promulgate any law, rule, regulation, standard, interpretation, order, decision, or judgment, including but not limited to those relating to any regulations pursuant to state or federal anti-kickback or physician self-referral statutes (collectively or individually "**Legal Event**"), which, in the written opinion of counsel for either Party (the "**Noticing Party**"), (i) makes continued implementation of this Agreement in accordance with its terms unlawful in material respects, or (ii) subjects the Noticing Party to a material risk of prosecution or civil monetary penalty, then the Noticing Party may give the other Party notice of intent to amend this Agreement solely for the purpose of (a) conforming to law and (b) preserving to each Party the economic effects as close to the provisions hereof as is feasible and would yet be lawful. In the event of such notice, the Parties shall have thirty (30) day from the giving of such notice ("**Renegotiation Period**") within which to attempt to amend this Agreement. If this Agreement is not so amended within the Renegotiation Period to the mutual satisfaction of each Party, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given.

17.4 Mutual Agreement. This Agreement may be terminated at any time by written agreement of the Parties, under such terms and with such effective date as they may mutually specify. If despite the good faith performance hereunder by both Parties, results of operations at HUH decline to such a level that it becomes no longer reasonably feasible for Howard to operate it as a viable business, then neither Party hereto will unreasonably withhold mutual consent to termination under this Section 17.4.

17.5 Without Cause Termination. Either Party may terminate this Agreement at the end of the third (3rd) year of the initial Term without cause upon no less than one hundred eighty (180) days' prior written notice.

17.6 Change of Control. Howard may terminate this agreement at any time upon sixty (60) days prior written notice to Manager in the event that Howard leases sells, conveys or otherwise engages in a change of control of governance or operation of HUH pursuant to which the Governing Body no longer has ultimate authority and control over the HUH Facilities and operation of HUH.

18. Effects of Termination. The termination of this Agreement for any reason shall be without prejudice to any payments or obligations which may have been earned and accrued or become due to any Party hereunder prior to the date of termination. Notwithstanding anything to the contrary herein, the following provisions shall survive any termination hereof: Sections 11 (Defense of Claims), 12 (Access to Records), 13 (Management Fee), 20 (Representation and Warranties) and 21 (Miscellaneous). Subject to Section 13, in the event this Agreement is terminated for any reason, Howard shall pay to Manager are unpaid fees as provided herein.

19. Transition Services. In the event of termination of this Agreement prior to expiration for any reason other than insolvency or bankruptcy of Howard, upon request of Howard, Manager shall be obligated to continue to provide Howard with the Management Services described herein for a period of up to one hundred twenty (120) days after such termination or expiration of this Agreement (the "**Transition Period**"), and during such Transition Period: (a) Howard shall continue to compensate Manager in accordance with this Agreement, (b) Manager shall fully cooperate in order to ensure the orderly and efficient transfer of its functions hereunder to Howard and/or another service provider; (c) Manager shall fully cooperate in order to ensure no disruption to patient care functions; and (d) the Parties shall cooperate in order to resolve any outstanding operational, financial, legal or other matters arising (including audits) from the period in which this Agreement was in effect .

20. Representations and Warranties.

20.1 Manager. As of the Effective Date, Manager represents and warrants to Howard as follows:

(b) Manager is a limited liability company duly organized, validly existing, and in good standing under the laws of the State of Delaware.

(c) Manager has full authority to enter into and perform this Agreement, and the signature of Manager's representative at the end hereof signifies that this Agreement has been duly authorized, executed and delivered and represents a legal, valid and binding

agreement enforceable against Manager in accordance with its terms (subject only to customary limitations on the enforceability and availability of remedies in accordance with principles of law and equity).

(d) The execution, delivery and performance of this Agreement by Manager does not (i) require any consent, waiver, approval, license or authorization of any person or public authority which has not been obtained and is not presently in effect; (ii) to the knowledge of Manager, violate any provision of law applicable to Manager; or (iii) conflict with or result in a default under, or create any lien upon any of the property or assets of Manager under, any agreement or instrument; or (iv) violate any judicial or administrative decree, contract, or other legal obligation to which Manager is subject or by which any of its assets are bound.

(e) There is no civil, criminal or administrative action, suit, demand, claim, hearing, proceeding or investigation pending or, to Manager's knowledge threatened against Manager that may materially delay or interfere with its entering into and fully and duly performing this Agreement.

(f) Neither Manager nor, to the knowledge of Manager, any Manager personnel (including any Senior Executive) is a person excluded or barred from the Medicare or Medicaid programs.

20.2 Howard. As of the Effective Date, Howard represents and warrants to Manager as follows:

(a) Howard is a non-profit corporation duly organized, validly existing, and in good standing under the laws of the District of Columbia.

(b) Howard has full authority to enter into and perform this Agreement, and the signature of Howard's representative at the end hereof signifies that this Agreement has been duly authorized, executed and delivered and represses a legal, valid and binding agreement enforceable against Howard in accordance with its terms (subject only to customary limitations on the enforceability and availability of remedies in accordance with principles of law and equity).

(c) The execution, delivery and performance of this Agreement by Howard does not (i) require any consent, waiver, approval, license or authorization of any person or public authority which has not been obtained and is not presently in effect; (ii) violate any provision of law applicable to Howard; or (iii) conflict with or result in a default under, or create any lien upon any of the property or assets of Howard under, any agreement or instrument; or (iv) violate any judicial or administrative decree, contract, or other legal obligation to which Howard is subject or by which any of its assets are bound.

(d) There is no civil, criminal or administrative action, suit, demand, claim, hearing, proceeding or investigation pending or, to Howard's knowledge threatened against Howard that may materially delay or interfere with its entering into and fully and duly performing this Agreement.

21. Miscellaneous.

21.1 Joint Venture Agreement. During the term of this Agreement, Howard and Manager intend to negotiate in good faith in with the goal of agreeing on the terms of a definitive Joint Venture Agreement to be implemented by the Parties as soon as reasonably practicable. The anticipated terms are summarized on **Exhibit C** hereto, but the Parties are not legally bound until and unless they agree on a definitive Joint Venture Agreement.

21.2 Non-Solicitation. During the Term hereof and for a period of two (2) years after its expiration or termination for any reason, neither Party (and its affiliates, officers, directors employees and agents) shall solicit for employment or contracted services, or employ or contract for services, with any person whom they first encountered as an employee or medical staff member of the other Party or its affiliates. In addition, Howard, on behalf of itself and its subsidiaries and affiliates and any person which may acquire all or substantially all of its assets agrees that, until two (2) years subsequent to the termination of this Agreement, it will not solicit, recruit, hire or otherwise engage any Senior Executive or other employee of the SE Employer that provided services to HUH or Manager relating to HUH while employed by SE Employer or its affiliates ("**SE Employer Solicited Person**"). As fair compensation for lost profits and all other damages to SE Employer, should Howard or any of its subsidiaries or affiliates or any person who acquires all or substantially all of its assets extend an offer of employment to or otherwise engage any SE Employer Solicited Person and should such offer be accepted, SE Employer shall be entitled to a fee from Howard equal to the SE Employer Solicited Person's standard hourly client billing rate at the time of the offer multiplied by 4,000 hours for a Managing Director, 3,000 hours for a Senior Director and 2,000 hours for any other SE Employer employee. Howard acknowledges and agrees that this fee fairly represents the loss that SE Employer will suffer if Howard or HUH breaches this provision. The fee shall be payable at the time of the SE Employer Solicited Person's acceptance of employment or engagement with Howard or any of its subsidiaries or affiliates.

21.3 Limitations on Competitive Activities. During the Term hereof and for a period of two (2) years after its expiration or termination for any reason (other than Howard's material breach or insolvency), neither Paladin Healthcare Management, LLC nor Manager, either directly or through any controlled affiliate shall within the District of Columbia, engage in providing management services to any other hospital or physician group practice or site or facility (other than United Medical Center if Howard and Manager agree upon terms thereof). SE Employer shall not be bound by this restriction.

21.4 Public Statements. Manager shall obtain Howard's prior written consent to any public statements about HUH, services provided, or its relationship hereunder, and shall refrain from making any such statements unless reasonably consented to by Howard, provided only that Manager may make any public statements reasonably necessary to comply with law or assert its legal rights in accordance with law and this Agreement.

21.5 Contacts with Government Officials. Except in emergencies (and then to the extent reasonably feasible given the circumstances), Manager shall not engage in substantive communications with officials of the District of Columbia of the U.S. Government concerning

this Agreement or activities related hereto, without prior good faith consultation with and notice to Howard's designated officials.

21.6 Use of Howard Name. Manager shall not use the Howard University or Howard University Hospital names in any manner except as authorized in writing pursuant to policies established by Howard hereunder, and in a manner reasonably necessary or conducive to performing its services hereunder. Manager may not use such names in marketing its services elsewhere, except that it may state accurately that it has performed under this Agreement.

21.7 Reimbursable Expenses. During the first twelve (12) months of the Term, Manager shall be promptly reimbursed for all reasonable expenses (to the extent of and pursuant to Howard's expense reimbursement policy for other personnel and contractors) incurred by Manager or third parties Manager contracts with in connection with the provision of the Management Services hereunder (e.g., Senior Executives), including, but not limited to transportation, lodging, meals, travel and office expenses upon submission to Howard of invoices therefore, provided, that such reimbursement of expenses shall be capped at 10% of Manager's Base Fee. The Parties shall negotiate in good faith and agree upon fair and reasonable provisions for reimbursement of expenses for subsequent periods during the Term. Howard agrees to pay invoices upon receipt.

21.8 Notices. All notices, requests, demands and other communications required or permitted to be given pursuant to this Agreement must be in writing and shall be (i) delivered to the appropriate address by hand, by nationally recognized overnight service (costs prepaid); (ii) sent by facsimile or email, or (iii) sent by registered or certified mail, return receipt requested, in each case to the following addresses, facsimile numbers or email addresses and marked to the attention of the person (by name or title) designated below (or to such other address, facsimile number, email address or person as a Party may designate by notice delivered to the other Party in accordance with this Section 21.77:

Manager:
Paladin-Howard Management, LLC
2121 Rosecrans Avenue, Suite 2320
El Segundo, CA 90245
Attention: Chief Executive Officer
Facsimile: (310) 414-2709
Email: jfreedman@pldn.com

with a copy (which shall not constitute notice) to:
Sheppard, Mullin, Richter & Hampton, LLP
1901 Avenue of the Stars Suite 1600
Los Angeles, CA 90067
Attention: Eric A. Klein, Esq.
Facsimile: (310) 228-3988
Email: eklein@sheppardmullin.com

Howard:	Howard University 2400 Georgia Avenue, NW Washington, DC 20059 Attention: General Counsel Facsimile: (202) 806-6357 Email: fprioleau@howard.edu
with a copy (which shall not constitute notice) to:	Hogan Lovells US LLP 555 Thirteenth Street, NW Washington, DC 20004-1109 Attention: Clifford D. Stromberg, Esq. Facsimile: (202) 637-5910 Email: clifford.stromberg@hoganlovells.com

All notices, requests, demands and other communications shall be deemed have been duly given (as applicable): (A) if delivered by hand, when delivered by hand; (B) if delivered by UPS, Federal Express, DHL or other nationally-recognized overnight delivery service, when delivered by such service; (C) if sent via registered or certified mail, three (3) Business Days after being deposited in the mail, postage prepaid; or (D) if delivered by email or facsimile, when transmitted if transmitted with confirmed delivery.

21.9 Severability. If any clause or provision of this Agreement is determined by a governmental body or a court having jurisdiction thereof to be illegal, invalid, or unenforceable under any present or future law, then the Parties agree that the remaining provisions of this Agreement that reasonably can be given effect apart from the illegal or unenforceable provision shall continue in effect and there shall be substituted for such invalid or unenforceable provision a provision as similar as is feasible and yet would be lawful.

21.10 Expenses. Except as otherwise expressly provided herein, each Party will bear its own legal, accounting, and other fees and expenses relating to the negotiation and preparation of this Agreement and the transactions contemplated hereby.

21.11 Public Announcements. The time and content of any announcements, press releases, or other public statements concerning this Agreement and the transactions described herein will be determined by a process agreed to by the Parties.

21.12 Entire Agreement. This Agreement (including exhibits and schedules) contain the entire agreement of the Parties with respect to the matters set forth herein and supersede all prior negotiations and agreements, whether oral or written, concerning the subject matter hereof, all of which are merged in this Agreement.

21.13 Captions. The captions or titles of the sections herein have been included for convenience only and shall not be considered as part of this Agreement.

21.14 Counterparts. This Agreement may be signed in counterparts, each of which shall be deemed an original. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or in electronic (“pdf” or “tif”) format shall be effective as delivery of a manually executed counterpart of this Agreement.

21.15 Force Majeure. If either Party hereto is delayed or hindered in, or prevented from, the performance of any obligation hereunder by reason of fire, strikes, lock-outs, severe weather, rain, earthquakes, other acts of God, labor troubles or shortages, inability to procure materials, failure of power, restrictive governmental laws or regulations, riots, insurrection, war, or other reasons of a like nature not the fault of the Party delayed in performing work or doing acts required under the terms of this Agreement (all of such reasons or causes referred to in this Agreement as "**Force Majeure**"), then performance of such acts shall be excused to the extent it is not possible, and for the period of the delay, and the period of the performance of any such act shall be extended for a period equivalent to the period of such delay; provided, that during such interregnum, the Party so impeded shall continue in good faith to perform to the full extent that remains reasonably feasible. If substantial nonperformance continues for more than one hundred twenty (120) days, the Party so harmed may terminate upon thirty (30) days written notice.

21.16 Consents. Whenever under this Agreement provision is made for either Party's securing the consent or approval of the other, such consent or approval shall be in writing and (except as otherwise provided herein) shall not be unreasonably withheld, delayed, or conditioned.

21.17 Binding Effect; Assignment. This Agreement is binding on, and is for the benefit of Howard and Manager and their successors, assigns, and legal representatives (and Paladin Healthcare Management, LLC to the extent stated in Section 21.21). A Party shall not assign its rights or delegate its obligations under this Agreement without the prior, written consent of the other Party; provided, that, subject to Section 5.2(a), Manager may (upon written notice to Howard) assign this Agreement to an affiliate of Manager, and/or to subcontract with any other parties for the performance of various aspects of its obligations hereunder, provided that Manager shall (a) adequately inform such subcontractors of their obligations hereunder, (b) ensure that they fully comply herewith, and (c) remain fully responsible for the performance of any such assignee and/or subcontractor.

21.18 Governing Law. This Agreement shall be governed and construed according to the laws of the District of Columbia, without giving effect to any choice or conflict of law provision or rule thereof.

21.19 Further Assurance. Each Party agrees to execute and deliver to the other such additional instruments, certificates, and documents as the requesting Party may reasonably request in order to assist the requesting Party in obtaining the rights and benefits to which such Party is entitled hereunder.

21.20 Third Party Beneficiaries. The Manager Indemnified Persons and Howard Indemnified Persons are express third party beneficiaries of Section 11 hereof. The Senior Executives and SE Employer are express third party beneficiaries of the provisions of this Agreement that relate to them.

21.21 Paladin Healthcare Management, LLC. In consideration for the potential benefits to Paladin Healthcare Management, LLC, as sole member or ultimate parent of Manager to be derived from the management fees and other benefits secured by Manager hereunder,

Paladin Healthcare Management, LLC hereby agrees fully to ensure that Manager duly and timely fulfills its performance obligations, financial obligations, indemnification obligations, and other obligations, under this Agreement.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date first written above.

HOWARD UNIVERSITY

By: _____
Name: WAYNE FREDERICK
Title: PRESIDENT

PALADIN-HOWARD MANAGEMENT, LLC

By: _____
Name: _____
Title: _____

Solely for Purposes of Section 21.21:

PALADIN HEALTHCARE MANAGEMENT, LLC

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date first written above.

HOWARD UNIVERSITY

By: _____
Name: _____
Title: _____

PALADIN-HOWARD MANAGEMENT, LLC

By: _____
Name: Joel Freedman
Title: Managing Member

Solely for Purposes of Section 21.21:

PALADIN HEALTHCARE MANAGEMENT, LLC

By: _____
Name: Joel Freedman
Title: Managing Member

Schedule 13.1(b)

Performance Targets for First Twelve Months

The Incentive Fee for the first contract year during the Term shall be divided into four (4) equal amounts attributable to each of the following Performance Target measures. The specific metric to define the numerical threshold for achieving each Performance Target shall be reasonably agreed to by the Parties with the intent that it represents meaningful improvement that is realistically achievable. Performance targets and numerical thresholds for future contract years shall be reasonably agreed to by the Parties based on the same principles.

Proposed Performance Targets		
Performance Metric	**Definition**	**Source**
I. Blended Core Measure Score	Blended average of the industry standard core inpatient hospital standards plus central line blood stream infections, based on data pertaining to a trailing 12-month period, with each inpatient core measure receiving equal weight. The baseline metric will be based on ttm data through October 1, 2014, with subsequent scores based on the periods between October 1 and September 30.	Core Measures scores will be calculated from the UHC Hospital Quality Measures Report. Definition of each core measure is referenced by the Apr 2013 - Jun 2013 UHC Hospital Quality Measures report.
II. Blended Patient Satisfaction Score	Blended average of four patient satisfaction scores (Recommend the Hospital; Communication with Nurses; Communication with Doctors; Responsiveness of Hospital Staff), based on data pertaining to a trailing 12-month period, with each patient satisfaction score receiving a 25% weight. The baseline metric will be based on ttm data through October 1, 2014, with subsequent scores based on the periods between October 1 and September 30.	Patient Satisfaction scores will be calculated from the annual Press Gainey Report. Definition of each domain is referenced by the Oct 2013-Dec 2013 HCAHPS report.
III. Net Patient Revenue	Net patient revenue as defined as inpatient and outpatient gross revenue less contractual adjustments, allowances for bad debt, and charity care. The baseline metric will be based on ttm data through October 1, 2014, with subsequent metrics based on the periods between October 1 and September 30.	Net patient revenue figures will be preliminarily assessed based on the Company's internal financial statements and final confirmed based on the Company's audited financial statements.
IV. Full-Time Equivalent Employees Per Adjusted Occupied Bed	The number of full-time equivalent staff per adjusted occupied bed. An adjusted occupied bed is defined as average daily census (inpatient days / days in period) multiplied by an adjustment factor. The adjustment factor is equal to gross patient revenue / gross inpatient revenue. The Baseline metric will be based on ttm data through October 1, 2014, with subsequent scores based on the periods between October 1 and September 30.	FTE/Adjusted Occupied Bed metrics will be determined by a mutually acceptable third party based on available information, including payroll and registry data reflected on internal financial statements and confirmed by audited financial statements, along with other information which is requested by said third party.

	Example Calculation for Howard FY'13 (for illustrative purposes only)	
	FTEs: 1700 (per file HUH Updated Information May 2014 FINAL)	
	Inpatient Days: 51,575	
	Average Daily Census: (51,575/365)=141.3	
	Inpatient Gross Patient Revenue: $365mm	
	Total Gross Patient Revenue: $604mm	
	Adjustment Factor: (604/365)=1.65	
	FTE Per Adjusted Occupied Bed: (1700/(141.3*1.65))=7.3	

The Parties shall work together in good faith to develop mutually acceptable Performance Targets for the remaining years of the Term as soon as practicable and in no event later than December 31, 2014.

- Performance Targets I and II at the end of Year Five is expected to equal an industry benchmark for comparable hospitals in comparable markets, as reasonably determined by mutual agreement.
- Performance Target III at the end of Year Five is expected to equal the baseline metric plus at least $85mm.
- Performance Target IV at the end of Year Five is expected to equal an industry benchmark for comparable hospitals in comparable markets, as reasonably determined by a mutually acceptable third party.
- Targets may be adjusted in accordance with Section 13.4 of the Agreement.

Achievement of any Performance Target shall be reasonably determined by the Management Committee.

In the event that the Parties are unable to agree on a particular matter (e.g., an industry benchmark), the matter will be resolved by the dispute resolution mechanism in Section 16.4 of the Agreement.

Exhibit A

Interim Strategic Plan

See attached.

HUH
HOWARD
UNIVERSITY
HOSPITAL

PRELIMINARY STRATEGIC PLAN

SEPTEMBER 2014

PALADIN
HEALTHCARE
CAPITAL

DISCLAIMER

This Preliminary Strategic Plan has been prepared from data provided to Paladin – Howard Management, LLC and/or its affiliates (collectively, "Paladin") by Howard University ("Howard"), its Howard University Hospital division ("HUH") and its advisors, as well as public information. Paladin, including any of its principals, officers, employees, representatives, or agents, as the preparer of the document, makes no representation or warranty, express or implied, as to the fairness, accuracy of completeness of any of the contents of this document and no liability whatsoever is assumed or implied by any such person with respect thereto.

This document is provided solely for information purposes and does not purport to contain all the information that a recipient may require in evaluating the business herein presented. All expressions of opinion reflect the judgment of Paladin at the date of this document and are subject to change. The information contained herein has been obtained from sources considered reliable, but the accuracy and completeness of such information is not guaranteed. Paladin and their respective principals, directors, officers, employees, representatives or agents expressly disclaim any and all liability which may be based on such information.

The contents of this document are strictly private and confidential and are subject to the terms of a confidentiality letter entered into between Paladin and Howard. Each recipient is reminded to ensure that the terms of the confidentiality letter are strictly adhered to. Any investment in the Company is speculative, and involves a high degree of risk.

The information contained herein includes "forward-looking statements" and forecasts which can be identified by the use of forward-looking terminology such as "believes," "expects," "may," "should," or "anticipates" or the negative thereof or given that the future results covered by the forward-looking statements will be achieved. The preceding matters constitute cautionary statements identifying important factors with respect to such forward-looking statements and forecasts, including certain risks and uncertainties that could cause actual results to vary materially from the future results covered in such forward-looking statements and forecasts. Other factors could also cause actual results to vary materially from the future results covered in such forward-looking statements and forecasts. No representations are made that any of these statements or forecasts will come to pass or that any forecast will be achieved.

In furnishing this document, neither Paladin, nor any of its principals, directors, officers, employees, representatives or agents undertake any obligation to provide the recipient with access to any additional information or to update this document or additional information or to correct any inaccuracies herein which may become apparent.

Accordingly, neither Paladin, nor any of its principals, directors, officers, employees, representatives or agents shall be liable for any errors or omissions in the content provided herein or for any actions taken by recipients in reliance thereon.

THE HOWARD UNIVERSITY INTEGRATED HEALTHCARE DELIVERY SYSTEM

Given new paradigms that are reshaping the healthcare industry, Paladin and its principals have made a commitment to develop population health strategies that favorably impact underrepresented and disadvantaged communities. The goal of these efforts is to help patients become more engaged in their own healthcare, identify value-based drivers to align providers and patients, and develop mechanisms to enable payors and providers to better communicate with beneficiaries in culturally sensitive ways such that beneficiaries clearly understand their health benefits and how best to access them. These and other tangible and innovative strategies offer the potential to dramatically improve health outcomes and overall quality of life among communities that are too often marginalized.

The principals of Paladin have developed and proven a business model that enables urban community hospitals to deliver quality acute care services on a cost-effective basis, collaborated with and studied a large network of FQHCs that deliver quality pre- and post-acute services on a cost-effective basis, and developed an understanding of advanced care coordination methodologies applied by successful managed care companies. This business model is portable (with some limitation) to urban centers across the United States, including the District of Columbia. Paladin's principals implemented its hospital operations model at several stand-alone urban hospitals they acquired in South and East Los Angeles (the "LA Hospitals") that were severely underperforming, both financially and clinically, and transformed them into a vibrant hospital system that delivers quality, cost-effective care and 24/7/365 emergency department ("ED") access to some of the most under-bedded and disadvantaged communities in the United States.

Paladin's hospital operating model is ideally suited for Howard University Hospital ("HUH" or the "Hospital) and offers the potential to transform the Hospital into a stable and reliable provider of high-quality, cost effective care that compliments that high academic, scientific, and social missions of the Howard University Health Sciences program (the "Health Sciences Program") and Faculty Practice Plan (the "FPP"). Adjacent strategies may facilitate the establishment of a comprehensive integrated delivery system and managed care infrastructure that will dramatically improve access and health outcomes among the communities served by HUH.

The preliminary strategi plan presented herein is based on Paladin's very deep knowledge of the business of and markets served by urban community hospitals in disadvantaged communities. It is based on preliminary due diligence over nine months, including various discussion with Howard personnel and advisors, a review of all information that was posted to the HUH data room, and a report prepared by WeiserMazars ("WM"). Additional due diligence and collaboration with HUH leadership and advisors will strengthen and enhance the operating plan presented herein.

PHASE ONE — STABILIZE THE HOSPITAL AND POSITION IT FOR LONG-TERM SUCCESS

Paladin's hospital operating model is tightly defined, highly successful, and portable to most hospitals. Several elements of the model can have a materially favorable impact on HUH. The model includes a wide range of clinical and operational improvement initiatives that can significantly improve clinical and financial performance, as well as employee and patient satisfaction, by maintaining strong disciplines in the areas of emergency department operations, care coordination, case management, clinical documentation, recruiting, staff flexing, purchasing, facilities management, contracting, revenue cycle, and capital strategies.

The foundational elements of Paladin's transition plan for HUH are rooted in these core drivers. Subject to further diligence, contemplated objectives include:

- Improve Emergency Department wait times and left-without-being-seen metrics, and attract increasing volumes of paramedic runs;
- Improve efficiencies and documentation through sophisticated hospitalist and case management programs, including protocols and training programs to support HUH clinicians;
- Decrease supply chain costs by standardizing purchasing activities and establishing stringent protocols;
- Control labor costs through disciplined staffing policies, while strengthening employee retention and recruitment activities;
- Increase cash collections by implementing tighter protocols and promoting discipline across the revenue cycle;
- Improve the coding, clinical, and billing documentation and compliance with governmental programs and private payor requirements, so as to increase proper fee realization in accordance with law;
- Realign administrative infrastructure to better capitalize on system scale and to standardize best practices;
- Empower physicians associated with Howard's affiliated physician group (the "Faculty Practice Plan") through clinical documentation education programs, care coordination tools and support, comprehensive physician scorecards, ambulatory infrastructure, and increased patient volumes;
- Establish a managed care infrastructure that enables the organization to prudently underwrite and manage risk, coordinate care, develop and manage a provider network, engage beneficiaries, ensure the consistent delivery of quality healthcare services, and generate profitable recurring revenue streams and increasing inpatient volumes;
- Ensure that the IT platform which underlies HUH and the FPP, and which will also underlie or be integrated with future ambulatory and managed care operations, is continually developed in highly efficient and productive manner;
- Strengthen the linkage between the clinical programs and student and resident academic training; and
- Enhance the Hospital's community service mission and engage in community activities that educate, inspire, and improve quality of life and overall health outcomes.

The business plan does not contemplate removing service lines at HUH. It centers on increasing volume at the facility and within an integrated healthcare delivery network, with a goal to stabilize those programs that are currently not financially sustainable due to a lack of scale.

GOVERNANCE

Management Services Agreement

Howard and Paladin-Howard Management, LLC ("ManageCo") have entered an exclusive Management Services Agreement (the "MSA"), whereby ManageCo will administer the day-to-day operations of HUH, subject to a mutually agreed to Strategic Plan and Budget (the "Strategic Plan"). The MSA defines the manner in which HUH will be governed and administered on an ongoing basis, with a requisite to safeguard HUH's ability to consistently provide quality-oriented, compassionate healthcare services, while supporting the high academic, scientific, and social missions of the Howard University Health Sciences program (the "Health Sciences Program") and Faculty Practice Plan (the "Faculty Practice Plan").

Academic Affiliation Agreement

Paladin recognizes the significant and ongoing commitment that has been made by Howard University College of Medicine in the area of clinical research and healthcare disparities, particularly in the biomedical sciences arena. Paladin is committed to ensuring that HUH continues to support the ongoing bioscience research studies at the College of Medicine and Health Sciences Program. This support will include maintaining related specialty programs at HUH and at the ambulatory clinics and health centers that are established pursuant to a mutually-designed clinical development strategy.

In support of an Academic Affiliation Agreement (the "AAA") between HUH and Howard, HUH will strive to always operate at a level expected of an premier academic medical centers. HUH will maintain viable programs in all clinical departments necessary for the medical school to maintain its accreditation by the Liaison Committee for Medical Education, including high-quality clinical rotations for Howard's medical students. Subject to market forces, the Hospital will maintain clinical volumes to satisfy the requirements of the Accreditation Council for Graduate Medical Education and the Residency Review Committees for graduate medical education (residency) programs.

The FPP will provide clinical coverage/call and assured staffing for HUH and will help to direct and supervise residents; and be compensated as appropriate at fair market rates. The FPP will also be actively engaged in the provision of medical services at the contemplated Howard-branded Ambulatory facilities. Other than qualified community-based physicians or as otherwise agreed to by Howard, medical staff will hold some category of faculty appointment from Howard. A methodology for sharing mutually agreed recruitments of Department Chairs, Division Chiefs, Service Chiefs, Medical Directors or other key physician leaders of clinical/academic programs will be mutually developed and agreed upon; as will an Academic Support program.

ManageCo will cooperate and maintain liaisons with the executive office of the Medical School and Health Sciences Program and assist with the management and administration of any academic affiliation agreements in effect between the University and its Medical School and/or the Health Sciences Program. Paladin will also use commercially reasonable efforts to support the expansion of clinical translational research (including clinical trials, population studies and related research) at HUH and will also collaborate regarding the development of various experiential learning programs that can enhance the missions of both HUH and Howard.

Medical Affairs Committee

In order to provide a forum for communication among representatives of the Medical Staff, it is anticipated that ManageCo will assist Howard to implement and administer a Medical Affairs Committee that will focus on developing and recommending policies and programs related to the academic philosophy and objectives of the University, including appointment, promotion, and dismissal of medical staff; interaction with, training, support, and utilization of medical staff; research, training, and community service activities; maintenance of high standards of professional practices in and at the hospital, clinics, or other HUH-affiliated patient-care facilities; capital improvements to the Hospital; strategy, real estate development, and operations relating to the Ambulatory Network; and University fundraising; among other considerations.

MANAGEMENT

The management team that has been assembled to oversee and transform the operations of Howard University Hospital is comprised of numerous industry leaders, most of whom have more than 25 years of experience in their respective areas of knowledge. The team provides broad collective strengths and proven track records in the areas of hospital operations, physician group operations, payer operations, regulatory compliance, managed care, real estate, and finance. Key members of the Paladin — Howard management team include:

Joel Freedman — Member, Executive Committee

Joel Freedman currently serves as President of Paladin Healthcare Capital and Paladin Healthcare Management. He recently served as President and co-founder of Avanti Hospitals LLC, which acquired, turned around, and continues to own and operate four highly successful community hospitals in South and East Los Angeles, among the most disadvantaged and underrepresented communities in the US.

Prior to establishing Avanti, Mr. Freedman served as Managing Partner of Paladin Capital, a corporate finance advisory firm, where he completed more than 175 transactions, including $800 million in the healthcare sector. In 2004, he co-founded CompWest Insurance Company, an innovative workers compensation insurance company that was sold in 2007 to a subsidiary of Blue Cross and Blue Shield of Michigan.

Mr. Freedman is a founding member of the Healthcare Policy Advisory Council for Harvard Medical School and Chairman of its Healthcare Markets and Regulatory Lab, which is deeply involved in the transformation of the healthcare system at both a federal and state level. He is also a member of the Board of the Leonard D. Schaeffer Center for Health Policy and Economics at the University of Southern California, which seeks to measurably improve value in health through evidence-based policy solutions, research excellence, transformative education, and private and public sector engagement. He also serves on the Boards of Children's Bureau, one of the largest investors in child abuse prevention in the US; and the Foundation for AltaMed Health Services, the largest independent Federally Qualified Community Health Center operator in the country, serving more than 140,000 community members through 43 clinics in underserved communities throughout Los Angeles and Orange Counties.

Keith Ghezzi — Member, Executive Committee

Dr. Keith Ghezzi is a Managing Director with Alvarez & Marsal Healthcare Industry Group, specializing in operational and financial turnarounds, performance improvement and interim management. His primary areas of focus include integrated health care systems, academic medical centers, large community hospitals and physician group practices. With more than 20 years of healthcare management experience, he has successfully led academic hospitals and community systems and has served as senior adviser to the management and Boards of private and public companies regarding business strategy, mergers and acquisitions, operational improvements and physician integration.

Dr. Ghezzi recently served as Interim Chief Executive Officer and President of the West Penn Allegheny Health System in Pittsburgh, Pennsylvania, and led the system through a successful affiliation with Highmark Blue Cross / Blue Shield. He previously served as President and CEO of Forum Health, where he led the three-hospital system from near insolvency to financial stability; and as Chief Operating Officer of Inova Fairfax Hospital and Vice President of the Inova Health System. Under his leadership, Inova Fairfax was named a magnet hospital for nursing, Top 100 hospital by HCIA / Mercer, and Best in Cardiology / Cardiac Surgery, Oncology, and Pulmonary by U.S. News and World Report.

Dr. Ghezzi also served as Chief Operating Officer and Medical Director of George Washington University Hospital, which he helped return to profitability and prepare for sale. He also served as a Director of the George Washington University Health Plan, inaugural Director of the Ronald Reagan Institute of Emergency Medicine, and Associate Professor of Emergency Medicine and Surgery at the George Washington University School of Medicine and Health Sciences. He is board certified in emergency medicine and a Fellow of the American College of Emergency Physicians.

Sandra Austin — Chief Executive Officer

Sandra Austin is a Managing Director with Alvarez & Marsal Healthcare Industry Group, specializing in executive leadership, operations, human resources, compliance, and financial management. She excels at leading high performing management teams and improving overall organizational performance.

Ms. Austin previously served as the Chief Executive Officer for the LSU Interim Public Hospital in New Orleans, where she managed day-to-day operations and led a transition that yielded significant cost reductions and operational improvements, while maintaining or enhancing service lines. She also served as Chief Responsible Officer (with CEO responsibilities) of Grady Health System in Atlanta, where she led the development and implementation of a comprehensive operational turnaround and financial restructuring plan. In addition, she led the development and implementation of a turnaround business plan for the University of Southern California, Keck School of Medicine, which resulted in substantial operating savings and operational improvement at its faculty practice plan, USC Care.

Ms. Austin has held several other leadership positions with major healthcare companies, including President of a $400 million homecare subsidiary of Caremark, a $2.5 billion healthcare services company; Chief Operating Officer of the University of Chicago Medical Center; President of Huron Road Hospital in Cleveland; Senior Vice President and General Manager of Medicine, Surgery and Psychiatry at University Hospitals of Cleveland; and Chief Executive Officer of two leading physician practice management firms, PhyServ and Sedona Healthcare Group.

Ms. Austin has also served on numerous corporate boards, including National City Corporation, Ferro Corporation, Cancer Treatment Centers of America, Gambro AB, and NCCI Holdings.

Diane Rafferty — Chief Operating Officer

Diane Rafferty is a Managing Director with Alvarez & Marsal Healthcare Industry Group, specializing in hospital operations, finance, quality and compliance, productivity improvement, and reorganization. She has held numerous leadership positions with hospitals in transition. Ms. Rafferty recently served as Interim CEO for the Oklahoma State Medical Center in Tulsa, where she led an operational turnaround; and as Interim CEO of University Physicians Hospital in Arizona, where she assisted the hospital to regain their deemed status from CMS, while also improving operational performance.

Ms. Rafferty also served as the Executive Vice President/Chief Administrative Officer for Brotman Medical Center, where she assumed day-to-day responsibility while the facility was in Chapter 11, and led a dramatic turnaround that led to substantial operational and financial improvements, improved quality, and a successful emergence from bankruptcy. She has also served as CEO of San Ramon Regional Medical Center with Tenet Healthcare; Chief Operating Officer of USC University Hospital; Chief Operating Officer of West Hills Medical Center with HCA; Chief Nursing Officer of UniHealth, Northridge Hospital Medical Center; and Surveyor/Clinical Investigator with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Doug Womer — Chief Financial Officer

Mr. Womer is a Senior Director with the Alvarez & Marsal Healthcare Industry Group, specializing in financial reporting, strategic planning, managed care contracting, revenue cycle management, project management, turnarounds, and due diligence for mergers, acquisitions and debt restructuring. He recently served as Chief Financial Officer for a two-hospital system affiliated with LSU Shreveport, which he helped to transition from public to private ownership, operationally redesigned all finance and accounting functions, established new banking relationships, created financial processes and policies for all aspects of finance, enhanced revenue cycle operations, and redesigned the supply chain. He also was responsible for the implementation of pre-transition plans, negotiations with an affiliated Medical School for physician services, and creation/execution of a 100 Day Plan to stabilize the hospital operations.

Mr. Womer previously served as the Chief Financial Officer for West Penn Allegheny Health System ($1.7B in net patient revenue, 750 employed physicians), where he established analytical tools through decision support to enhance Net Revenue, improved accounts receivable recovery and rate reimbursement accuracy, and developed a comprehensive performance improvement program which identified and quantified more than $75mm of operational improvements. He previously served as the Chief Financial Officer for Cardiovascular Consultants, a 55-physician cardiology practice in Phoenix, Arizona; and has held Corporate-level positions at Sound Inpatient Systems, the Johns Hopkins Medical Services subsidiary of the Johns Hopkins Health System, EPIC Healthcare Group (a 43-hospital system), Sisters of Charity, Christus Health, and Incarnate World Health Care System.

Kathleen Millgard — Chief Nursing Officer

Kathleen Millgard is a Director with the Alvarez & Marsal Healthcare Industry Group, specializing in hospital operations, process re-design, case management, regulatory compliance, clinical resource management, physician practice management, spatial analysis and planning, process re-design, and cross-cultural settings. Her managerial experience began as a clinic department head and progressed to the level of CEO/COO. Her experience includes acute care, psychiatric, and academic teaching facilities in both domestic and international settings in facilities/systems up to 1,000 beds in both the public and private sector.

Ms. Millgard served as Chief Executive Officer for a rural hospital system managed by Quorum Health Resources; and as Chief Operating Officer for several underperforming hospitals, including the University of Michigan Health System (Ann Arbor), Oak Hill Hospital (Joplin); and Maricopa Medical Center (Phoenix), where she achieved consistent successes in the areas of operational efficiencies, quality, safety, clinical resource management, staff productivity, cost containment, and new markets/product offerings.

Ms. Millgard began her career as a staff nurse in Critical Care and Emergency Services and later in Maternal/Child Services. She maintains her status as a Registered Nurse and is also Certified Professional in Healthcare Quality.

Mark Bell, MD — Advisor, Hospital Operations

Dr. Mark Bell currently serves as President and Founder of Emergent Medical Associates, a leading provider of Emergency Department and Inpatient management services. He is a co-founder and current Chief Medical Officer of Avanti Hospitals, which acquired, turned around, and continues to own and operate four acute care hospitals in South and East Los Angeles. As a leading provider of emergency and episodic care management services to patients, communities, physician groups, and hospitals throughout California. EMA's proven physicians, proprietary methods, management techniques, and uncompromising standards allow EMA to create "Hospitals of Excellence" for its acute care clients. EMA currently operates 20 emergency departments caring for 550,000 patients annually, along with a high-performance hospitalist program. EMA brings unparalleled emergency department and hospitalist operations expertise to the Paladin team.

Dr. Bell's expertise is particularly strong in ED efficiencies, hospitalist programs, customer service, strategic planning, quality, Core Measures, and business development. He frequently lectures on many topics including Nuclear Biological and Chemical Warfare, EMTALA, and toxicology, among others. He is a Diplomat of the American Board of Emergency Medicine and Fellow of the American College of Emergency Physicians.

Irv Edwards, MD — Advisor, Hospital Operations

Dr. Irv Edwards currently serves as Chairman and Founder of Emergent Medical Associates, a leading provider of Emergency Department and Inpatient management services. He is a co-founder and active board member of Avanti Hospitals, which acquired, turned around, and continues to own and operate four acute care hospitals in South and East Los Angeles. His expertise includes emergency department operations, inpatient management (including hospitalist and case management programs), care coordination, and clinical documentation. Working closely with Dr. Mark Bell, Emergent has spent considerable time analyzing Emergency Department Operations and developed a proprietary business model which consistently transforms underperforming departments into Departments of Excellence that are more efficient, deliver improved quality, and attract increased paramedic volumes and associated admissions.

Dr. Edwards is responsible for managing the emergency departments at Chino Valley Medical Center, Tarzana Regional Medical Center, La Palma Intercommunity Hospital, Mission Community Hospital, Montclair Hospital Medical Center, Sherman Oaks Hospital, Centinela Freeman Hospital Medical Center, Valley Presbyterian Hospital, West Hills Medical Center, Alvarado Medical Center, and several others.

Dr. Edwards is a Diplomat of the American Board of Emergency Medicine and American Board of Quality Assurance & Utilization Review, and a Fellow of the American College of Emergency Physicians.

Everett T. Lyn, MD, Advisor, Emergency Department Operations

Dr. Everett Lyn currently serves as an executive with Emergent Medical Systems, a leading provider of Emergency Department management services. He specializes in operational efficiencies, clinical pathways, quality measures, high-risk population care management, and fiscal management. He recently served as Chairman of the Department of Emergency Medicine for Partners HealthCare in Boston, where he led the turnaround of several emergency departments. He previously held several positions with Brigham and Women's Hospital, including Director of Medical Education, Director of Academic and Faculty Affairs, and Director of Clinical Affairs, among others. He has served on numerous industry boards, and been the recipients of several awards and research grants.

REPORTING TO HOWARD

Strategic Plan and Budget

Each year, Howard and ManageCo will adopt an annual plan for the business and operations of the Hospital and the budgets regarding such activities (the "Strategic Plan"). The Strategic Plan will be delivered at least thirty (30) days prior to the end of each year of the term of this MSA and will set forth, among other matters:

- Strategic initiatives;
- Operational initiatives such as profit improvement methods, business development objectives, cost reduction policies, synergistic opportunities, and efficiency improvements;
- An operating budget setting forth an estimate of operating revenues and expenses for the next contract year, which operating budget shall be in reasonable detail and shall contain an explanation of anticipated changes in utilization, patient charges, payroll, and other factors differing significantly from the current contract year;
- Capital strategies;
- A capital expenditures budget outlining a program of capital expenditures for the next contract year, which budget shall designate expenditure items as either mandatory or desirable; and
- A projection of cash receipts and disbursements based upon the proposed capital expenditures and operating budgets, which projection shall contain recommendations concerning use of excess cash flow, if any.

Data Deck

ManageCo will closely track performance metrics to ensure that protocols and procedures are followed. Each month, the organization will compile a Data Deck which will be made available to each member of the Executive Committee (and other select personnel) in advance of each committee meeting to ensure consistent visibility into the financial and operational performance of the Hospital. Turning around a hospital is an extremely complicated and sensitive process, and quality data is mission critical. To the extent that HUH's current IT system is limited in its ability to produce meaningful and accurate reports, significant effort will be made to design workarounds to facilitate the production of such data, as was the case following the acquisition of each of the LA Hospitals.

In addition to unaudited monthly financial statements, the Data Deck shall include the following:

- **Quality of Care and Service Excellence Metrics.** ManageCo will review quality metrics on a monthly basis, including closely tracking those quality indicators that will likely relate to the pay-for-performance aspects of healthcare reform. Specific outcomes or cases that negatively impact quality scores will be reviewed and the appropriate staff educated on the correct response. ManageCo will also track patient, employee and physician satisfaction scores; turnover rates; and changes to the medical staff.
- **Patient Days, Average Daily Census, & Average Length of Stay.** Patient days and discharges by bed type will be tracked, along with an Average Daily Census and Average Length of Stay (by payor type) to illustrate patient flow on a monthly and yearly basis. By actively sharing these statistics with HUH physicians, ManageCo will require greater diligence and efficiency from the physicians, resulting in improved length of stay statistics.

- **Case Mix Index.** The Case Mix Index measures the level of acuity of admitted patients. Statistics are kept for Medicare Case Mix, with numbers greater than 1.3 generally considered in the high range and fairly acute. ManageCo will institute clinical documentation training and review practices that it believes will lead to more accurate measures of Case Mix Index at HUH.

- **ED Measurements.** Paladin's ED-centric model requires a particular emphasis on indicators such as visits, diversion hours, left without being seen, length of stay, and paramedic runs. Similarly to the inpatient operations statistics described above, ManageCo will communicate these results to the ED Directors and physicians, which Paladin believes will result in greater diligence and efficiency in the management of patient care at HUH, as has been the case at Avanti's hospitals.

- **Revenue Management.** The dynamics associated with each particular payor class require management to break down net revenue and track monthly and yearly trends by class. Each month, ManageCo will review the net revenue by payor class, net patient revenue per adjusted patient day (and any future capitation revenue per member per month) against budgeted figures. Outlier cases will be highlighted and discussed with appropriate management personnel and billing office directors.

- **Cost and Productivity Measurements.** ManageCo will track expenses and margins for the inpatient and outpatient sides of the business, as well as variable expenses and total expenses on a per adjusted patient day basis. Close attention will be paid to productivity measurements such as employees per adjusted bed and salaries/benefits as a percentage of net revenue. "Employees per adjusted patient day" will help to ensure that the Hospital is staffed appropriately and efficiently, subject to limitations under the CBA.

- **Physician Scorecards.** ManageCo will create and maintain, by individual doctor, Physician Scorecards that serve as user-friendly tools to enable physicians to compare their performance with that their peers. Physician Scorecards will include data that is designed to balance clinical efficiency with quality of care, including metrics associated with length of stay by case mix versus a peer length of stay benchmark; quality indicators such as readmission, infection, mortality, and comorbidity rates; and other objective data. Physician Scorecards will help to decrease lengths of stay, reduce readmission rates, and increase the number of physicians who achieve targeted benchmarks. They also help to align physician accountability with organizational objectives by expanding awareness and understanding of how physicians impact the Hospital, promoting discussions among physicians regarding best practices and clinical pathways, and creating numerous mentoring opportunities for physician leaders.

Daily reports measuring volume, collections, cash balances, registry hours, ED statistics, and quality metrics, among others, will be distributed and reviewed by members of management. In addition, a monthly key performance indicator dashboard, highlighting operational, financial, quality and service, materials and facility management, managed care, and legal statistics on a monthly and year-to-date basis in comparison to budget or benchmarks will be distributed to all members of the management team. By monitoring these metrics and identifying trends on a daily and monthly basis, ManageCo can proactively manage and control expenditures, while ensuring high levels of patient care.

THE PLAN TO TRANSITION AND STABILIZE HOSPITAL OPERATIONS

HUH has been providing comprehensive healthcare services to the Washington DC market (the "District") for nearly 150 years. Despite increasing profitability between FY'10 to FY'12, HUH has experienced a significant deterioration in its financial condition over the past two years. Revenue has dropped due to a steady decline in volume that has been the result of a combination of increased competition from health plans and their affiliated hospitals, difficulty recruiting physicians, sharp increases in observation days leading to decreased reimbursement, and reduced paramedic volumes at a time when such volumes are increasing across the District. Concurrently, operating expenses have remained flat, utilization has declined, certain service lines have not had sufficient scale to overcome minimum staffing requirements, and insurance costs have skyrocketed. These and other factors have contributed to EBITDA falling by more than $30mm per annum, and a buildup of deferred capital requirements of approximately $9mm (according to HUH management).

A leadership change in late 2012 was designed to positively impact HUH's operations and culture during 2013. In early 2014, however, it became clear that more aggressive steps were needed to return the hospital to financial stability, and HUH engaged WM to assess the operations and identify additional opportunities for operational improvements. HUH has provided Paladin with a copy of WM's initial assessment report, and Paladin has reviewed and considered the findings of the report in connection with its own turnaround plan initiatives and projections.

Based on the limited information that has been made available to Paladin by HUH and its advisors, Paladin has developed, and continues to refine its own financial projections and assumptions for HUH on a post-transaction basis, as driven by a range of profit improvement initiatives, economies of scale, and synergies that Paladin has identified, leveraging its operational, financial and clinical expertise relating to the operation of community hospitals in underrepresented communities comprised predominantly of government beneficiaries.

As currently contemplated, the foundational elements of Paladin's transition plan for HUH are as follows:

Promote a Culture of Excellence in Care Delivery and Customer Service

ManageCo will be heavily focused on affirming the Hospital's reputation as a leader in providing quality care to disadvantaged communities. Changes to the leadership style, corporate culture, and overall mission and values at each of the LA Hospitals resulted in dramatic and accelerated improvements in quality scores that ultimately measured up to, and in some categories beat, the best known hospitals in Southern California. At Memorial Hospital of Gardena ("MHG"), which ranked 46th out of 52 area hospitals in the region in Appropriate Care Measures ("Core Measures"), with scores approximating 30% during the year preceeding the acquisition of MHG by Paladin's principals. Within 18 months of the acquisition, MHG had improved its ranking to 2nd in the region, achieving an ACM Score of 94%. Patient and employee satisfaction scores improved so dramatically that one of its hospital's executives was recognized by Press Ganey.

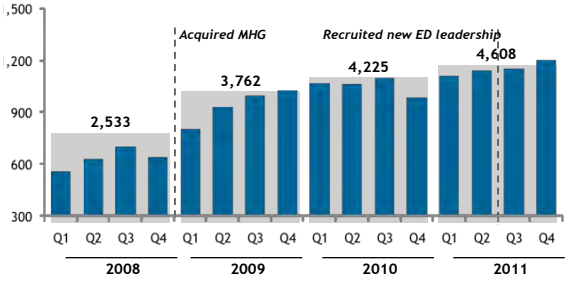
The culture and environment at HUH should be friendly, confidence-inspiring, and rewarding for patients and employees. The creation of a quality culture is often a slow and painful process, but the success Paladin has had in improving quality metrics and patient and employee satisfaction, while reducing employee turnover rates, validates that dramatic improvements can be achieved within a relatively short period of time. Accordingly, ManageCo intends implement comparable enterprise-wide operational policies and procedures at HUH, which Paladin believes will not only lead to greater consistency and quality of service delivery, but enable the flexible utilization of operational resources when necessary.

To support the quality initiative, ManageCo will institute a program designed to train and empower administrative and clinical personnel to drive improvements in care quality and patient satisfaction, while also achieving greater operational efficiencies and employee satisfaction. The program will help to facilitate reductions in length of stay, improved clinical outcomes, improved charge capture, and efficient utilization.

Optimize Emergency Department

A particular strength and focus of Paladin's business model is ED management. Following its acquisition of the LA Hospitals, a conscious decision was made to view emergency medical technicians and paramedics (together, "Paramedics") as vital customers of the hospitals. A significant effort was expended to establish strong, coordinated relationships with the Paramedics, and to gain their confidence that they were safely and efficiently presenting patients at competent hospitals. A further commitment was made to keep the EDs open and accessible on a 24/7/365 basis, whereas most EDs in the market were on diversion between 40% and 50% of the time. Within a short period of time, each ED achieved industry-leading metrics for quality and efficiency, leading to increases in Paramedic volumes of more than 40% (Chart 1) and comparable increases in hospital admissions. These increases enabled the LA Hospitals to achieve scale without having to reduce staffing levels, which is counter to most turnaround strategies.

Chart 1 — MHG ED Admissions



MHG refers to Memorial Hospital of Gardena, which serves Inglewood, Hawthorne, Compton, Lynwood, Gardena, and other South Los Angeles communities.

Given the size and current ED volumes at HUH, Paladin is highly confident that its operations expertise can enable the HUH ED to become the most efficient and effective in the District by:

- Reducing Wall Times (time between a Paramedic's arrival to an ED and the patient being seen by a physician and the Paramedic can leave),
- Reducing ED LOS (time between a patient's arrival to the ED before being admitted or discharged),
- Reducing Left-Without-Being-Seen (percentage of patients presenting to the ED that leave prior to receiving treatment, most often due to excessive Wait Times),
- Reducing Diversion Hours (when a hospital is not accepting Paramedic runs), and
- Increasing Patient Satisfaction (often a byproduct of all of the above).

Based on its business model and ability to execute, Paladin will help drive substantial improvements to ED operations. In addition, there are several dynamics in the District that could greatly favor the Hospital. Despite recent reductions in Paramedic Volumes at HUH, volumes across the district have been increased by an estimated 6% annually, with a disproportionate share of the growth attributed to Wards 7 & 8. There appear to be opportunities to recapture emergencies that were historically presented to HUH but which are being redirected to other area hospitals due to increased competition from MedStar and other factors. Dr. Tuckson is engaged in active discussions with Mayor Gray, AmeriHealth, and others that have indicated a strong commitment to encouraging the use of HUH if there is more certainty as to the stability and efficacy of the Hospital and the ED in particular.

By leveraging Paladin's expertise in hardwiring ED efficiencies, and by placing a hospitalist in the ED, dramatic increases in Paramedic Volumes and Hospital Admissions can be realized. Even a modest 2% increase in paramedic volumes and associated admissions can yield profit improvements of up to $4.6mm (Table 1).

Table 1 – Prospective Financial Impact of ED Initiative

	Current	2%	3%	4%
ED Visits	52,627	53,680	54,206	54,732
Additional Admissions (1)	-	161	242	323
Net Revenue		$ 3,189,273	$ 4,783,909	$ 6,378,546
EBITDA Contribution (2)		**692,986**	**1,039,479**	**1,385,972**

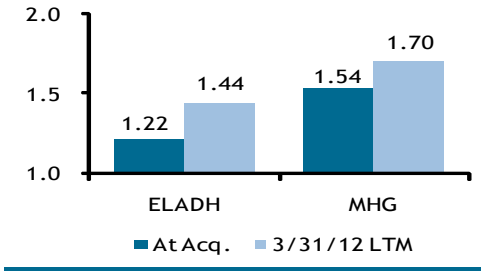
	Current	2%	3%	4%
ED Conversion Rate	15.3%			
Additional Admission (3)		1,084	1,626	2,189
Net Revenue		$ 21,440,793	$ 32,161,190	$ 43,297,912
EBITDA Contribution (2)		**4,658,795**	**6,988,193**	**9,408,053**

(1) At Current Admission Rate
(2) Assume 26.3% margin on incremental business (fixed cost adjusted)
(3) Including 3% Additional ED Visits

Impeccable Clinical Documentation

Paladin places a significant emphasis on accurate and comprehensive documentation. Improved documentation increases charge capture, which can have an immediate and dramatic impact on the bottom line. In addition, precise documentation can increase patient safety, improve workflow, promote collaboration and improve communication among clinicians, and allow for more nurse-patient time and better utilization of physician time. More precise documentation has successfully impacted CMI at each of the LA Hospitals (Chart 2), driving increases of more than 10%.

Chart 2 – CMI Improvements at MHG & ELADH



Paladin's documentation training and support program empowers physicians by enabling them to document with consistently improving levels of precision to more accurately reflect CMI and favorably impact clinical and financial outcomes. There is a clear disconnect at HUH between Case Mix Index and length of stay, indicating that physicians are leaving justifiable charges on the table, that inpatient management is sub-optimal, or a combination thereof. Paladin's preliminary assessment indicates there are significant opportunities to improve documentation processes at HUH and capture justifiable charges, facilitating estimated profit improvements of up to $6.5mm per annum based solely on improvements to Medicare documentation (Table 2). Please note that the magnitude of such profit improvements assumes that WM has not already included CMI improvements in its "Revenue Capture" assumptions.

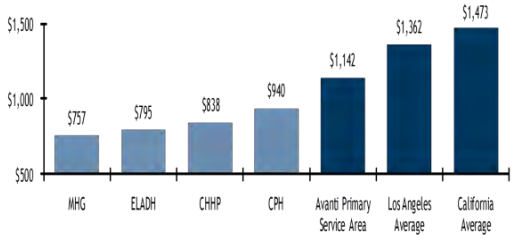
Table 2 — Prospective Financial Impact of Documentation Initiative

	Current	11%	13%	15%
Case Mix Index (CMI)	1.40	1.55	1.58	1.61
Medicare Base Rate	$ 12,724			
CMI Adjusted Medicare Rate	$ 17,814	$ 19,774	$ 20,130	$ 20,486
Annual Medicare Discharges	2,432			
EBITDA Contribution		**$ 4,764,861**	**$ 5,631,199**	**$ 6,497,537**

Consistent Enforcement of Tight Staffing Policies and Procedures

In order to consistently provide quality care on a cost-effective basis, a key strategy is to maintain sustainable staffing ratios and enforce a flex-staffing model that varies based upon census and seasonality. The current CBA at Howard is relatively onerous in this regard, but Paladin believes that policies and be enforced and disciplines instilled that will mitigate the slippage that appears to be occurring on a regular basis. The Paladin model is very effective in ensuring that the right number of personnel is in place and conducting appropriate activities at all times, which enabled the LA Hospitals to drive its cost to below-market levels (Chart 3), while simultaneously achieving dramatic improvements in quality (Chart 4). Despite the constraints that are inherent in HUH's CBAs, Paladin is confident that its approach to staffing will have a favorable impact on the Hospital's cost structure, additional if not substantial improvements available should the CBAs be adjusted to market terms.

Chart 3 — SW&B per Adjusted Patient Day



An optimal staffing policy and management system should yield labor costs of between 50% and 60% of Net Revenue. A significantly higher labor cost structure is generally not sustainable, especially in the wake of forthcoming reimbursement adjustments. Based on preliminary due diligence, it appears that HUH has experienced total labor costs of approximately 70% of Net Revenue, excluding allocations for Howard faculty. Paladin would seek to work closely with labor unions to continue HUH's current staffing initiatives, and identify any additional ways to reduce this percentage (including a detailed review of WM's staff reduction analysis), with a goal to facilitate a sustainable staffing model that meets the needs of the Hospitals, employees, and community, with an absolute commitment to ensure that the Hospitals delivers good quality on a constant basis. Further analysis is required to quantify potential savings from this initiative, which could include better management of staffing levels, overtime, and use of registry, which could lead to substantial profit improvements.

Preliminary analysis indicates that a reduction of at least 3% in personnel costs is achievable through better management of staffing levels, overtime, and use of registry, which could lead to profit improvements of up to $7.7mm per annum (Table 3). Paladin is aware of the staffing goals set forth by WM, which includes significant staffing reductions, yet has taken a more conservative approach for purposes of the financial projections that it is developing for HUH. Should volumes increase, additional reductions in SW&B per adjusted patient day ("APD") will be realized, as many departments can support increased volumes without adding staff. Paladin will refine its estimates with respect to its staffing-related profit improvement initiatives following more comprehensive due diligence and a deep understanding of the limitations and opportunities under current and anticipated CBAs.

Table 3— Prospective Financial Impact of Staffing Initiative

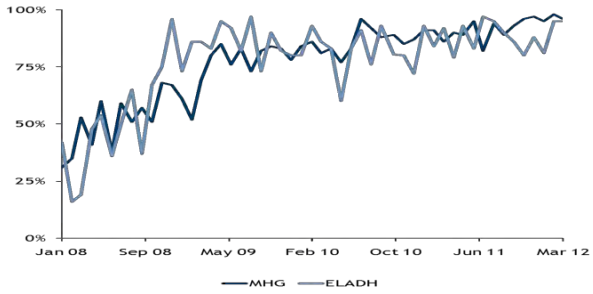
	Current	2%	3%	4%
SW&B as a % of Net Patient Revenue	70%	68%	67%	66%
Net Patient Revenue	$ 257,466,545			
Reduction in SW&B		**$ 5,149,331**	**$ 7,723,996**	**$ 10,298,662**
SW&B per Adjusted Patient Day	$ 4,040	$ 3,960	$ 3,919	$ 3,879

	MHG	ELADH	CHHP	Coast
Avanti SW&B / APD	$ 786	$ 897	$ 777	$ 1,023

Efficient Inpatient Management

Paladin's hospital operating model is grounded in the belief that "efficiency is the friend of quality care" and vice versa. Paladin's principals developed "home-grown" hospitalist and case management programs at the LA Hospitals that have proven to be extremely effective. These programs had an almost immediate and substantial impact on efficiency, while also resulting in a dramatic improvement in quality measures at each of Avanti's hospitals (Chart 4), which previously had been among the lowest quality providers in Southern California.

Chart 4 — Core Measure Improvements at MHG & ELADH



ELADH refers to East Los Angeles Doctors Hospital, which serves East LA, City of Commerce, Bell, Huntington Park, Vernon, and other East Los Angeles communities

With respect to HUH, ManageCo will institute a case management program that will ensure that patients are admitted and transitioned to the appropriate level of care, and physicians/hospitalists are in the right place at the right time to make timely and clinically-appropriate decisions. Case managers are responsible for the implementation of patient care plans, including communication and coordination with patients, families, and third-party providers. As a result, physicians can focus on what they do best — diagnosing patients and developing appropriate care plans.

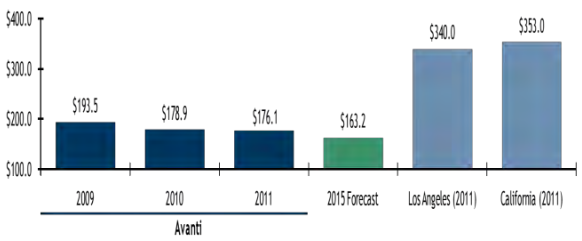
Paladin believes that the academic orientation and commitment to quality of HUH's physicians and nurses, coupled with Paladin's ability to educate and empower such clinicians, will lend to the development of highly effective hospitalist and case management programs at HUH. As a result, Paladin believes there are opportunities to improve inpatient management such that average lengths of stay for Medicare and Medicaid patients will be reduced, yielding estimated profit improvements of up to $12.6mm per annum (Table 4).

Table 4 — Prospective Financial Impact of Hospitalist and Case Management Initiatives

	Current	6%	8%	10%
Hospital LOS	5.20	4.89	4.79	4.68
Reduction in LOS		0.31	0.42	0.52
Medicare/Medicaid PD Reduction		1,541	2,055	2,569
Variable Exp / Patient Day	$ 4,105			
EBITDA Contribution		**$ 6,326,947**	**$ 8,435,929**	**$ 10,544,911**

Drive Margin by Reducing Supplies Expense

Chart 5 — Supply Expense Per Adjusted Patient Day



Paladin has successfully implemented numerous expense reduction strategies to lower supply chain costs at each of the LA Hospitals, often driving costs per APD to the lowest levels in the Los Angeles market (Chart 5). The LA Hospitals rapidly reduced its relative supplies expense by standardizing clinical and non-clinical supplies, centralizing decision making, establishing stringent policies and procedures, and instituting a range of operational projects across the supply chain such as SKU reduction, tight formularies and operating guidelines, reprocessing, and electronic forms management, among several others. ManageCo will institute comparable policies and procedures at HUH.

Based on Paladin's model and considering the volumes and structure of HUH's current supply chain, Paladin believes that it can help the Hospital lower supply costs by as much $44 per APD, thereby achieving up to $2.8mm of annualized profit improvements (Table 5), a total corroborated by WM in their initial estimate.

Table 5 — Prospective Financial Impact of Supply Expense Initiative

	Current	5%	7%	9%
Supply Expense per Adjusted Patient Day	$ 485	$ 461	$ 451	$ 441
Reduction in Supply Expense		**$ 1,545,302**	**$ 2,163,422**	**$ 2,781,543**

Review of Insurance Policies and Programs

Paladin believes that proper insurance coverage and a strong orientation toward risk management are the primary drivers of a successful insurance program. This is especially true in high-intensity environments such as hospitals. With the assistance of its strategic partner, Lockton Associates, ManageCo will conduct a complete review of HUH's insurance policies and risk management programs to ensure that the Hospitals have cost-effective, comprehensive coverage to protect their patients, employees, physicians, and mission. During the next phase of due diligence, Paladin will engage Lockton to help identify specific costs savings that may be available through renegotiation and competitive bidding with new carriers, and risk management strategies that can improve safety and reduce claims. Based upon preliminary due diligence, Paladin believes that there may be opportunities to drive value within the Hospitals' insurance programs and employee benefit plans; however, comprehensive due diligence is required before developing and quantifying a viable plan. Under any plan, the goal is to maintain a healthy workforce, which is not only important to control benefits costs, but to ensuring the performance, productivity, and well-being of HUH employees.

OPERATING INITIATIVES IDENTIFIED BY WEISERMAZARS

In aggregate, based on preliminary due diligence, Paladin identified between $23mm and $41mm of prospective profit improvements, without touching the union contract or having the opportunity to perform a more granular analysis, as there are numerous operational levers that can be pulled to drive incremental improvements to quality and/or financial performance that, in aggregate, can add up to a considerable amount of profit improvements. WM identified a number of prospective levers in its report. Some of the opportunities identified by WM which do not overlap with the items referenced above include:

Near-Term Opportunities

- Staffing rationalization — WM has identified a staffing reduction of approximately 400 FTEs, with an estimated annualized (FY16) net financial impact in the range of $30m.

- Managed care contracts — Certain contracts have lapsed or are in early stages of renegotiation, and others may be at below-market terms. The estimated near-term profit improvement for this initiative is $1.5mm.

- Revenue capture — A thorough review of revenue cycle has identified in excess of $12mm in profit improvements ($3mm in 2015) through enhancements to front-end verification, precertification, and cash collections.

- Employee Health Plan — A variety of inefficiencies inherent in the current HUH employee benefit plan can yield near-term improvements of $1mm, with additional economies in the outer years.

- Cell Phone Usage — Opportunities exist to control cellphone usage, yielding moderate but meaningful savings.

Additional Near-Term Opportunities Not Yet Quantified:

- Meaningful Use — Millions of dollars are at stake if HUH does not achieve meaningful use on schedule, yet launching new versions of the HUH IT platform prematurely can have disastrous consequences. WM is assessing the issue and will have a more exacting assessment of meaningful use risk and opportunity by the end of July.

- Observation Patients — WM believes there are opportunities to mitigate the financial impact resulting from a rise in observation days.

- Peri-Operative Services — WM believes that cost reductions are available through improvements in OR turnaround, case times, supply chain, and more efficient scheduling of appropriate cases in the operating rooms.

- Staff Scheduling — WM identified possible efficiencies and cost reductions through adjustments to staff scheduling, some of which are available under the current collective bargaining agreements and others, such as the ability to flex staff, which are appropriate yet constrained by current provisions in the CBAs; with additional opportunities tied to better management at the department level (e.g., telemetry, radiology, laboratory, respiratory therapy) and/or updating certain pieces of equipment.

- HRIS and Time and Attendance Systems — Currently there are no reliable HRIS and time and attendance systems. The absence of these rudimentary payroll tools is impairing the ability of front line managers to control and monitor labor costs. WM believes that the establishment of such systems can yield significant financial benefits.

- Front-line Management Personnel — WM believes that there exists a great degree of variation in the talents, motivation, and discipline among front line managers, some of whom are anticipated to be included in the staff rationalization plan mentioned above. Remaining managers will benefit from training, tighter management and controls, and improved processes and systems; and new managers will need to be developed or recruited.

- HR Support — WM believes that the H/R department can be improved in all facets, which would have a ripple effect across several elements of the business and potentially yield favorable results in recruiting, productivity, staffing, labor arbitration, and other critical areas.

- Monitoring and Controlling Contract Labor — WM believes that improved processes and controls will help to control the use of contract labor which will lower relative costs and increase productivity.

Mid-Term Opportunities

- Physical plant — In addition to safety and/or regulatory related improvements, certain cosmetic and/or structural improvements to the physical plant can provide an ROI, and WM is embarking on an assessment to evaluate needs and opportunities.

- Physician Recruitment — The complement and mix of physicians whose practice is dedicated to HUH requires analysis and further investment, with recruitment likely in the areas of primary care, advanced practice nursing, and other targeted specialties.

- Clinic Wait Times and No-Show Rates — Waiting time for clinic appointments and no-show rates are having a direct effect on productivity, teaching, reputation, and financial performance. WM believes that improvements to industry standards can yield near-term savings of $1mm/year and long-term savings of $5mm/year.

- Physician Productivity and Incentive Contracts — WM has not yet assessed this area but believes that there are a range of opportunities to improve productivity.

- Process Redesign and Productivity Standards — By establishing productivity standards, WM believes that improvements in productivity can be available across the enterprise, especially in clinical areas such as the OR and clinics, financial areas such as accounts payable and accounts receivable, and operational areas such as admitting and customer service.

- Charge Master, Charge Capture and Strategic Pricing — It is conceivable that financial improvements may be realized through adjustments to HUH's charge master, improvements to charge capture, and strategic pricing.

- Adjustments to FPP Compensation — Subject to limitations under the CBAs and the needs and objectives of the University, WM believes that adjustments to the manner in which the FPP operates and is compensated could yield millions of dollars in profit improvements to the Hospital.

Summary of Preliminary Profit Improvement Initiatives

Based on Paladin's preliminary analysis and driven solely by the core profit improvements identified a, aggregate profit improvements are estimated to range between $23mm and $41mm (Table 6), excluding the prospective impact of the initiatives identified by WM, other yet-to-be-quantified operational initiatives, or the strategic initiatives presented below, including contemplated revenue increases resulting from rate increases and revenue cycle improvements. Accordingly, Paladin considers its estimates to be conservative.

Table 6 – Summary of Prospective Financial Impact of Profit Improvement Initiatives

Profit Improvement Initiative	EBITDA Contribution		
	Low	Medium	High
Increase ED Visits	$692,986	$1,039,479	$1,385,972
Increase ED Conversion Rate	4,658,795	6,988,193	9,408,053
Improve Case Mix Index	4,764,861	5,631,199	6,497,537
Reduce Length of Stay	6,326,947	8,435,929	10,544,911
Optimize Stafffing Ratios / Flex-Staff	5,149,331	7,723,996	10,298,662
Reduce Supply Chain Expense	1,545,302	2,163,422	2,781,543
PALADIN TOTAL	**$ 23,138,221**	**$ 31,982,219**	**$ 40,916,678**
Managed Care Contracts	1,500,000	2,250,000	3,000,000
Revenue Capture	3,300,000	4,902,035	12,000,000
Employee Health Plan	1,000,000	1,500,000	2,000,000
Cell Phones	200,000	200,000	200,000
Clinic Improvement	1,000,000	3,000,000	5,000,000
MAZAR TOTAL	**$ 7,000,000**	**$ 11,852,035**	**$ 22,200,000**
Volume Increases	TBD	TBD	TBD
Contracting	TBD	TBD	TBD
Managed Care	TBD	TBD	TBD
Outpatient/Ambulatory Revenue	TBD	TBD	TBD
Revenue Cycle Improvements	TBD	TBD	TBD
Insurance	TBD	TBD	TBD
TOTAL IMPROVEMENTS	**$ 30,138,221**	**$ 43,834,254**	**$ 63,116,678**

OTHER HOSPITAL OPERATIONS INITIATIVES

Partnering with United Medical Center

Paladin is currently engaged in discussions with the management of UMC regarding a prospective acquisition of UMC. Paladin is in the process of conducting preliminary due diligence in order to identify profit improvement initiatives that can stabilize the facility and transition it to a sustainable enterprise. Many of the core operating initiatives that Paladin plans for HUH appear to be relevant at UMC; that is, driving significant efficiencies across the enterprise and engaging paramedics and EMTs to capture available and appropriate paramedic volumes. Adjacent to these core concepts, there are numerous ways that HUH and UHW can work together to improve their respective operations and to better serve the community.

Because of the close proximity of the facilities, it will be possible to consolidate many of the administrative and operational functions, which can quickly reduce each hospital's operating costs, while improving the efficacy of critical functions. Opportunities include consolidating and standardizing purchasing to reduce supply costs, including pharmaceuticals; consolidating the central business offices and introducing a number of revenue cycle management initiatives; creating a unified charge master; implementing joint contracting to garner additional leverage and negotiate more favorable arrangements; consolidating service lines to ensure scale and financial viability; and/or adding service lines to better meet community needs; among others.

From a clinical perspective, there appear to be opportunities to consolidate certain services lines at one hospital or the other to achieve necessary scale to ensure that such specialty service lines remain available to the community. It may make sense to consolidate most specialty programs at HUH, to consolidate pediatrics programs at UMC given the success of its partnership with Children's National Medical Center, and to otherwise have UMC function as a highly efficient non-tertiary ED-centric hospital that is an expert at coordinating transfers to other hospitals (with an emphasis on HUH) for higher levels of care.

Paladin is prepared to collaborate with Howard to jointly pursue the UMC opportunity.

Leveraging and Enhancing the Faculty Practice Plan

ManageCo is committed to deeply strengthening and enhancing the relationship between the hospital, the Faculty Practice Plan, and other qualified community-based physicians. Effective provider integration will strengthen the organization's overall market position and ability to respond clinically and financially to forthcoming adjustments to health policy. Paladin considers physician input to be crucial, especially as it relates to clinical and strategic considerations. It is important for physicians to buy in on decisions involving medical and administrative staff, service line adjustments, and strategic planning, and that they have confidence that their recommendations will be considered.

As noted, a Medical Affairs Committee will be formed to ensure a consistently open forum for communication among representatives of the Medical Staff and Senior Management of the Hospital. The Medical Affairs Committee will focus on developing and proposing academic policies and programs, staffing, training, utilization, research, community service, strategy, quality, and fundraising, among other considerations.

Community Engagement

Paladin's marketing strategy for HUH centers on enhancing the already-strong image and reputation of the Hospital through a comprehensive plan to promote positive community relations by highlighting the quality of service, commitment to community, and new outreach programs such as health screenings for targeted chronic disease populations. Strategies include the development and distribution of new hospital collateral that reflects the strength of the organization under new leadership; coordination and implementation of community support programs such as scholarships, health festivals, toy fairs, education and other programs; and the strategic use of print, radio and television media. Of significance will be the organization's plan to establish a comprehensive HUH-branded network of Ambulatory Clinics and Community Health Centers, as various marketing opportunities will arise as each facility opens. Paladin is also contemplating the establishment of a charitable foundation that will be focused on combating healthcare disparities in the communities surrounding HUH.

PHASE TWO — ESTABLISHING A HOWARD-BRANDED COMPREHENSIVE AMBULATORY INFRASTRUCTURE AND CLINICAL DELIVERY SYSTEM

Over the past 50 years, the dominant health challenges in America have shifted to chronic diseases such as diabetes, asthma, Alzheimer's, arthritis, and heart conditions. As the principal cause of disability, chronic disease is responsible for the overwhelming majority of our healthcare expenditures. As a result, the goals of providers, patients, and payors are shifting toward prevention, early diagnosis, and patient education to enable individuals to make better lifestyle choices and manage their own health, in partnership with a healthcare team, family members, and the community.

To pursue this goal, and to be more accessible to the patients treated by HUH, Paladin and its real estate partner, Stanton Road Capital, intend to fund the establishment of a network of multi-specialty clinics and health centers within the markets served by HUH, with an emphasis on Wards 7 & 8. As currently envisioned, this would involve the acquisition of underutilized medical office facilities that will be transformed into vibrant ambulatory operations and/or the acquisition of underperforming strip malls that would be converted to Family Care Centers in which each "store" is transformed into a specialty clinic, with a common back office. Each facility will provide a range of critical services for a range of community members from children and pregnant women to seniors and persons with disabilities.

Services may include, among others:

- Family medicine
- Podiatry
- Cardiology
- Urgent care
- Geriatric medicine
- Endocrinology
- Diagnostic Testing
- Gynecologic care

- Obstetrics
- Oncology
- Orthopedic care
- Otolaryngology
- Dental care
- Pediatrics
- Urology
- Radiology
- Psychiatry
- Wellness & Nutrition
- Education programs

In addition to the Family Care Centers (i.e., multispecialty clinics), Paladin anticipates establishing Family Health Centers which would be single unit facilities positioned around the community. Each center will provide health screenings, pregnancy tests, and other diagnostic tests in order to establish the current health condition of persons receiving such services. Those who are determined to require additional care will be routed to the multispecialty clinics, hospitals, or other network providers as appropriate, with transportation services available to those in need.

The identification and selection of real estate locations will be determined by the Executive Committee, with recommendation from ManageCo. In advance of each real estate transaction, the Hospital, in collaboration with HU leadership and the FPP, will developed a business plan to operate and/or sublet the available space such that it can best serve the local community while also covering related costs.

Under any plan, a commitment to quality and operating discipline will be firmly embedded in the operation of each Family Care Center and Family Health Center. Patient care, as well as clinical ancillary and support services, will be planned, organized, directed and staffed in a manner commensurate with patient acuity, volume, and the scope of services offered. Operating statistics will be carefully tracked, enabling management to flex staff for each shift in accordance with staffing ratio requirements and patient volume. Each clinic will have a Medical Director and Nurse Director who will regularly meet with rotating clinical staff members. Staff members will be assigned clinical and managerial responsibilities based on educational preparation, applicable licensing laws and regulations, and an assessment of competence. In order to measure improvements in patient care quality and operating efficiencies, a dashboard of operating metrics will be developed and issued on a monthly basis.

Preliminary goals and objectives of this initiative include:

- Establish a care coordination platform that will reduce the community's reliance on HUH's emergency department and provide good access to appropriate levels of care for non-emergent patients across the DC area;

- Enable FPP physicians, HUH nurses, and other providers work in both the clinic and hospital settings so that a comprehensive healthcare team is able to follow patients from the clinics to the hospital(s) and then back to the clinics or other network providers for aftercare services, follow up, and monitoring

- Provide a range of episodic care services for patients who would otherwise be diverted to the emergency department at HUH or other appropriate hospital;

- Coordinate service delivery among physicians, nurses, and other affiliated and contracted providers who work at the clinics, Hospital and other facilities, thereby enabling clinicians to follow patients as they transfer between acute and non-acute clinical environments;

- Achieve reductions in hospital readmissions by coordinating post-discharge care between the Hospital(s), Family Care Centers and Health Centers, affiliated physicians, and other ancillary service providers;

- Develop a fully integrated IT platform with electronic medical records and comprehensive data analytics that will lead to improved quality, lower costs, and better coordination and communication among providers (and to ultimately improve the organization's ability to fundamentally underwrite risk should it decide to assume such risk in the future);

- Build a contracted ancillary provider network that will both lower costs and improve clinical outcomes at the clinics and Hospital;

- Institute community outreach and health education programs focused on prevalent conditions and co-morbidities associated with heart disease, diabetes, and obesity, among other health challenges that are prevalent in the communities served by HUH; and

- Increase availability of and better access to basic and critically needed healthcare services for children, adults, seniors, and persons with disabilities.

Ultimately, the goal is to develop an innovative care model for the underserved population of DC that creates a collaborative environment for patients to receive and physicians, nurses, clinics, and hospitals to deliver quality cost-effective care. By combining the best values received by the hospitals with the reach and breadth of the clinics, HUH and its partners hope to keep its communities healthy and out of the emergency room.

INTEGRATED, MODERN, AND PATIENT-CENTERED MANAGED CARE PLATFORM

The HUH Family Care Centers and Family Health Centers will serve as a central hub for administering a proactive, integrated system of care that combines preemptive health screenings, education programs, wellness, and value-based incentives when people are well; and proactive medical management, care coordination, and Care Team support when people are sick. Primary Care Physician ("PCPs") will function as the primary gatekeepers of care for beneficiaries who have not yet developed severe illnesses or chronic diseases; and an Extensivist (typically a physician who specializes in a particular illness) will assume the gatekeeper role for chronically sick patients, with the support of Care Teams (e.g., nurse practitioners, case managers) that will implement a high-touch model in which the beneficiaries are regularly communicated with (often daily) by a team of experts who develop personal relationships with beneficiaries and their families, have expertise in dealing with the day-to-day challenges of the relevant condition, and understand when it is appropriate to refer patients for more specialized or acute care if necessary.

In addition to HUH, the ambulatory network, and possibly UMC, it will be necessary to round the integrated healthcare delivery system network by adding select Primary Care Physicians and establishing a contracted network of ancillary service providers, thereby providing access to a full continuum of healthcare services for community members. The contracted network will be designed to extend and facilitate the primary care provided by FPP physicians and HUH nurses. Ancillary services will cover diagnostic services such as audiology, radiology, pulmonary testing and clinical lab services; therapeutic services such as physical therapy, occupational therapy, speech therapy, radiation therapy, nutrition therapy, and weight management; and custodial ancillary services focus on hospice, home health, and skilled nursing facility (SNF) care, and durable medical equipment, among others. Many of these services can be provided at the HUH-branded facilities, with gaps filled at certain providers' existing locations.

Care Coordination and Utilization Management

The ambulatory clinics and health centers will enable the introduction of a proactive, integrated system of care that combines preemptive health screenings, education programs, wellness, and value-based incentives for people who are well; and proactive medical management, care coordination, and Care Team support for people who are sick. As noted earlier, PCPs will function as the primary gatekeepers of care for non-chronic beneficiaries; and Extensivists will assume the gatekeeper role for chronic patients, with the support of Care Teams (e.g., nurse practitioners, case managers).

HUH will establish a Utilization Management (UM) Program to ensure that medically-necessary services are rendered at the appropriate level of care in a timely and cost-effective manner. The UM Program will involve close interaction and coordination of member information with providers. HUH managed care personnel will conduct prospective, concurrent, and retrospective review, and will also act as a liaison for discharge planning.

Services will generally be divided into three levels of authorization, based on type of procedure, diagnosis and location of service. All requests will be screened by UM nurses and may be approved based on accepted medical criteria. Services not meeting standard medical necessity criteria will be forwarded to Medical Directors or designees for review. Delegated physicians will be required to comply with defined referral and authorization protocols.

By partnering with efficient providers of quality healthcare and ancillary services to actively manage patients, HUH will be able to streamline care while offering high quality services, thereby lowering bed day costs and utilization of expensive tests, pharmaceuticals, and ultimately reduce readmissions and overall healthcare utilization.

Underwriting

The Affordable Care Act promotes the transition of US healthcare from a fee-for-service reimbursement system to one based on value. Value-based reimbursement ("VBR") models are designed to reward value instead of volume by aligning payers and providers through modified risk relationships. The objective is to use reimbursement as a lever to change the way providers deliver care. In theory, VBR programs can help to reduce costs, improve quality, and minimize waste. While the promise of VBR is significant and perhaps the best prospect to ensure the long-term sustainability of the US healthcare system, the transition to such a model is extremely complicated and likely to place a significant financial strain on hospitals. To remain viable and vibrant in the long-term, HUH must overcome the challenges of this transition and build an integrated healthcare delivery system that coordinates and delivers a complete spectrum of quality acute care, physician, and ancillary services on a financially-sustainable basis that may involve some underwriting risk.

As its managed care infrastructure evolves, HUH will be in a better position to establish a managed care infrastructure and enter into institutional, professional, and/or global capitation arrangements. However, risk will not be taken lightly, particularly in a rapidly-evolving reimbursement environment. As the HUH integrated healthcare delivery system takes effect across the DC market, it may attract patients that have had insufficient access to quality healthcare and which, in aggregate, represent a disproportionately high-risk population. Early on, forthcoming reimbursement models may not accurately account for these necessary types of geographic-centric risk adjustments. Such a dynamic can lead to substantial and rapid losses. In order to ensure that appropriate and manageable risks are accepted, it is critical to establish a stringent underwriting policy that includes comprehensive actuarial analysis rooted in quality data, and to have a clear understanding of the organization's operational ability to manage targeted patient populations. Developing such an understanding through an operational assessment will be achievable, but if quality data does not exist, risk should not be assumed.

Paladin brings to HUH a deep level of knowledge, insight, and ideas to help HUH make this transition in an optimal manner. Under the leadership of Paladin's principals, the LA Hospitals built a sizeable managed care business of more than 125,000 capitated lives. This book of business was built through the establishment of capitation agreements with five different health plans, shared-risk arrangements with 13 different Independent Practice Associations ("IPAs"), and administrative agreements with five different Management Services Organizations ("MSOs"). While the number of partners made it a difficult business to standardize and manage at the hospital level, the business was profitable, and Paladin's principals learned the mechanics of administering such a business, as well as the challenges involved, including those stemming from the unique characteristics of the patient populations (mostly MediCal) covered by such programs.

Corporate underwriting policy, which will include class targets, pricing, underwriting criteria and workflow, will be determined by the Executive Committee. Outside advisors such as reinsurers, reinsurance brokers, and select service providers may also have input into ongoing refinements of the underwriting policy. The Company believes that the best underwriting decisions are based upon a collaborative process that considers market trends, claims trends and changes within the economy and the benefits delivery system.

Insurance underwriting generally involves two key functions: analyzing individual risks and managing portfolios of risks. Individual risk selection requires gathering the appropriate data to determine eligibility and pricing for a particular insurance product. Portfolio management involves product development, determination of product-specific business rules, pricing, and ongoing adjustments based on results analysis. The success of these initiatives is largely dictated by the quality, quantity, and timeliness of the data used to make decisions.

Fully-Enabled Managed Care IT Infrastructure

As a foundational strategy, a Managed Care IT platform will be established that improves data quality, lowers transaction costs, and enhances service. Existing payors have been unable to fully leverage recent improvements in information technology because they are locked in to major capital and workflow investments in legacy systems. However, there are several vendors who have developed state-of-the-art payor platforms that are scalable, flexible, and cost-effective. Such systems are more capable of improving operational efficiency, reducing operational costs, enhancing medical cost management, and better engaging members and providers, all while increasing speed-to-market for a newly established managed care operation.

The Managed Care IT system will include customizable modules in the areas of claims processing, member and provider management, benefit plan management, new product development, care management, medical management, and decision support/analytics. A web-based interface will allow members, providers, and brokers to input and/or access account information and receive non-binding quotes, while providing access to account-level claims information. An integrated database will offer extensive reporting and querying capabilities, including statistical and regulatory reporting.

One of Paladin's principals, Ravi Sharma, is among the healthcare industry's leading IT experts. He was the first Global Director of GE's Six Sigma business, and served as General Manager of GE Healthcare's most successful division. He left GE to serve as CEO for three early-stage healthcare technology companies, each of which he built into successful operations which provided progressive solutions in clinical integration to a range of cloud-based healthcare companies. Ravi has a deep understanding of healthcare IT, including transformational technologies across the healthcare spectrum that offer the potential to increase efficiency, improve quality, decrease costs, enhance decision making, and engage patients. He will be a key contributor to defining ways that HUH can maximize the use of electronic health information technology to coordinate care across multiple care settings.

The ultimate goal is to deploy a range of IT-enabled tools to provide, enhance, and expedite the delivery of health care services to the populations served by its portfolio companies. Telemedicine, for example, is an emerging tool that offers the potential for providers to provide consultations, information, diagnostic images, and data through a range of electronic media, providing a powerful mechanism to communicate with patients to and from virtually any location at any time. In the coming years, Paladin anticipates that telemedicine will prove to be one of the most effective and cost-effective ways to facilitate timely communication between patients and clinicians or between clinicians.

Community-Based Population Health Promotion and Disease Prevention

In densely populated urban areas, there is often a lack of facilities and outdoor areas for exercise and recreation. Air quality is often lower due to proximity to emission sources which can contribute to chronic diseases such as asthma, especially in children. Similarly, some populations in urban areas do not have ready access to fresh produce and instead rely heavily on corner stores for processed foods. Lack of basic infrastructure can further perpetuate the cycle of poverty. As a result, these populations face barriers to care, receive poorer quality care, and disproportionately use emergency systems. The goal of Paladin is to develop an economically sustainable model of care that empowers members and the community to not only access medical care, but also take control and improve their own health.

Outreach, education and logistical accessibility will be integral in the ability of the clinics to increase access to care, quality of health services, and organizational sustainability. These activities will need to have a broad spectrum to facilitate access to health services, including case management, transportation, interpretation, education, and help navigating the health care system such assistance in applying for government services and benefits.

By leveraging the existing relationship between HUH, local physicians, and the community at large, HUH is positioned to reach out for collaboration and coalition building to ensure a comprehensive, complementary, and sustainable healthcare system in the community. Such a grass roots program can be very effective. It is anticipated that HUH will also actively outreach to schools, churches, senior centers, community centers, and sponsor health fairs at various targeted locations throughout the community to foster more widespread understanding about navigating the health care system, chronic diseases, co-morbidities, obesity, and general well-being. It can be further supported through a targeted media campaign that emphasizes the availability of free health screenings, diagnostic tests, pregnancy tests, and immunizations that will be available at the health centers, and more comprehensive services that will be available at the multispecialty clinics and HUH.

To become an active partner in the health promotion and health maintenance of the residents local to HUH, Paladin's plan entails the implementation of a Community Action Plan that includes an ongoing series of health education programs and services that are regularly offered at local churches, community centers, and the Family Care Centers and Family Health Centers. The goal is to curtail the healthcare disparities that arise in the communities served by HUH, and will include Physicians, nurses, and various educators. The mission in developing this program is for participations to develop habits that are conducive to the promotion, maintenance, and/or restoration of health. In developing the appropriate interventions, all factors that affect health, wellness, and disease — including the psychosocial and spiritual dimensions of people's lives — will be taken into consideration, and whenever possible, low-tech, low-cost interventions that are effective will be employed. Services may include progressive modalities of care that are supported by high-quality scientific evidence of safety and effectiveness.

Possibilities include:

- Nutritional Education. Obesity has reached epidemic proportions in the US, with nearly 58mm people overweight, 40mm obese, and 3mm morbidly obese nationwide. By teaming with local organizations to teach families how to eat properly, develop diets, and cook healthy foods, HUH can impact not just those that currently are heavy utilizers of the healthcare system, but also the forthcoming generations.

- Family Planning. Reproductive health care is a key issue in many communities, and particularly those without adequate health coverage. Proactive education can help to prevent unintended pregnancies, reduce the spread of sexually transmitted diseases, and screen for cervical and other cancers.

- Health Plan Enrollment. Many community members are qualified for healthcare coverage offered by Medicaid, Medicare and the insurance exchanges. HUH can help to educate community members on the types of coverage and benefits that are available and the qualifications needed to secure such coverage. HUH can take this a step further by providing support to ensure that such members enroll and secure the best coverage available to meet their particular needs.

- General Health Education and Examinations. Mini Health Festivals could be offered in conjunction with churches and community centers. Services may include free blood pressure tests, eye exams, diabetes screenings, distribution of educational pamphlets, and one-on-one conversations with professionals with related expertise.

- Diabetes Education. Diabetes is among the fastest growing diseases in the US, with particularly high levels among African-Americans and Latinos. Since 1990, there has been an over 75% increase in Type II diabetes among adults age 30 to 40 years old. An estimated 21mm Americans are affected by diabetes, with another 41mm showing the pre-diabetic conditions of high blood sugar, putting them at a high risk for developing the disease in the future.

- Women's Health. There are many health issues that are specific to the female population. HUH could offer educational programs that cover women's health issues such as menstruation, contraception, maternal health, child birth, menopause and breast cancer.

- Children's Health. Children grow and change so quickly. HUH can offer a program that addresses a range of growth and development topics to inform parents of what to expect at each stage of their child's growth. Topics may include newborns & infants, immunizations, infections, skin care, digestive, respiratory, injuries & safety, behavior & development, nutrition & fitness, ADHD & ADD, first aid & safety, and parenting, among others.

- AIDS/HIV Education. The effect of HIV and AIDS impacts millions in the US every day, and the African-American community is particularly affected by this epidemic. According to the Centers for Disease Control and Prevention, nearly half (46%) of those living with HIV/AIDS in the US are of African-American descent. Many uninsured Americans struggle to access good HIV care and antiretroviral therapy. Prevention efforts are still the best way to combat the AIDS epidemic.

There are a multitude of challenges facing the underrepresented communities of Washington DC. Many of these issues can be prevented or mitigated through education and early detection. Such problems often go untreated because the people affected by them have inadequate or no healthcare coverage; or they are simply uninformed. By assessing members of the community through the HUH facilities and Community Action Plan outlets described above, HUH can educate and inspire a community of people to take better care of themselves and live long, happy, healthier lives; while fostering a bond with the community that is truly unique and impactful.

Addressing Behavioral Health

In non-psychiatric acute care facilities, psychiatric patients are regularly admitted but often pose challenges to clinicians and staff members. If adequate volumes exist or related service lines are established, the care of psychiatrist patients should ideally be led by a dually-trained internist-psychiatrist hospitalist that can establish care plans that lead to shorter lengths of stay, better disease resolution, and fewer readmissions.

There are some integrated models emerging that can effectively serve such patient populations in both acute and ambulatory settings. Companies like Brand New Day HMO have developed innovative and comprehensive models of care for individuals with chronic mental illness. The program enables such beneficiaries to have direct access to a coordinated Care Team that includes a personal medical doctor, a psychiatrist, a behavioral health trained life coach, a day treatment program, and a nurse, with a case manager leading the implementation of a collectively developed care plans that address any behavioral or health issues, along with recommended preventative health services. Paladin has an established relationship with Brand New Day but has conducted only cursory discussions given a lack of need at the LA Hospitals. However, both Paladin and HUH can learn from Brand New Day and other experts in hopes that such methodologies will prove to be effective in supporting the needs of the District's special needs population.

By working with HUH clinicians and local payers, and by collaborating with industry leaders such as Brand New Day, Paladin is confident that it can help HUH develop a business plan around behavioral health, integrate such a plan into operations, and manage the program on a go-forward basis (either independently or by overseeing a third party management company).

Exhibit B

Data Deck

See attached.

HOWARD UNIVERSITY HOSPITAL

EXAMPLE DATA BOOK

SEPTEMBER 2014

PALADIN HEALTHCARE CAPITAL

Contents

AVANTI DASHBOARD 2

OPERATIONS

YEAR-TO-DATE														CURRENT MONTH - June										
MHG			ELADH			CHHP			COAST					MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	INPATIENT OPERATIONS	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
26,832	26,673	25,508	13,743	13,813	13,553	7,581	9,745	5,608	7,399	8,368	8,377	Total Patient Days	4,283	4,265	4,008	2,047	2,164	2,001	1,156	1,575	858	1,108	1,028	1,180
2,702	2,496	2,466	962	1,022	992	2,097	2,687	1,561	1,522	1,563	1,497	ED Admissions	453	395	390	134	131	127	327	389	226	255	190	182
3,386	3,673	3,509	1,887	2,140	2,080	2,131	3,303	1,931	1,697	2,033	2,028	Total Admissions	543	623	580	274	373	362	312	569	323	265	241	277
149.1	148.2	141.7	76.4	76.7	75.3	42.1	54.1	31.2	41.1	46.5	46.5	Average Daily Census	142.8	142.2	133.6	68.2	72.1	66.7	38.5	52.5	28.6	36.9	34.3	39.3
633	718	688	526	511	499	456	676	397	276	234	237	IP OR Surgical Cases	84	124	119	74	78	76	81	112	64	42	37	42
1,035	993	948	411	363	403	631	860	503	582	568	565	Medicare Admits	157	150	139	62	61	72	80	163	93	91	66	76
5.2	4.6	4.6	6.0	5.7	5.9	3.5	3.5	3.5	5.6	5.4	5.3	Medicare Acute LOS	5.0	3.5	3.5	6.2	5.2	5.3	3.6	3.4	3.0	5.2	5.4	5.4
1.74	1.60	1.70	1.48	1.45	1.45	1.17	1.00	1.06	1.60	1.63	1.53	Medicare Case Mix Index	1.66	1.60	1.60	1.55	1.45	1.39	1.15	1.00	1.00	1.50	1.63	1.63
4.72	5.20	4.93	4.42	6.00	4.21	3.62	3.49	3.40	4.48	5.61	5.51	Geometric Mean LOS	4.44	4.96	4.70	4.09	6.24	3.54	3.61	3.55	3.34	4.27	5.15	4.83
10,239	13,247	12,696	5,385	6,036	5,790	1,579	1,169	671	839	879	862	Medi-Cal Patient Days	1,620	1,731	1,637	840	878	801	295	215	117	161	122	140
5.0	4.2	4.3	3.6	4.3	4.5	3.9	3.4	3.4	5.6	5.1	5.1	MS MediCal LOS	5.2	3.9	3.9	2.7	2.7	3.0	4.5	2.3	2.3	4.5	4.9	4.8
4%	10%	17%	3%	10%	15%	5%	10%	18%	5%	10%	16%	MediCal Denial %	2%	10%	18%	4%	10%	12%	7%	10%	18%	1%	10%	7%
379	1,087	1,048	186	740	723	838	861	493	472	533	529	Self-Pay Patient Days	89	120	112	43	65	56	91	195	106	89	59	68
263	328	314	118	147	140	422	388	227	141	163	165	Self-Pay Admits	38	53	50	16	29	27	60	98	56	24	35	40
2.2	3.1	3.2	3.0	5.2	5.4	2.7	2.3	2.4	4.1	2.9	3.4	Self-Pay LOS	2.7	1.7	1.7	4.3	2.5	2.0	3.2	2.3	2.6	4.5	1.8	2.3
554	627	627	399	386	383	-	-	-	-	-	-	OB Deliveries	83	126	126	70	69	65	-	-	-	-	-	-
2.66	3.00	2.28	3.11	3.00	2.77	-	-	-	-	-	-	OB LOS	2.58	3.00	2.19	2.89	3.00	2.44	-	-	-	-	-	-
25,573		25,451	2,829		12,966	12,257		4,182	6,078		9,262	Registry Hours	3,244		4,990	132		1,763	1,696		668	161		1,251
												OUTPATIENT OPERATIONS												
18,208	17,355	16,136	7,172	7,936	7,762	16,826	18,055	14,555	7,052	7,090	6,790	ED Visits	2,669	2,715	1,668	1,095	1,003	1,027	2,578	2,662	2,146	1,119	1,157	1,107
90.3	24.0	54.0	18.0	24.0	26.0	18.0	24.0	-	-	24.0	-	ED Diversion Hours	-	4.0	8.0	-	4.0	3.0	2.0	4.0	-	-	4.0	-
7.6%	0.0%	3.5%	5.3%	0.0%	5.3%	10.8%	0.0%	5.9%	4.7%	0.0%	2.1%	ED LWOBS	5.2%	0.0%	5.4%	4.7%	0.0%	5.2%	5.7%	0.0%	11.0%	4.2%	0.0%	5.3%
5.62		3.35	4.62		3.38	0.24		0.14	4.22		0.82	ED LOS	5.40		4.60	4.60		4.33	0.22		0.14	3.90		4.90
4,120	4,272	4,272	1,084	690	690	3,155	4	4	1,671	854	854	Paramedic Runs	760	676	656	144	132	132	663	4	4	296	108	108
587	701	701	375	420	380	464	443	443	120	70	72	OP OR Surgical Cases	81	106	106	59	74	34	84	78	78	15	12	14
3,071	6,837	7,807	2,429	2,202	2,228	594	671	671	1,030	597	597	Non-ED OP Visits	417	800	1,900	387	335	361	96	78	78	122	88	88

AVANTI DASHBOARD 2

FINANCIAL

YEAR-TO-DATE														CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST					MHG			ELADH			CHHP			COAST		
ACT	BUD	ACT	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		REVENUE MANAGEMENT	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
41.0%	0.0%	42.6%	32.7%	0.0%	35.7%	32.5%	0.0%	39.2%	44.4%	0.0%	49.6%	Payor Mix	Medicare (% of Gross Rev)	36.6%	0.0%	30.4%	23.4%	0.0%	23.8%	29.6%	0.0%	18.7%	44.8%	0.0%	39.0%
43.5%	0.0%	45.2%	46.8%	0.0%	51.1%	42.7%	0.0%	51.5%	30.6%	0.0%	34.2%		MediCal (% of Gross Rev)	51.0%	0.0%	33.5%	53.4%	0.0%	34.8%	45.1%	0.0%	27.0%	31.4%	0.0%	35.2%
5.6%	0.0%	5.9%	7.8%	0.0%	8.5%	19.9%	0.0%	24.0%	15.1%	0.0%	16.8%		Self-Pay (% of Gross Rev)	5.4%	0.0%	30.7%	7.1%	0.0%	8.0%	20.9%	0.0%	15.3%	17.1%	0.0%	15.6%
3.0%	0.0%	3.1%	7.9%	0.0%	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Capitation (% of Gross Rev)	5.4%	0.0%	30.7%	10.3%	0.0%	6.4%	0.0%	0.0%	6.8%	0.0%	0.0%	0.1%
1.9%	0.0%	1.9%	0.8%	0.0%	0.9%	0.9%	0.0%	1.1%	4.5%	0.0%	5.0%		Other (% of Gross Rev)	1.4%	0.0%	1.4%	2.9%	0.0%	26.1%	0.8%	0.0%	30.7%	0.9%	0.0%	1.1%
$ 1,720	$ 2,163	$ 1,443	$ 1,851	$ 1,855	$ 1,526	$ 1,505	$ 1,463	$ 1,374	$ 2,416	$ 2,578	$ 1,757		Net Patient Rev per APD (Net of BD and Other Rev)	$ 1,993	$ 1,750	$ 1,634	$ 1,904	$ 1,991	$ 1,609	$ 1,187	$ 1,474	$ 1,286	$ 2,372	$ 3,182	$ 2,054
#DIV/0!		$ 55.25	#DIV/0!		$ 43.20	$ -		$ -	$ -		$ -		Capitation Revenue PMPM	#DIV/0!		$ 58.75	#DIV/0!		$ 45.96	$ -		$ -	$ -		$ -
$ 16,626	$ 16,023	$ 13,484	$ 6,178	$ 6,739	$ 5,789	$ 13,068	$ 17,208	$ 2,135	$ 5,533	$ 887	$ 671		Total Bad Debt (000)	$ 2,778	$ 2,557	$ 2,400	$ 1,015	$ 1,058	$ 1,010	$ 1,901	$ 2,783	$ 356	$ 807	$ 114	$ 118
75.1%	78.6%	79.4%	76.8%	77.1%	79.1%	78.6%	78.8%	87.2%	73.3%	76.3%	78.5%		Contractuals (% of Gross Rev)	74.8%	78.5%	79.0%	77.9%	76.8%	78.0%	82.5%	78.7%	87.7%	74.0%	70.7%	78.3%
22.1%	21.7%	22.5%	16.3%	17.7%	18.6%	40.9%	40.8%	13.4%	19.1%	3.0%	3.2%		Bad Debt (% of Net Pat Rev)	22.4%	21.6%	24.5%	17.9%	17.5%	21.2%	44.3%	40.6%	15.4%	18.8%	2.5%	3.6%
3.3%	2.2%	2.5%	7.5%	4.8%	4.8%	5.5%	9.6%	20.1%	7.5%	0.0%	0.0%		Charity (% of Net Pat Rev)	2.7%	2.2%	0.9%	18.0%	4.8%	2.0%	10.1%	9.6%	17.9%	7.2%	0.0%	0.0%
													COST MANAGEMENT												
													FTE per Med/Surg AOB												
													FTE per Sub-Acute AOB												
3.1	3.9	3.2	3.5	4.0	3.8	9.7	2.6	4.3	4.7	4.5	4.1		FTE per AOB	3.5	3.3	3.9	3.8	4.6	4.6	4.0	2.8	5.1	5.1	5.6	4.9
26.4	19.8	24.7	4.0	8.3	15.4	14.3	3.4	4.1	8.2	11.9	12.0		Contract Labor FTE	26.2	26.0	31.2	3.2	4.7	22.2	25.6	4.2	4.2	5.1	19.2	19.2
$ 1,561,930	$ 1,593,714	$ 1,543,505	$ 783,347	$ 934,483	$ 999,972	$ 547,063	$ 506,802	$ 491,207	$ 589,671	$ 607,984	$ 484,593		Premium Pay ($)	$ 250,262	$ 266,121	$ 263,897	$ 119,909	$ 151,999	$ 166,872	$ 94,107	$ 83,487	$ 98,799	$ 87,814	$ 104,494	$ 99,223
$ 794.32	$ 1,011.33	$ 820.65	$ 852.29	$ 852.83	$ 894.41	$ 825.75	$ 593.37	$ 967.56	$ 1,032.41	$ 970.54	$ 857.46		Labor Cost per APD	$ 933.17	$ 813.19	$ 992.13	$ 957.86	$ 923.58	$ 1,053.49	$ 908.37	$ 605.12	$ 1,130.67	$ 1,126.47	$ 1,200.35	$ 1,057.95
$ 183.13	$ 234.44	$ 188.94	$ 171.76	$ 174.46	$ 197.71	$ 171.28	$ 149.27	$ 140.18	$ 343.42	$ 326.03	$ 265.82		Supply Cost per APD	$ 181.25	$ 188.33	$ 194.56	$ 183.22	$ 187.66	$ 238.78	$ 200.33	$ 150.04	$ 110.81	$ 245.50	$ 382.99	$ 298.51
$ 1,429.15	$ 1,789.10	$ 1,284.98	$ 1,582.61	$ 1,574.53	$ 1,429.89	$ 1,509.69	$ 1,183.73	$ 1,447.25	$ 2,276.09	$ 2,104.17	$ 1,510.91		Total Expense (Net of BD) per APD	$ 1,648.04	$ 1,455.77	$ 1,514.40	$ 1,822.94	$ 1,722.98	$ 1,682.27	$ 1,669.11	$ 1,209.62	$ 1,605.73	$ 2,319.57	$ 2,606.69	$ 1,817.71
#DIV/0!		$ 53.76	#DIV/0!		$ 39.61	$ -		$ -	$ -		$ -		Capitation Expense PMPM	#DIV/0!		$ 71.69	#DIV/0!		$ 43.13	$ -		$ -	$ -		$ -
													PROFITABILITY												
$ 58,508,444	$ 57,697,463	$ 46,539,879	$ 31,671,427	$ 31,244,344	$ 25,355,865	$ 18,909,765	$ 24,967,286	$ 13,743,981	$ 23,403,815	$ 28,344,607	$ 20,191,634		Net Patient Rev (Net of Bad Debt)	$ 9,642,698	$ 9,275,361	$ 7,390,411	$ 4,658,820	$ 4,979,040	$ 3,750,371	$ 2,389,613	$ 4,069,364	$ 1,953,410	$ 3,491,182	$ 4,527,768	$ 3,199,704
$ -		$ 1,168,052	$ -		$ 1,583,894	$ -		$ -	$ -		$ -		Grants & Gov't Subsidies	$ -		$ -	$ -		$ 215,887	$ -		$ -	$ -		$ -
$ 1,303,117	$ 1,243,440	$ 1,217,987	$ 1,131,424	$ 842,136	$ 1,013,143	$ 567,703	$ 738,498	$ 731,171	$ 887,537	$ 1,027,896	$ 614,900		Other Revenue	$ 291,399	$ 207,240	$ 194,633	$ 296,945	$ 140,356	$ 210,487	$ (54,715)	$ 123,083	$ 120,791	$ 229,309	$ 171,316	$ 105,796
$ 27,016,198	$ 26,975,214	$ 26,465,825	$ 14,585,458	$ 14,367,529	$ 14,860,559	$ 10,373,088	$ 10,128,259	$ 9,681,295	$ 10,001,506	$ 10,671,727	$ 9,853,639		Total Labor Cost	$ 4,514,513	$ 4,310,744	$ 4,486,761	$ 2,343,326	$ 2,309,881	$ 2,455,292	$ 1,828,134	$ 1,670,505	$ 1,717,761	$ 1,658,238	$ 1,708,013	$ 1,648,313
$ 48,607,560	$ 47,720,560	$ 41,440,430	$ 27,083,585	$ 26,525,809	$ 23,757,613	$ 18,964,794	$ 20,205,117	$ 14,480,910	$ 22,049,811	$ 23,136,844	$ 17,362,985		Total Operating Costs (Net of BD/Cap)	$ 7,972,913	$ 7,717,044	$ 6,848,593	$ 4,459,681	$ 4,309,188	$ 3,920,751	$ 3,359,146	$ 3,339,311	$ 2,439,501	$ 3,414,549	$ 3,709,134	$ 2,832,040
$ 2,697,833	$ 1,197,498	$ 4,460,097	$ 12,939,025	$ 9,931,932	$ 13,835,795	$ -	$ -	$ -	$ -	$ -	$ -		Capitation Revenue	$ 162,435	$ 199,583	$ 753,825	$ 1,708,295	$ 1,655,322	$ 2,550,031	$ -	$ -	$ -	$ -	$ -	$ -
$ 3,399,054	$ 967,776	$ 4,330,366	$ 12,912,506	$ 8,000,634	$ 12,665,899	$ -	$ -	$ -	$ -	$ -	$ -		Capitation Expense	$ 103,259	$ 161,296	$ 919,754	$ 1,948,943	$ 1,333,439	$ 2,392,896	$ -	$ -	$ -	$ -	$ -	$ -
$ 11,204,001	$ 11,220,343	$ 6,317,435	$ 5,719,266	$ 5,560,671	$ 2,611,395	$ 512,674	$ 5,500,667	$ (5,757)	$ 2,241,541	$ 6,235,659	$ 3,443,549		Operating Income - Hospital (Net of Other Revenue)	$ 1,961,184	$ 1,765,557	$ 736,451	$ 496,084	$ 810,208	$ 40,107	$ (1,024,248)	$ 853,136	$ (365,300)	$ 305,942	$ 989,950	$ 473,460
$ (701,221)	$ 229,722	$ 129,731	$ 26,519	$ 1,931,298	$ 1,169,896	$ -	$ -	$ -	$ -	$ -	$ -		Operating Income - Capitation	$ 59,176	$ 38,287	$ (165,929)	$ (240,648)	$ 321,883	$ 157,135	$ -	$ -	$ -	$ -	$ -	$ -
$ 10,502,780	$ 11,450,065	$ 6,447,166	$ 5,745,785	$ 7,491,969	$ 3,781,291	$ 512,674	$ 5,500,667	$ (5,757)	$ 2,241,541	$ 6,235,659	$ 3,443,549		Operating Income - TOTAL	$ 2,020,360	$ 1,803,844	$ 570,522	$ 255,436	$ 1,132,091	$ 197,242	$ (1,024,248)	$ 853,136	$ (365,300)	$ 305,942	$ 989,950	$ 473,460
$ 6,341,102	$ 11,450,065	$ (1,182,574)	$ 2,352,185	$ 7,491,969	$ (2,449,664)	$ (2,422,280)	$ 5,500,667	$ (5,386,510)	$ 1,300,327	$ 6,235,659	$ 1,717,987		Normalized Operating Income - TOTAL	$ 1,326,747	$ 1,803,844	$ (123,091)	$ (310,164)	$ 1,132,091	$ (368,358)	$ (1,513,407)	$ 853,136	$ (854,459)	$ 149,073	$ 989,950	$ 316,591
19.1%	19.4%	13.6%	18.1%	17.8%	10.3%	2.7%	22.0%	0.0%	9.6%	22.0%	17.1%		Operating Income % - Hospital	20.3%	19.0%	10.0%	10.6%	16.3%	1.1%	-42.9%	21.0%	-18.7%	8.8%	21.9%	14.8%
-26.0%	19.2%	2.9%	0.2%	19.4%	8.5%	-	#DIV/0!	-	-	#DIV/0!	-		Operating Income % - Capitation	36.4%	19.2%	-22.0%	-14.1%	19.4%	6.2%	-	#DIV/0!	-	-	#DIV/0!	-
16.8%	19.0%	12.3%	12.6%	17.8%	9.4%	2.6%	21.4%	0.0%	9.2%	21.2%	16.6%		Operating Income % - TOTAL	20.0%	18.6%	6.8%	3.8%	16.7%	3.0%	-43.9%	20.3%	-17.6%	8.2%	21.1%	14.3%
13.3%	19.0%	-3.2%	5.5%	17.8%	-6.6%	-12.4%	21.4%	-37.2%	5.4%	21.2%	8.3%		Normalized Operating Income % - TOTAL	13.1%	18.6%	-1.5%	-5.4%	16.7%	-6.6%	-64.8%	20.3%	-41.2%	4.0%	21.1%	9.6%
$ 329.42	$ 420.66	$ 195.89	$ 334.20	$ 330.07	$ 157.17	$ 40.81	$ 322.26	$ (0.58)	$ 231.38	$ 567.10	$ 299.65		Operating Income - Hospital per APD	$ 405.39	$ 333.06	$ 162.85	$ 202.78	$ 323.95	$ 17.21	$ (508.93)	$ 309.04	$ (240.45)	$ 207.83	$ 695.71	$ 303.88
$ 207.06	$ 420.66	$ (40.69)	$ 135.90	$ 330.07	$ (217.85)	$ (192.82)	$ 322.26	$ (538.34)	$ 134.23	$ 567.10	$ 149.50		Normalized Op Income - Hosp per APD	$ 262.01	$ 333.06	$ 9.47	$ (28.42)	$ 323.95	$ (225.47)	$ (751.99)	$ 309.04	$ (562.42)	$ 101.27	$ 695.71	$ 203.20
$ 367.73	$ 467.28	$ 233.66	$ 400.31	$ 380.06	$ 218.15	$ 86.00	$ 365.53	$ 72.50	$ 323.00	$ 660.58	$ 353.16		Operating Income - Total Hospital (Net of Cap)	$ 465.62	$ 372.16	$ 205.89	$ 324.16	$ 380.07	$ 107.52	$ (536.12)	$ 353.62	$ (160.94)	$ 363.61	$ 816.11	$ 371.79
#DIV/0!	$ -	$ 1.49	#DIV/0!	$ -	$ 3.59	$ -	$ -	$ -	$ -	$ -	$ -		Operating Income - Capitation PMPM	#DIV/0!	$ -	$ (12.93)	#DIV/0!	$ -	$ 2.83	$ -	$ -	$ -	$ -	$ -	$ -
$ 308.80	$ 429.28	$ 199.91	$ 168.94	$ 444.71	$ 117.25	$ 40.81	$ 322.26	$ (0.58)	$ 231.38	$ 567.10	$ 299.65		Operating Income - TOTAL per APD	$ 417.62	$ 340.28	$ 126.16	$ 104.41	$ 452.65	$ 84.63	$ (508.93)	$ 309.04	$ (240.45)	$ 207.83	$ 695.71	$ 303.88
													ASSET MANAGEMENT												
-		-	-		-								Net Days in A/R	-		-	-		-	-		-	-		-
$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -		Total Collections	$ -		$ -	$ -		$ -	$ -		$ -	$ -		$ -
$ 97		$ 5,665,748	$ -		$ 7,526,208	$ -		$ -	$ -		$ -		Discharged, Not Final Billed (DNFB)	$ -		$ 311,639	$ -		$ 3,484,751	$ -		$ -	$ -		$ -
-		3.46	-		8.69	-		-	-		-		DNFB Days	-		0.20	-		4.50	-		-	-		-
													Liquidity												

AVANTI DASHBOARD 2

QUALITY

YEAR-TO-DATE AVERAGE													CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST				MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
2.3%		2.6%	2.4%		2.0%	1.5%		0.6%	2.2%		2.2%	Inpatient Mortality	1.6%		2.0%	1.5%		2.0%	1.8%		0.9%	2.7%		2.6%
95.5%		80.5%	80.5%		98.8%	81.7%		0.0%	60.7%		0.0%	Appropriate Care Measures (Total)	97.2%		0.0%	100.0%		97.0%	100.0%		0.0%	0.0%		0.0%
85.1%		83.3%	81.5%		100.0%	83.3%		83.3%	76.4%		0.0%	AMI Perfect Patient Score (All/None)	85.7%		0.0%	100.0%		100.0%	100.0%		100.0%	100.0%		0.0%
91.9%		45.7%	79.5%		96.7%	83.3%		100.0%	59.5%		0.0%	CHF Perfect Patient Score (All/None)	88.9%		0.0%	100.0%		80.0%	100.0%		100.0%	0.0%		0.0%
97.9%		49.3%	81.3%		98.7%	83.3%		100.0%	78.8%		0.0%	Pneumonia Perfect Patient Score (All/None)	100.0%		0.0%	100.0%		100.0%	100.0%		100.0%	100.0%		0.0%
87.0%		48.3%	79.2%		98.5%	71.7%		100.0%	33.3%		0.0%	SCIP Perfect Patient Score (All/None)	100.0%		0.0%	100.0%		100.0%	100.0%		100.0%	0.0%		0.0%
100.0%		15.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	Outpatient SCIP Perfect Score	100.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%

PAY-FOR-PERFORMANCE

YEAR-TO-DATE AVERAGE													CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST				MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
56.7%		57.4%	66.4%		71.7%	63.3%		75.8%	61.0%		50.0%	HCAHPS Result	55.6%		59.0%	73.9%		88.0%	52.3%		70.0%	63.6%		52.0%
2.17		0.62	0.67		3.58	-		-	-		-	Hospital Acquired Ventilator Pneumonia Rate (per 1000 Vent Days)	-		-	-		-	-		-	-		-
0.28		0.87	2.03		3.78	0.13		-	0.67		0.83	Central Line Associated Blood Stream Infection Rate (per 1000 Device Days)	-		-	-		-	-		-	-		-
0.03		0.57	3.32		3.35	0.27		0.20	0.50		-	Catheter Associated UTI Rate	-		-	-		6.30	0.90		-	-		-
-		-	-		-	-		-	-		-	Other Sentinel Events / Reportable Events	-		-	-		-	-		-	-		-
-		-	-		-	-		-	-		-	Readmissions at 30 Days	-		-	-		-	-		-	-		-
0.14		1.83	1.04		1.93	1.35		3.91	-		2.70	Falls (per 1000 Patient Days)	-		0.45	-		0.72	-		3.50	-		4
-		0.07	-		-	-		1.24	-		0.12	Falls With Injuries (per 1000 Patient Days)	-		-	-		-	-		1.16	-		-

SERVICE EXCELLENCE

YEAR-TO-DATE AVERAGE													CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST				MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
76.6%		9.9%	67.4%		0.0%	54.0%		0.0%	0.0%		8.6%	Patient Satisfaction Score (Mean)	79.2%		59.4%	84.4%		0.0%	58.4%		0.0%	0.0%		51.7%
75.9%		76.4%	0.0%		0.0%	0.0%		0.0%	79.6%		78.2%	ED Patient Satisfaction	81.9%		78.5%	0.0%		0.0%	0.0%		0.0%	81.9%		77.5%
0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	Employee Satisfaction Score (Mean)	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%
9.8%		0.0%	3.1%		0.0%	5.8%		0.0%	7.2%		0.0%	1st Year Turnover Rate	13.9%		0.0%	3.3%		0.0%	11.0%		0.0%	3.9%		0.0%
4.3%		3.5%	7.6%		3.8%	7.2%		4.3%	2.8%		9.5%	Overall Turnover Rate	7.9%		6.6%	10.5%		8.9%	11.4%		7.0%	2.2%		17.2%
0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	Overall Retention Rate	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%
0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	Physician Satisfaction Score (Mean)	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%	0.0%		0.0%
-		1.5	1.7		1.3	1.3		2.0	3.3		3.3	New Applicants - Medical Staff	-		2	-		3	-		2	-		-
-		6.2	-		0.7	0.2		0.8	2.0		6.5	Resignations - Medical Staff	-		9	-		2	-		-	-		-

AVANTI DASHBOARD 2

MATERIALS AND FACILITY MANAGEMENT

YEAR-TO-DATE													CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST				MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
10.3x		9.8x	7.7x		7.4x	10.3x		5.5x	7.5x		5.5x	Facility Inventory Turns	8.7x		10.7x	7.x		7.7x	11.6x		13.4x	4.9x		5.x
$ 183.13	$ 234.44	$ 188.94	$ 171.76	$ 174.46	$ 197.71	$ 171.28	$ 149.27	$ 140.18	$ 343.42	$ 326.03	$ 265.82	Supply Expense per APD	$ 181.25	$ 188.33	$ 194.56	$ 183.22	$ 187.66	$ 238.78	$ 200.33	$ 150.04	$ 110.81	$ 245.50	$ 382.99	$ 298.51
7.9%	8.2%	9.3%	5.7%	6.0%	7.1%	6.6%	5.9%	8.4%	11.2%	11.8%	14.2%	Supply Expense (% of Net Revenue)	6.8%	8.2%	8.2%	5.8%	6.0%	7.4%	9.5%	5.9%	6.9%	8.0%	11.3%	13.6%
$ 673,807		$ 4,638,848	$ 489,001		$ 2,182,489	$ 256,939		$ 2,421,705	$ 275,746		$ 1,701,570	Capital Expenditures	$ 314,465		$ 487,065	$ 172,656		$ 315,423	$ 148,635		$ 483,197	$ 149,636		$ 227,502
												Capital Projects Completed												
												Capital Projects in Progress												

LEGAL

YEAR-TO-DATE													CURRENT MONTH - June											
MHG			ELADH			CHHP			COAST				MHG			ELADH			CHHP			COAST		
ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR		ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR	ACT	BUD	PRIOR
7			4			2			2			Open Suits	7			4			2			2		
18			5			4			2			Total Cases	7			4			2			2		
$ 785,235			$ 189,358			$ 205,878			$ 165,358			Legal Expense	$ 108,556			$ 35,399			$ 23,807			$ 10,586		

M&A / OPPORTUNITIES

Opportunities in Play - Hospitals

Downey; Mission; Pacific Health Corp; Pomona Valley; East Valley Medical Center

Other Opportunities to Discuss

Indian Opportunity; Clinics; Sub-Acute

Acuity Trend Report

MEMORIAL HOSPITAL OF GARDENA

	06-2013							05-2013							04-2013							03-2013						
	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count
Total:	334	16%	785	38%	936	46%	2055	296	14%	921	44%	877	42%	2094	309	14%	899	42%	958	44%	2166	460	19%	924	39%	1016	42%	2400
ADETOLA MD, ADEGBENGA A.	2	11%	10	56%	6	33%	**18**			1	10%	9	90%	**10**			87	83%	18	17%	**105**	5	2%	100	47%	106	50%	**211**
ALLEN MD, GWEN M.			5	100%			**5**			3	100%			**3**			2	100%			**2**							
BEVERLY, SHEREEN L.																						1	10%	9	90%			**10**
BURCOGLU-ORAL, ARSINUR	11	12%	37	41%	42	47%	**90**			12	46%	14	54%	**26**			1	33%	2	67%	**3**							
CEPEDA MD, PEDRO J.	3	60%			2	40%	**5**	2	22%	6	67%	1	11%	**9**														
CHANG MD, DUKE M.	9	8%	33	31%	65	61%	**107**	7	7%	58	61%	30	32%	**95**	13	14%	40	42%	42	44%	**95**	16	13%	55	45%	50	41%	**121**
CHEGOUNCHI, MARJAN	10	14%	28	39%	33	46%	**71**	38	20%	96	49%	60	31%	**194**	29	27%	47	44%	32	30%	**108**	60	33%	80	44%	43	23%	**183**
CLARK MD, STEVAN R.			1	100%			**1**			17	81%	4	19%	**21**			13	81%	3	19%	**16**			9	82%	2	18%	**11**
DEMIROZU, MEHMET C.					3	100%	**3**	8	62%			5	38%	**13**	9	75%	3	25%			**12**					3	100%	**3**
ESSILFIE MD, WILLIAM								15	75%	5	25%			**20**	4	80%	1	20%			**5**	16	67%	6	25%	2	8%	**24**
FOX MD, ARTHUR H.			15	68%	7	32%	**22**	3	18%	5	29%	9	53%	**17**			30	100%			**30**			13	87%	2	13%	**15**
GINSBURG MD, GREGORY T.										4	57%	3	43%	**7**			12	100%			**12**							
GOLBARI MD, ABRAHAM	10	7%	66	43%	76	50%	**152**	33	17%	100	51%	63	32%	**196**	30	12%	123	49%	97	39%	**250**	53	22%	82	34%	105	44%	**240**
HAKIMIAN, NAVID												3	100%	**3**			2	100%			**2**	2	11%	4	22%	12	67%	**18**
KHALEELI MD, HOSAYN			1	25%	3	75%	**4**			7	100%			**7**					10	100%	**10**	15	63%	3	13%	6	25%	**24**
KHALEELI MD, MOYEEN																			4	100%	**4**							
KUMAR MD, ASHOK	85	21%	103	26%	208	53%	**396**	38	13%	73	25%	178	62%	**289**	67	19%	59	17%	227	64%	**353**	96	28%	69	20%	180	52%	**345**
MCKILLOP MD, HAZEL	13	39%	9	27%	11	33%	**33**	2	4%	27	59%	17	37%	**46**	16	21%	13	17%	48	62%	**77**	31	60%	11	21%	10	19%	**52**
METRY, ADEL S.			2	22%	7	78%	**9**	5	8%	39	59%	22	33%	**66**	3	4%	8	11%	61	85%	**72**	2	12%			15	88%	**17**
MIRSAIDI MD, MANSOOR										9	100%			**9**			1	100%			**1**							
NOORIAN MD, BEHZAD H.	3	15%	4	20%	13	65%	**20**	1	8%	5	38%	7	54%	**13**	2	7%	13	43%	15	50%	**30**			9	56%	7	44%	**16**
NOSRATIAN MD, FARSHAD J.					3	100%	**3**								4	57%			3	43%	**7**							
PATEL, GNYANDEV	9	13%	27	39%	34	49%	**70**			3	100%			**3**														
PLUT MD, JOHN D.			10	100%			**10**			31	100%			**31**			4	100%			**4**			8	100%			**8**
SOUREHNISSANI MD, MEHRAN			56	55%	46	45%	**102**	5	3%	70	41%	95	56%	**170**	2	4%	15	31%	32	65%	**49**	6	5%	44	37%	70	58%	**120**
TABASSIAN MD, ZAHRA																												
TAMHANE, SHRIKANT K.	146	23%	256	40%	242	38%	**644**	110	18%	261	42%	245	40%	**616**	124	17%	325	43%	302	40%	**751**	133	17%	311	40%	331	43%	**775**
THOMPSON MD, GEORGE D.	1	6%	2	13%	13	81%	**16**	1	3%	17	47%	18	50%	**36**					10	100%	**10**	5	24%	16	76%			**21**
UDOH MD, NNAEMEKA			5	71%	2	29%	**7**			3	100%			**3**	6	18%	20	59%	8	24%	**34**			23	79%	6	21%	**29**
WALLACE MD, OKULEMI A.	29	12%	111	45%	109	44%	**249**	20	12%	60	35%	92	53%	**172**			76	66%	40	34%	**116**	18	14%	49	38%	61	48%	**128**

Acuity Trend Report

MEMORIAL HOSPITAL OF GARDENA

	02-2013							01-2013							YTD 2013						YTD 2012					
	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count	ICU	ICU %	MED	MED %	TELE	TELE %	Total Count	ICU	ICU %	MED	MED %	TELE	TELE %	ICU	ICU %	MED	MED %	TELE	TELE %
Total:	357	16%	871	40%	969	44%	2197	410	17%	980	41%	1002	42%	2392	2214	16%	5517	41%	5889	43%	2544	17%	5841	40%	6171	42%
ADETOLA MD, ADEGBENGA A.	6	4%	54	32%	109	64%	169	14	8%	74	44%	79	47%	167	27	4%	326	48%	327	48%	66	7%	429	46%	435	47%
ALLEN MD, GWEN M.			6	100%			6			8	100%			8			24	100%			1	2%	44	80%	10	18%
BEVERLY, SHEREEN L.										3	100%			3	1	8%	12	92%					11	100%		
BURCOGLU-ORAL, ARSINUR					6	100%	6								14	11%	50	38%	69	52%			16	89%	2	11%
CEPEDA MD, PEDRO J.										2	100%			2	8	42%	8	42%	3	16%			20	100%		
CHANG MD, DUKE M.	8	10%	35	44%	37	46%	80	9	10%	40	43%	43	47%	92	64	10%	273	44%	279	45%	123	17%	294	41%	305	42%
CHEGOUNCHI, MARJAN	37	26%	49	35%	55	39%	141			51	67%	25	33%	76	174	22%	356	45%	253	32%	64	10%	320	51%	246	39%
CLARK MD, STEVAN R.			1	8%	11	92%	12	20	63%	9	28%	3	9%	32	20	21%	52	54%	24	25%	6	5%	90	69%	34	26%
DEMIROZU, MEHMET C.										11	73%	4	27%	15	17	37%	14	30%	15	33%	22	33%	17	26%	27	41%
ESSILFIE MD, WILLIAM	11	52%	10	48%			21			5	100%			5	46	58%	31	39%	2	3%	5	10%	27	54%	18	36%
FOX MD, ARTHUR H.			28	90%	3	10%	31			11	41%	16	59%	27	3	2%	103	72%	37	26%			70	96%	3	4%
GINSBURG MD, GREGORY T.										3	100%			3			19	86%	3	14%			14	100%		
GOLBARI MD, ABRAHAM	48	22%	92	42%	77	35%	217	54	18%	120	39%	134	44%	308	228	16%	602	43%	573	41%	254	17%	621	41%	648	43%
HAKIMIAN, NAVID	1	6%			17	94%	18								3	7%	6	15%	32	78%	4	7%	30	51%	25	42%
KHALEELI MD, HOSAYN								1	20%	2	40%	2	40%	5	16	32%	13	26%	21	42%			6	50%	6	50%
KHALEELI MD, MOYEEN								11	92%	1	8%			12	11	69%	1	6%	4	25%	13	81%			3	19%
KUMAR MD, ASHOK	70	19%	110	31%	180	50%	360	65	16%	127	30%	225	54%	417	431	19%	563	25%	1230	55%	530	25%	539	25%	1067	50%
MCKILLOP MD, HAZEL	16	36%	11	25%	17	39%	44	17	25%	31	46%	20	29%	68	95	29%	104	32%	125	39%	242	29%	310	37%	280	34%
METRY, ADEL S.	5	19%	6	23%	15	58%	26	3	5%	28	46%	30	49%	61	18	7%	83	33%	150	60%	110	18%	154	25%	351	57%
MIRSAIDI MD, MANSOOR																	10	100%					6	86%	1	14%
NOORIAN MD, BEHZAD H.			6	24%	19	76%	25			9	38%	15	63%	24	6	5%	46	36%	76	59%	49	27%	51	28%	82	45%
NOSRATIAN MD, FARSHAD J.			3	43%	4	57%	7			2	100%			2	4	19%	6	29%	11	52%			11	48%	12	52%
PATEL, GNYANDEV															9	10%	42	46%	41	45%						
PLUT MD, JOHN D.			5	100%			5			5	100%			5			63	100%					63	93%	5	7%
SOUREHNISSANI MD, MEHRAN	20	14%	63	43%	64	44%	147	35	29%	25	20%	62	51%	122	68	10%	273	38%	369	52%	102	11%	367	39%	461	50%
TABASSIAN MD, ZAHRA										9	60%	6	40%	15			9	60%	6	40%			10	77%	3	23%
TAMHANE, SHRIKANT K.	95	14%	319	48%	248	37%	662	146	21%	347	49%	216	30%	709	776	18%	1861	44%	1616	38%	858	19%	1824	41%	1805	40%
THOMPSON MD, GEORGE D.	7	32%	12	55%	3	14%	22	9	82%	1	9%	1	9%	11	23	20%	48	41%	45	39%	26	37%	7	10%	38	54%
UDOH MD, NNAEMEKA										5	100%			5	6	8%	56	72%	16	21%			59	94%	4	6%
WALLACE MD, OKULEMI A.	33	18%	53	28%	102	54%	188	26	14%	42	23%	118	63%	186	131	12%	402	38%	533	50%	66	11%	273	47%	244	42%

MD Admitting Trend Report for MHG

Range 2011-07 to 2013-06

	2011					2012													2013								
	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04	05	06	Prior 12	Current 12	Difference
ADETOLA, ADEGBENGA	3	4	2	3	3	4	7	9	24	27	24	20	23	22	29	23	21	33	32	36	38	11	2	7	130	277	147
ALLEN, GWEN	17	20	16	13	19	11	19	17	20	18	22	17	19	24	31	32	25	15	26	17	22	15	18	12	209	256	47
AZIZ-ZADEH, NASSER	14	12	12	16	14	18	13	12	6	12	18	13	6	10	8	11	16	7	5	11	11	9	6	2	160	102	(58)
BALETTE,LILLY	29	29	20	16	20	29	22	22	16	18	19	22	22	26	27	35	30	14	26	23	21	20	26	16	262	286	24
BEVERLY, SHEREEN L.	8	4	3	6	4	9	3	10	2	3	1	7	6	10	5	8	8	4	6	2	6	7	1	4	60	67	7
BURCOGLU-ORAL, ARSINUR	0	3	2	2	6	1	2	0	0	0	0	1	0	1	0	0	3	0	0	1	0	2	6	17	17	30	13
CEPEDA, PEDRO	12	5	17	13	16	16	12	9	17	12	9	8	8	12	13	5	10	10	11	16	13	10	12	10	146	130	(16)
CHANG,DUKE	21	28	28	18	13	18	21	26	19	27	20	29	30	30	19	25	30	26	18	23	31	22	27	37	268	318	50
CHEGOUNCHI MARJAN	23	25	32	56	21	32	32	32	15	13	21	23	16	21	35	16	26	21	22	34	27	24	39	14	325	295	(30)
CLARK, STEVAN	4	3	5	3	6	2	6	2	8	2	1	4	5	4	4	3	2	1	4	0	2	4	5	1	46	35	(11)
DEMIROZU, MEHMET C.	2	1	0	0	0	1	0	0	0	0	0	0	0	0	3	5	0	0	2	0	1	6	5	1	4	23	19
ESSILFIE, WILLIAM	4	1	5	4	1	1	1	1	1	0	0	1	6	6	5	2	4	4	3	3	3	1	4	2	20	43	23
FORD, GARY	0	1	1	1	0	1	0	2	3	1	1	1	3	3	1	2	1	1	0	0	0	1	0	2	12	14	2
FOX, ARTHUR	7	8	2	5	4	2	3	2	4	6	3	3	2	4	3	4	4	3	6	3	5	9	2	6	49	51	2
GOLBARI, ABRAHAM	59	39	58	53	57	47	44	53	54	51	37	39	44	77	44	46	51	69	59	49	38	69	43	46	591	635	44
HAKIMIAN, NAVID	2	13	5	1	5	7	1	1	0	1	0	1	3	1	4	1	0	0	0	7	5	1	2	0	37	24	(13)
KHALEELI, HOSAYN	0	1	1	0	0	0	3	0	1	0	1	0	0	0	1	0	1	0	3	0	2	0	2	1	7	10	3
KOVACS, GEORGE	5	7	6	12	5	6	4	3	3	4	4	10	5	7	7	11	6	11	5	4	7	4	1	4	69	72	3
KUMAR, ASHOK	74	50	89	77	87	55	86	88	92	71	70	67	68	77	71	76	81	78	99	60	75	87	76	102	906	950	44
MCKILLOP, HAZEL	37	30	21	49	25	19	19	24	1	2	25	22	21	13	27	19	20	16	18	13	9	23	11	7	274	197	(77)
METRY, ADEL	4	10	4	3	6	10	2	12	26	16	18	20	14	26	14	9	13	14	11	3	4	16	8	3	131	135	4
MIRSAIDI, MANSOOR	13	23	20	18	19	17	12	18	17	9	15	15	12	15	10	17	17	8	13	11	11	10	8	9	196	141	(55)
MOOSSAZADEH, FARSHID	36	53	40	35	35	35	54	36	34	39	40	46	32	24	41	41	35	26	38	30	27	30	34	24	483	382	(101)
NOORIAN,BEHZAD	33	37	9	1	2	2	4	4	7	10	3	5	5	5	3	8	7	2	5	4	4	5	2	4	117	54	(63)
NOSRATIAN, FARSHAD	2	2	3	2	2	2	3	0	7	4	4	0	1	1	2	1	1	3	1	2	0	1	0	1	31	14	(17)
PATEL, GNYANDEV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	27	0	28	28
PLUT, JOHN	4	2	2	2	5	1	5	3	0	4	0	4	0	2	4	1	0	4	2	1	3	1	7	1	32	26	(6)
RAZI, DAVID	73	78	60	25	58	55	27	33	34	26	19	28	24	29	23	28	26	23	23	22	18	26	20	22	516	284	(232)
SEHDEVA, PARKASH	7	4	1	2	8	4	2	9	3	4	3	4	2	7	2	5	4	5	2	2	2	2	4	3	51	40	(11)
SHENOUDA,EMILE	19	31	19	34	34	19	33	13	21	20	25	32	24	28	30	31	23	16	31	11	13	14	18	25	300	264	(36)
SOUREHNISSANI, MEHRAN	7	16	10	10	32	9	27	36	46	46	31	36	51	31	35	32	35	33	34	29	31	11	50	33	306	405	99
TAMHANE, SHRIKANT	66	137	125	159	114	183	163	117	137	128	154	133	142	131	160	150	142	148	160	127	162	159	128	124	1616	1733	117
THOMPSON, GEORGE	4	3	2	5	7	6	8	4	2	2	2	4	6	2	4	1	4	7	3	5	5	3	6	2	49	48	(1)
UDOH, NNAEMEKA	2	3	3	0	2	1	3	2	1	2	3	5	3	2	2	2	6	1	2	0	4	6	0	2	27	30	3
VIDAL, MARTHA	30	24	31	24	31	31	27	23	21	21	22	39	31	42	28	31	25	21	23	25	17	35	26	26	324	330	6
WALLACE,OLUKEMI	7	0	2	14	15	2	4	18	41	32	19	14	7	2	15	17	17	12	23	20	20	15	22	21	168	191	23
WILLIAMS, JOHN	6	11	9	3	10	3	7	1	0	0	1	2	1	2	3	4	3	0	1	0	3	0	0	0	53	17	(36)
YOON, SAM	25	15	31	20	25	26	26	30	26	23	24	29	21	25	23	26	14	23	20	22	21	33	23	18	300	269	(31)

RDL: AdmittingTrendReportRev 20110404/EPICAZO

MHG-ED Patient Flow Matrix

	06-2012	07-2012	08-2012	09-2012	10-2012	11-2012	12-2012	01-2013	02-2013	03-2013	04-2013	05-2013	06-2013	YTD	
A. Patients														**Total**	**Average**
Days in the Month	**30**	**31**	**31**	**30**	**31**	**30**	**31**	**31**	**28**	**31**	**30**	**31**	**30**		
Total Patients	1794	2827	3015	2952	2870	2743	2872	3275	2717	2928	2721	2947	2705	36366	2797.4
Patients per Day (avg)	60	91	97	98	93	91	93	106	97	94	91	95	90		
Patients Admitted thru ED	280	430	451	473	426	429	453	481	408	460	470	439	454	5654	434.9
% Patients Admitted thru ED	15.6%	15.2%	15.0%	16.0%	14.8%	15.6%	15.8%	14.7%	15.0%	15.7%	17.3%	14.9%	16.8%		
Total Hospital Acute Admissions	507	677	723	739	726	713	662	726	614	665	693	651	640	8736	
% ED Admissions as % of Total Admits	55.2%	63.5%	62.4%	64.0%	58.7%	60.2%	68.4%	66.3%	66.4%	69.2%	67.8%	67.4%	70.9%	64.7%	
Patients Transferred	40	92	101	124	112	112	117	122	93	104	78	79	83	1257	142.8
B. Length of Stays (LOS) Goal=3 Hrs.															
Emergency Department LOS(hrs)	5.6	5.2	5.2	5.3	5.8	5.0	5.0	6.0	6.5	6.3	5.5	4.9	5.4	5.5	
C. Premature Patient Disposition															
Left Without Being Seen (LWBS)	150	195	175	172	209	104	120	337	228	316	155	158	142	2461	189.3
% LWBS (<2%)	8.4%	6.9%	5.8%	5.8%	7.3%	3.8%	4.2%	10.3%	8.4%	10.8%	5.7%	5.4%	5.2%	6.8%	
Against Medical Advice(AMA)	24	22	32	22	27	26	21	25	28	21	18	25	31	322	24.8
% AMA	1.3%	0.8%	1.1%	0.7%	0.9%	0.9%	0.7%	0.8%	1.0%	0.7%	0.7%	0.8%	1.1%	0.9%	
D. LAB Turnaround Time Goal=80%															
Basic Metabolic < 60 min								62.4%	63.2%	59.6%	70.8%	80.6%	84.6%		
CBC < 60 min								87.9%	86.1%	84.9%	89.3%	92.2%	93.2%		
Troponin < 60 min								64.5%	67.4%	61.7%	71.0%	77.4%	80.4%		
Urinalysis < 60 min								94.7%	95.0%	88.5%	92.7%	96.7%	98.6%		
E. Radiology % Meeting (Benchmark) Goal=80%															
Xray < 30 min (Order Time to Process Time)								67.1%	55.7%	57.2%	62.4%	67.6%	76.8%		
US < 60 min (Order Time to Process Time)								27.5%	37.2%	26.9%	37.1%	40.5%	40.7%		
CT < 60 min								76.0%	79.1%	73.0%	75.4%	92.5%	97.2%		
F. Door "To" Times															
Q-Reg to Triage -15 min	27.3	29.8	30.3	29.8	32.5	26.0	27.6	46.7	40.1	41.5	28.2	28.8	24.2	32.1	
Q-Reg to Bed - 30 min	46.6	45.4	40.5	43.3	49.1	29.6	33.3	66.0	59.2	57.6	42.2	38.5	36.5	45.3	
Q-Reg to RN - 30 min	66.9	65.7	57.3	68.2	73.8	54.7	50.7	95.3	91.2	89.6	67.5	56.2	58.1	68.8	
Q-Reg to MD - 45 min	82.9	83.9	79.5	81.7	84.1	69.6	65.9	96.8	90.9	88.0	71.8	68.9	74.2	80.0	
MD to Disposition	197.5	165.4	160.0	170.1	194.5	153.9	155.4	171.4	195.0	209.0	187.0	176.3	189.6	178.1	
Disposition to Depart	52.7	65.7	69.9	66.5	72.2	76.5	79.6	93.9	103.1	83.2	70.3	50.9	61.4	73.4	
G. Traffic & Staffing															
Diversion Hours - 0 Hrs										32.25	0	0	0	32.25	2.5
Total EMS	466	780	740	780	787	727	783	863	686	718	654	756	760	9500	730.8

MHG-ED_Daily Log (Full) For June

Date	ED Census	LWBS	%LWBS	MLK Admit	Admits	% of ED Census	ICU Admit	Medicare ICUAdmit	Medicare Non ICU Admits	Medicare Treated	% Medicare Pts Treated	Un Insured Admit	LOS	Eloped	AMA	Avanti Transfer	Other Hospitals	EMS	Hours on Sat.	AM Phys.	PM Phys.	Acute Census
01	86	1	1.2%	3	15	17%	3	1	2	7	43%	0	6.4	1	2	0	1	29	0	Tran/Dugard	Edalat/Ruggeri	153
02	87	4	4.6%	0	15	17%	2	0	3	7	43%	1	5.4	1	1	0	2	20	0	Furoy/Tsou	Lucas/Edalat	147
03	96	2	2.1%	1	15	16%	0	0	9	17	53%	0	5.1	1	1	0	2	23	0	Bei/Heil	Lucas/Ngaripin	146
04	88	7	8.0%	1	16	18%	1	0	2	9	22%	2	6.3	2	1	0	4	31	0	Shehu/Tran	Heil/Tsou	146
05	96	9	9.4%	3	16	17%	3	1	3	13	31%	2	6.5	2	2	0	4	26	0	Lucas/Lara	Nguyen/Bei	147
06	84	2	2.4%	1	16	19%	2	1	5	11	55%	1	5.0	1	0	0	0	22	0	Ruggeri/Young	Shehu/Bei	146
07	94	3	3.2%	1	12	13%	0	0	5	11	45%	2	4.6	3	1	0	4	22	0	Grant/Ruggeri	Lucas/Tsou	149
08	80	5	6.3%	3	13	16%	1	0	5	9	56%	0	5.1	1	0	0	1	23	0	Nguyen/Lau	Ngaripin/Sekhon	143
09	79	0	0.0%	2	16	20%	0	0	4	6	67%	2	4.8	0	2	0	5	32	0	Nguyen/Tsou	Sekhon/Tran	133
10	91	1	1.1%	3	17	19%	5	1	5	9	67%	1	4.4	2	0	0	5	32	0	Ruggeri/Dugard	Tran/Bei	133
11	74	2	2.7%	1	11	15%	2	1	1	6	33%	2	5.7	3	0	0	3	13	0	Tsou/Greenburg	Furoy/Sekhon	129
12	89	6	6.7%	2	14	16%	1	0	4	7	57%	0	7.8	2	2	0	1	16	0	Ruggeri/Lucas	Grant/Tran	132
13	107	12	11.2%	3	22	21%	5	3	6	17	53%	1	6.3	1	3	0	2	28	0	Sekhon/Bei	Shehu/Bei	138
14	91	1	1.1%	0	20	22%	4	1	4	12	42%	1	4.7	0	0	0	2	27	0	Tsou/Roberts	Lucas/Prince	144
15	70	1	1.4%	1	6	9%	1	0	2	7	29%	1	3.5	3	1	0	3	12	0	Bei/Ruggeri	Dugard/Ngaripin	128
16	73	1	1.4%	2	12	16%	4	0	1	1	100%	0	4.4	1	0	0	1	27	0	Bei/Edalat	Prince/Tran	131
17	89	4	4.5%	4	13	15%	3	2	2	8	50%	2	4.7	0	3	0	2	28	0	Lucas/Edalat	Ruggeri/Dugard	137
18	95	3	3.2%	0	16	17%	2	0	8	12	67%	0	5.1	2	0	0	4	24	0	Dugard/Sekhon	Bei/Tsou	138
19	92	5	5.4%	0	17	18%	1	0	6	12	50%	1	6.0	2	2	0	0	30	0	Prince/Sekhon	Ruggeri/Lucas	150
20	92	7	7.6%	0	18	20%	1	0	5	12	42%	2	6.6	1	0	0	4	30	0	Lucas/Ruggeri	Hatton/Dugard	154
21	111	8	7.2%	2	15	14%	0	0	5	10	50%	1	4.9	3	1	0	3	25	0	Furoy/Bei	Hatton/Nguyen	148
22	102	10	9.8%	4	15	15%	0	0	4	14	29%	4	6.8	0	0	0	5	27	0	Cervantes/Roberts	Nguyen/Prince	150
23	86	7	8.1%	1	9	10%	1	1	2	6	50%	2	5.0	0	2	0	0	24	0	Cervantes/Lara	Sekhon/Prince	149
24	101	12	11.9%	0	18	18%	3	0	5	8	63%	0	5.7	1	1	0	3	31	0	Prince/Furoy	Lau/Bei	144
25	104	7	6.7%	2	20	19%	1	0	4	8	50%	3	5.3	4	0	0	2	34	0	Dugard/Nguyen	Sekhon/Bei	145
26	99	9	9.1%	4	12	12%	1	0	4	7	57%	1	5.2	2	2	0	4	21	0	Prince/Lara	Ruggeri/Grant	149
27	78	2	2.6%	2	17	22%	1	1	5	11	55%	2	5.6	2	0	0	6	24	0	Cervantes/Greenburg	Ruggeri/Furoy	148
28	89	4	4.5%	1	22	25%	0	0	5	12	42%	2	5.5	0	1	0	2	26	0	Cervantes/Roberts	Greenburg/Furoy	148
29	96	6	6.3%	1	11	11%	3	1	3	12	33%	0	4.6	0	2	0	6	24	0	Tran/Tsou	Franklin/Bei	148
30	86	1	1.2%	1	15	17%	0	0	9	14	64%	0	4.4	2	1	0	2	29	0	Tran/Nguyen	Franklin/Bei	146
06-2013	**2705**	**142**	**5.2%**	**49**	**454**	**17%**	**51**	**14**	**128**	**295**	**48%**	**36**	**5.4**	**43**	**31**	**0**	**83**	**760**	**0**			**144**
06-13 Avg	**90**	**5**		**2**	**15**		**2**	**0**	**4**	**10**		**1**		**1**	**1**	**0**	**3**	**25**	**0.0**			
05-2013	**2864**	**152**	**5.3%**	**38**	**425**	**15%**	**38**	**10**	**132**	**291**	**49%**	**23**	**4.9**	**40**	**24**	**0**	**75**	**730**	**0**			**142**
05-13 Avg	**92**	**5**		**1**	**14**		**1**	**0**	**4**	**9**		**1**		**1**	**1**	**0**	**2**	**24**	**0.0**			
06-2012	**1794**	**150**	**8.4%**	**35**	**280**	**16%**	**29**	**16**	**90**	**222**	**48%**	**12**	**5.6**	**27**	**24**	**0**	**40**	**466**				**137**
06-12 Avg	**1**	**1**		**1**	**280**		**1**	**16**	**90**	**222**		**1**		**1**	**24**	**0**	**40**	**466**				

Inpatient Matrix 2013

Memorial Hospital of Gardena

SURGERIES	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
GI Cases	604	70	98	89	85	61	75	257	221	478
Inpatient	798	140	131	117	129	115	108	388	352	740
Outpatient	791	134	128	133	111	110	92	395	313	708
Total Surgeries	2193	344	357	339	325	286	275	1040	886	1926

ACUTE	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Patient Days	13702	2326	2100	2285	2059	2015	1972	6711	6046	12757
ADC	68.2	75.0	75.0	73.7	68.6	65.0	65.7	74.5	66.4	70.5
Admissions	3025	483	396	462	467	443	458	1341	1368	2709
Discharges	3063	500	414	468	495	425	456	1382	1376	2758
LOS	4.4	4.6	4.9	4.5	4.4	4.1	4.1	4.6	4.2	4.4
CMI	1.32	1.47	1.58	1.38	1.34	1.30	1.33	1.47	1.32	1.40

CHAMPUS	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	1		1	0	1	0	1	1	2	3
LOS	3.0		4.0		2.0		4.0	4.0	3.0	3.3

COMMERCIAL	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	153	17	17	31	21	22	21	65	64	129
LOS	3.5	3.5	3.5	4.7	4.8	3.3	2.5	4.0	3.6	3.8

MANAGED CARE	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	30	3	3	1	5	4	7	7	16	23
LOS	3.6	0.7	3.3	1.5	2.7	3.3	2.9	1.9	2.9	2.5

MEDI-CAL CAPITATION	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	122	32	23	23	17	1	4	78	22	100
LOS	3.0	3.1	3.0	4.2	1.6	2.0	3.0	3.4	2.0	3.2

MEDI-CAL MANAGED CARE	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	811	111	99	105	146	131	138	315	415	730
LOS	3.8	4.3	3.7	3.5	3.4	4.0	3.2	3.9	3.5	3.7

MEDI-CAL TRADITIONAL	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	356	52	46	47	53	54	54	145	161	306
LOS	5.7	5.3	7.7	6.0	8.9	6.4	8.5	6.3	8.0	7.1

MEDICARE	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	1013	188	140	170	150	132	143	498	425	923
LOS	5.0	5.5	5.8	5.3	4.8	4.1	4.5	5.5	4.5	5.0
GLOS	4.56	4.83	5.22	4.48	4.35	4.29	4.44	4.82	4.36	4.61
CMI	1.61	1.71	2.01	1.53	1.46	1.47	1.56	1.73	1.50	1.62
Outlier Days	731	129	108	130	88	120	110	367	319	685

MEDICARE MANAGED CARE	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	248	49	38	50	54	40	41	137	135	272
LOS	4.2	4.1	3.9	3.1	3.0	3.2	3.5	3.7	3.2	3.4
GLOS	4.12	3.83	4.14	3.84	3.65	3.96	4.05	3.92	3.86	3.89
CMI	1.38	1.28	1.37	1.26	1.17	1.30	1.31	1.30	1.25	1.27
Outlier Days	220	45	39	67	72	46	56	151	173	324

OTHER	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	97	14	14	8	17	14	14	36	45	81
LOS	3.4	3.7	2.4	2.6	3.0	2.3	2.0	3.0	2.4	2.7

SELF PAY	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	227	34	33	33	31	25	33	100	89	189
LOS	3.1	2.7	4.6	3.9	2.8	2.1	2.4	3.8	2.4	3.1

WORKERS COMPENSATION	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Discharges	5					2			2	2
LOS	5.2		3.0			3.0		3.0	3.0	3.0

Inpatient Matrix 2013

Memorial Hospital of Gardena

OB

	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Patient Days	**2201**	310	278	286	306	276	267	**874**	**849**	**1723**
ADC	**11.0**	10.0	9.9	9.2	10.2	8.9	8.9	**9.7**	**9.3**	**9.5**
Admissions	**850**	115	109	103	111	102	88	**327**	**301**	**628**
Discharges	**849**	111	105	118	114	101	101	**334**	**316**	**650**
LOS	**2.3**	2.1	2.4	2.7	1.7	2.2	1.5	**2.4**	**1.8**	**2.1**
CHAMPUS	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**2**	1						**1**		**1**
LOS	**1.2**	3.0						**3.0**	**0.0**	**1.5**
COMMERCIAL	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**31**	2	2	8	4	2	5	**12**	**11**	**23**
LOS	**1.6**	1.0	1.6	1.6	1.2	0.7	1.5	**1.5**	**1.2**	**1.3**
MANAGED CARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**6**	1	1	2		1	2	**4**	**3**	**7**
LOS	**1.9**	1.0	1.5	2.5		3.0	3.0	**1.7**	**3.0**	**2.1**
MEDI-CAL CAPITATION	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**79**	16	10	14	7	2		**40**	**9**	**49**
LOS	**2.0**	2.0	1.5	2.1	2.9	1.7		**1.9**	**2.4**	**2.0**
MEDI-CAL MANAGED CARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**326**	42	40	37	43	42	36	**119**	**121**	**240**
LOS	**1.3**	1.2	1.3	1.3	1.1	1.4	1.2	**1.3**	**1.2**	**1.2**
MEDI-CAL TRADITIONAL	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**363**	43	47	50	56	43	50	**140**	**149**	**289**
LOS	**3.7**	3.3	3.3	3.7	2.4	2.7	1.8	**3.5**	**2.3**	**2.9**
MEDICARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**5**	1		1		2	2	**2**	**4**	**6**
LOS	**2.1**	0.7		3.0		2.5	2.0	**1.3**	**1.8**	**1.6**
MEDICARE MANAGED CARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**1**			0			1	**0**	**1**	**1**
LOS	**6.0**			2.0			2.0	**2.0**	**1.0**	**1.3**
OTHER	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**1**	1		1		1		**2**	**1**	**3**
LOS	**0.7**	1.0		8.8		5.0		**4.1**	**5.0**	**4.2**
SELF PAY	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**35**	4	5	5	4	8	5	**14**	**17**	**31**
LOS	**1.4**	1.6	7.2	4.4	1.1	5.3	1.8	**4.0**	**2.8**	**3.4**

Inpatient Matrix 2013

Memorial Hospital of Gardena

SUBACUTE

	2012	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Q1-2013	Q2-2013	2013
Patient Days	**13266**	2107	1906	2104	2061	2090	2047	**6117**	**6198**	**12315**
ADC	**66.0**	68.0	68.1	67.9	68.7	67.4	68.2	**67.8**	**68.1**	**67.9**
Admissions	**98**	19	17	12	6	11	10	**48**	**27**	**75**
Discharges	**101**	16	17	11	6	13	7	**44**	**26**	**70**
MEDI-CAL CAPITATION	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**1**	0	0	1			1	**1**	**1**	**2**
LOS	**77.0**			34.0			161.0	**34.0**	**161.0**	**97.5**
MEDI-CAL MANAGED CARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**5**	0	2	1	1	1	2	**3**	**4**	**7**
LOS	**20.4**		63.0	46.0	45.0	134.0	44.0	**57.3**	**66.8**	**62.7**
MEDI-CAL TRADITIONAL	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**32**	5	4	6	2	6	1	**15**	**9**	**24**
LOS	**287.2**	230.2	231.0	76.0	61.5	89.0	87.0	**162.9**	**83.3**	**132.3**
MEDICARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**58**	10	11	3	3	5	3	**24**	**11**	**35**
LOS	**108.3**	359.0	102.0	32.3	75.3	77.0	42.7	**211.1**	**67.2**	**165.9**
GLOS	**10.63**	8.60	11.65	9.67	9.17	12.50	6.70	**10.00**	**10.01**	**10.01**
CMI	**4.49**	3.58	4.96	4.03	3.83	5.36	2.81	**4.21**	**4.25**	**4.22**
Outlier Days	**25**		2	5		6	1	**6**	**7**	**13**
MEDICARE MANAGED CARE	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**1**	1						**1**		**1**
LOS	**8.0**	120.0						**120.0**		**120.0**
GLOS	**12.60**	12.50						**12.50**		**12.50**
CMI	**5.29**	5.36						**5.36**		**5.36**
Outlier Days	**5**									
SELF PAY	**2012**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Q1-2013**	**Q2-2013**	**2013**
Discharges	**4**	0	0	0		1	0	**0**	**1**	**1**
LOS										

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. ALLEN MD, GWEN M.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	13	**2.51**	**0.76**	**2.92**	**5.40**	**16**	**2.53**	**0.77**	**2.38**	**0.00**	**16**	**2.51**	**0.72**	**2.25**	**0.00**	**23**	**2.52**	**0.75**	**2.61**	**2.00**	**17**	**2.45**	**0.72**	**2.59**	**2.40**	**25**	**2.53**	**0.80**	**2.48**	**0.00**	**266**	**2.45**	**0.73**	**2.67**	**60.10**
CHAMPUS																														1	2.10	0.58	2.00	0.00
COMMERCIAL	1	2.90	0.86	3.00	0.10											1	2.50	0.66	2.00	0.00										9	2.46	0.66	1.89	0.00
MEDI-CAL CAPITATION						1	2.90	0.86	3.00	0.10	1	3.80	1.22	3.00	0.00	5	2.92	0.99	2.80	0.00	4	2.40	0.67	3.25	3.40	7	2.61	0.90	2.57	0.00	50	2.52	0.82	2.84	16.20
MEDI-CAL MANAGED CARE	9	2.33	0.72	3.00	6.00	11	2.53	0.79	2.36	0.00	10	2.47	0.69	2.30	0.00	11	2.55	0.74	2.73	2.00	9	2.34	0.70	2.22	0.00	15	2.47	0.76	2.53	1.00	163	2.42	0.72	2.72	47.90
MEDI-CAL TRADITIONAL	3	2.90	0.86	2.67	0.00	4	2.43	0.68	2.25	0.00	5	2.34	0.69	2.00	0.00	6	2.15	0.60	2.33	1.10	4	2.73	0.81	2.75	0.10	2	2.50	0.72	1.50	0.00	41	2.44	0.70	2.49	1.90
SELF PAY																										1	2.90	0.86	3.00	0.10	2	2.85	0.82	2.50	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 11
Average Charge per Visit: 6

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. BALETTE, LILY C.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	20	**3.38**	**0.26**	**2.55**	**0.00**	**19**	**3.60**	**0.71**	**2.05**	**0.00**	**21**	**2.98**	**0.29**	**2.38**	**0.00**	**20**	**3.79**	**0.53**	**2.30**	**0.00**	**23**	**3.08**	**0.36**	**2.00**	**0.00**	**26**	**2.91**	**0.41**	**2.23**	**0.00**	**284**	**3.26**	**0.43**	**2.30**	**0.00**
COMMERCIAL																					1	3.40	1.23	3.00	0.00						3	3.17	0.70	2.33	0.00
MANAGED CARE	2	5.85	1.10	2.50	0.00											1	3.10	0.17	2.00	0.00						1	3.10	0.17	1.00	0.00	5	4.20	0.54	1.80	0.00
MEDI-CAL CAPITATION						1	3.10	0.17	3.00	0.00	4	3.10	0.17	2.75	0.00	3	3.20	0.52	2.67	0.00	3	3.10	0.17	2.67	0.00	5	3.10	0.17	2.80	0.00	28	3.28	0.39	2.71	0.00
MEDI-CAL MANAGED CARE	5	3.10	0.17	2.60	0.00	4	3.10	0.17	2.25	0.00	5	3.10	0.17	2.60	0.00	4	3.10	0.17	2.00	0.00	6	3.15	0.34	1.67	0.00	8	2.94	0.33	1.75	0.00	93	3.02	0.35	2.16	0.00
MEDI-CAL TRADITIONAL	12	3.10	0.17	2.50	0.00	14	3.78	0.90	1.93	0.00	11	2.86	0.41	2.09	0.00	12	4.23	0.68	2.33	0.00	12	3.02	0.37	2.00	0.00	12	2.80	0.59	2.42	0.00	146	3.36	0.46	2.32	0.00
SELF PAY	1	3.10	0.17	3.00	0.00						1	3.10	0.17	3.00	0.00						1	3.10	0.17	1.00	0.00						9	3.46	0.79	2.44	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 6
Average Charge per Visit: 8

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. BURCOGLU-ORAL, ARSINUR

	06-2013					05-2013					04-2013					02-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	15	**3.96**	**1.23**	**4.33**	**5.60**	**6**	**3.80**	**1.16**	**4.17**	**2.20**	**1**	**3.90**	**1.19**	**1.00**	**0.00**	**1**	**5.20**	**1.88**	**6.00**	**0.80**	**27**	**3.93**	**1.20**	**4.15**	**6.00**
MEDI-CAL CAPITATION	2	4.65	1.52	5.50	1.70																2	4.65	1.52	5.50	1.70
MEDI-CAL MANAGED CARE	5	3.20	0.95	3.00	0.00	2	3.10	0.81	3.50	0.80	1	3.90	1.19	1.00	0.00						9	3.31	0.93	3.22	0.00
MEDI-CAL TRADITIONAL						1	4.10	1.25	3.00	0.00											1	4.10	1.25	3.00	0.00
MEDICARE	8	4.26	1.32	4.88	4.90	3	4.17	1.36	5.00	2.50						1	5.20	1.88	6.00	0.80	13	4.28	1.37	5.00	9.30
MEDICARE MANAGED CARE																					1	2.80	0.74	2.00	0.00
SELF PAY																					1	4.30	1.19	2.00	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 26
Average Charge per Visit: 14

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. CHANG MD, DUKE M.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	27	**3.33**	**1.02**	**2.26**	**0.00**	**27**	**3.51**	**1.13**	**3.37**	**0.00**	**27**	**3.96**	**1.31**	**3.89**	**0.00**	**30**	**4.22**	**1.44**	**3.87**	**0.00**	**20**	**4.08**	**1.40**	**3.55**	**0.00**	**27**	**3.69**	**1.21**	**3.67**	**0.00**	**328**	**4.10**	**1.40**	**3.72**	**0.00**
COMMERCIAL	4	5.53	2.19	2.75	0.00	2	3.60	0.90	4.50	1.80						1	2.40	0.76	3.00	0.60	1	1.90	0.58	3.00	1.10	2	4.70	1.68	7.00	4.60	23	4.36	1.60	4.22	0.00
MANAGED CARE																					1	2.90	0.71	3.00	0.10						2	3.50	0.98	3.00	0.00
MEDI-CAL CAPITATION																															2	4.15	1.35	3.00	0.00
MEDI-CAL MANAGED CARE	6	3.15	0.87	2.50	0.00	8	3.19	1.04	4.13	7.50	9	3.26	0.88	2.78	0.00	2	8.85	3.46	8.00	0.00	5	5.40	2.00	3.60	0.00	5	2.72	0.77	3.40	3.40	73	3.83	1.24	3.95	8.10
MEDI-CAL TRADITIONAL	1	3.10	0.82	1.00	0.00	8	2.99	1.04	2.75	0.00	4	5.18	1.96	8.50	13.30	1	4.50	1.18	3.00	0.00	4	3.73	1.22	3.75	0.10	6	3.87	1.23	3.17	0.00	41	3.78	1.26	3.85	3.20
MEDICARE	11	2.92	0.81	2.55	0.00	6	4.53	1.49	3.33	0.00	10	4.42	1.59	4.10	0.00	20	3.89	1.30	3.85	0.00	5	4.38	1.56	3.80	0.00	9	4.40	1.57	4.00	0.00	117	4.63	1.66	4.12	0.00
MEDICARE MANAGED CARE											1	5.10	1.49	1.00	0.00	2	4.85	1.73	2.00	0.00	1	4.90	1.78	4.00	0.00	1	3.60	0.95	4.00	0.40	17	4.75	1.62	3.94	0.00
OTHER	2	3.20	0.88	1.50	0.00	1	4.80	1.53	3.00	0.00	1	4.20	1.10	2.00	0.00						2	2.30	0.66	1.50	0.00	1	2.00	0.55	3.00	1.00	20	3.63	1.14	2.10	0.00
SELF PAY	3	2.47	0.67	1.00	0.00	2	3.10	0.82	2.00	0.00	2	1.70	0.56	1.00	0.00	4	3.63	1.23	3.25	0.00	1	3.40	1.02	6.00	2.60	3	2.70	0.82	2.00	0.00	33	3.02	0.89	2.21	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 25
Average Charge per Visit: 22

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. CHEGOUNCHI, MARJAN

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	18	**4.68**	**1.71**	**6.83**	**38.80**	**34**	**3.96**	**1.26**	**4.38**	**14.40**	**23**	**4.21**	**1.51**	**6.43**	**51.20**	**29**	**4.40**	**1.53**	**5.52**	**32.50**	**25**	**4.07**	**1.41**	**3.60**	**0.00**	**20**	**3.05**	**0.83**	**3.75**	**14.00**	**306**	**3.83**	**1.26**	**4.43**	**183.10**
COMMERCIAL	1	5.90	1.98	1.00	0.00	3	3.30	1.18	1.33	0.00						2	7.55	3.22	18.50	21.90	2	4.60	1.70	3.50	0.00	1	1.70	0.56	2.00	0.30	24	3.84	1.33	3.96	2.90
MANAGED CARE	1	2.80	0.74	1.00	0.00											1	2.40	0.73	2.00	0.00						1	2.90	0.76	1.00	0.00	3	2.70	0.74	1.33	0.00
MEDI-CAL MANAGED CARE	4	2.73	0.76	4.00	5.10	7	3.97	1.20	5.43	10.20	4	2.10	0.65	1.50	0.00	5	3.36	0.93	4.40	5.20	1	2.20	0.56	1.00	0.00	4	3.00	0.75	3.00	0.00	52	3.43	1.09	3.87	22.50
MEDI-CAL TRADITIONAL	1	20.90	10.88	24.00	3.10	7	5.27	1.87	6.43	8.10	6	6.80	2.87	15.67	53.20	3	7.07	2.79	6.33	0.00	3	6.20	2.43	5.00	0.00	4	2.98	0.79	6.00	12.10	47	4.83	1.72	6.57	81.80
MEDICARE	6	2.90	0.78	3.83	5.60	6	3.77	1.20	3.50	0.00	4	3.75	1.21	3.00	0.00	15	4.31	1.48	5.00	10.40	10	4.03	1.29	3.90	0.00	9	3.42	0.95	3.89	4.20	107	3.87	1.27	4.21	35.60
MEDICARE MANAGED CARE	2	7.15	2.82	20.00	25.70	2	4.60	1.35	5.00	0.80																				15	4.37	1.41	6.87	37.50
OTHER	1	4.20	1.10	1.00	0.00	5	2.74	0.78	3.00	1.30	4	4.15	1.26	4.25	0.40	1	2.50	0.66	2.00	0.00	2	2.35	0.65	2.50	0.30						26	2.99	0.86	2.96	0.00
SELF PAY	2	3.90	1.32	8.50	9.20	4	3.63	1.04	4.00	1.50	5	3.20	1.01	3.80	3.00	2	2.45	0.71	1.50	0.00	7	3.83	1.38	3.29	0.00	1	1.70	0.56	1.00	0.00	32	3.39	1.06	3.63	7.60

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 24
Average Charge per Visit: 22

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. GOLBARI MD, ABRAHAM

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	46	**3.56**	**1.11**	**3.41**	**0.00**	**43**	**3.80**	**1.25**	**3.95**	**6.40**	**67**	**3.65**	**1.16**	**3.37**	**0.00**	**47**	**4.21**	**1.55**	**6.30**	**97.90**	**39**	**5.26**	**2.14**	**4.77**	**0.00**	**64**	**4.07**	**1.40**	**5.06**	**63.30**	**651**	**3.91**	**1.32**	**4.19**	**186.30**
CHAMPUS	1	3.10	0.82	4.00	0.90																1	2.90	0.71	4.00	1.10						3	3.00	0.74	3.67	2.00
COMMERCIAL	4	2.30	0.64	2.00	0.00	1	2.50	0.78	1.00	0.00	2	4.65	1.81	4.50	0.00	3	4.70	1.56	5.00	0.90										29	3.67	1.21	3.66	0.00
MANAGED CARE																1	3.80	1.00	3.00	0.00						1	3.80	1.00			7	3.33	1.01	2.14	0.00
MEDI-CAL CAPITATION											2	2.75	0.71	5.50	5.50	4	2.58	0.70	2.75	0.70	5	3.06	0.79	2.00	0.00	8	3.41	1.03	3.63	1.70	34	3.13	0.88	3.06	0.00
MEDI-CAL MANAGED CARE	10	3.48	1.04	4.90	14.20	20	3.93	1.28	4.55	12.50	18	2.98	0.88	1.83	0.00	9	3.20	1.15	4.00	7.20	11	4.02	1.40	3.64	0.00	20	5.08	2.01	7.85	55.40	196	3.57	1.18	4.08	99.80
MEDI-CAL TRADITIONAL	11	3.77	1.19	4.00	2.50	3	3.83	1.11	4.67	2.50	7	4.43	1.62	4.43	0.00	7	4.70	1.80	6.14	10.10	3	4.73	1.65	3.67	0.00	2	2.50	0.75	1.00	0.00	76	4.18	1.41	4.64	35.30
MEDICARE	14	3.99	1.34	3.36	0.00	14	4.07	1.41	3.71	0.00	25	4.03	1.29	4.44	10.20	14	4.17	1.55	6.79	36.60	16	7.48	3.48	7.38	0.00	22	3.91	1.20	4.45	12.00	223	4.41	1.57	4.67	57.00
MEDICARE MANAGED CARE	2	3.90	1.13	1.50	0.00	1	3.80	1.00	7.00	3.20	8	3.94	1.16	3.13	0.00	5	7.22	3.01	7.40	0.90						4	3.40	0.92	4.50	4.40	33	4.22	1.35	3.85	0.00
OTHER						1	2.60	0.76	1.00	0.00	3	2.77	0.74	1.33	0.00	1	2.40	0.70	4.00	1.60						2	2.80	0.85	2.00	0.00	14	2.98	0.86	2.71	0.00
SELF PAY	4	2.90	0.81	0.50	0.00	3	2.57	0.90	1.33	0.00	2	2.35	0.70	1.00	0.00	3	3.77	1.33	17.33	40.70	3	2.97	0.90	1.00	0.00	5	3.56	1.32	3.20	0.00	36	3.25	1.04	3.78	19.10

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 54
Average Charge per Visit: 26

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. KUMAR MD, ASHOK

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	92	**3.89**	**1.31**	**3.63**	**0.00**	**73**	**3.86**	**1.24**	**4.21**	**25.00**	**85**	**4.04**	**1.40**	**3.60**	**0.00**	**70**	**4.19**	**1.45**	**4.81**	**43.90**	**64**	**4.57**	**1.60**	**4.97**	**25.50**	**92**	**4.22**	**1.45**	**4.26**	**3.50**	**932**	**4.07**	**1.38**	**4.30**	**212.90**
COMMERCIAL	4	3.13	1.14	3.25	0.50	9	3.96	1.15	3.56	0.00	7	4.26	1.56	4.14	0.00	5	4.82	1.89	5.60	3.90	6	4.75	1.85	3.00	0.00	6	3.88	1.26	2.17	0.00	62	3.94	1.35	3.08	0.00
MANAGED CARE	3	3.33	1.03	3.33	0.00	1	2.20	0.74	1.00	0.00	3	2.97	0.86	1.67	0.00						1	2.90	0.71	2.00	0.00	1	2.50	0.70	1.00	0.00	18	2.96	0.87	2.94	0.00
MEDI-CAL CAPITATION																														1	1.80	0.51	2.00	0.20
MEDI-CAL MANAGED CARE	16	2.88	0.81	2.69	0.00	9	3.31	1.00	2.44	0.00	13	3.12	0.85	2.46	0.00	7	2.81	0.89	2.43	0.00	11	3.60	1.04	3.09	0.00	10	4.11	1.47	3.50	0.00	124	3.25	0.97	3.47	26.80
MEDI-CAL TRADITIONAL	6	3.53	0.98	4.50	5.80	8	4.51	1.62	10.88	50.90	7	8.14	3.71	10.29	15.00	3	5.77	2.39	19.00	39.70	5	5.78	2.35	12.20	32.10	8	4.79	1.94	5.13	2.70	81	4.82	1.79	7.16	189.40
MEDICARE	31	4.73	1.76	4.74	0.40	19	3.79	1.18	4.11	6.00	16	3.68	1.20	3.75	1.20	24	5.38	1.98	5.88	12.00	17	5.55	2.07	5.82	4.70	34	5.10	1.83	5.41	10.70	296	4.66	1.64	5.07	120.20
MEDICARE MANAGED CARE	30	3.84	1.23	2.73	0.00	23	4.20	1.38	3.43	0.00	33	3.71	1.22	2.82	0.00	29	3.35	1.02	2.97	0.00	20	4.22	1.39	4.45	4.70	28	3.43	1.03	3.61	5.10	302	3.90	1.28	3.56	0.00
OTHER	1	3.80	1.00	6.00	2.20	1	3.10	0.88	2.00	0.00	1	2.70	0.69	3.00	0.30						1	2.60	0.76			1	2.10	0.68	3.00	0.90	12	2.73	0.78	2.75	0.20
SELF PAY	1	2.60	1.39	6.00	3.40	3	2.23	0.81	2.00	0.00	5	4.70	1.68	2.40	0.00	2	2.90	1.01	4.00	2.20	2	3.25	0.88	6.00	5.50	4	3.00	0.82	3.50	2.00	35	3.05	0.97	3.97	32.30
WORKERS COMPENSATION																					1	4.90	1.80	3.00	0.00						1	4.90	1.80	3.00	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 131
Average Charge per Visit: 33

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. MOOSSAZADEH MD, FARSHID

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	28	**2.75**	**0.82**	**2.96**	**5.90**	**31**	**2.55**	**0.75**	**3.00**	**14.00**	**27**	**2.61**	**0.76**	**3.11**	**13.50**	**29**	**2.52**	**0.77**	**3.10**	**16.90**	**33**	**2.58**	**0.76**	**2.88**	**9.70**	**33**	**2.58**	**0.75**	**2.97**	**12.90**	**414**	**2.57**	**0.75**	**2.90**	**137.40**
COMMERCIAL	1	3.80	1.22	3.00	0.00	1	2.10	0.58	2.00	0.00						2	2.30	0.91	3.00	1.40	1	2.90	0.86	4.00	1.10						12	2.43	0.76	2.75	3.90
MANAGED CARE	1	2.10	0.58	3.00	0.90	1	3.80	1.22	3.00	0.00																				3	2.67	0.77	3.00	1.00
MEDI-CAL CAPITATION											2	2.50	0.72	3.00	1.00	2	2.10	0.58	2.50	0.80	2	2.30	0.91	3.00	1.40	4	2.60	0.74	3.25	2.60	31	2.67	0.78	3.00	10.20
MEDI-CAL MANAGED CARE	10	2.85	0.85	3.10	2.50	16	2.51	0.75	3.00	7.80	9	2.64	0.77	3.33	6.20	7	2.59	0.82	2.86	1.90	10	2.64	0.77	3.00	3.60	11	2.55	0.74	2.73	2.00	142	2.59	0.76	2.87	38.60
MEDI-CAL TRADITIONAL	15	2.59	0.76	2.87	4.10	12	2.50	0.72	3.08	7.00	16	2.61	0.76	3.00	6.30	17	2.61	0.75	3.24	10.70	19	2.59	0.75	2.84	4.70	17	2.58	0.75	3.06	8.20	217	2.55	0.73	2.93	82.30
OTHER																1	1.90	0.88	4.00	2.10										1	1.90	0.88	4.00	2.10
SELF PAY	1	3.80	1.22	3.00	0.00	1	2.90	0.86	3.00	0.10											1	2.10	0.58	1.00	0.00	1	2.90	0.86	3.00	0.10	8	2.46	0.76	2.38	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 10
Average Charge per Visit: 4

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. PATEL, GNYANDEV

	06-2013					05-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	26	**3.72**	**1.19**	**1.85**	**0.00**	**1**	**3.70**	**1.02**	**3.00**	**0.00**	**27**	**3.72**	**1.19**	**1.89**	**0.00**
COMMERCIAL	1	5.10	2.29								1	5.10	2.29		0.00
MEDI-CAL MANAGED CARE	7	5.01	1.76	2.29	0.00						7	5.01	1.76	2.29	0.00
MEDI-CAL TRADITIONAL	2	4.05	1.39	4.00	0.00						2	4.05	1.39	4.00	0.00
MEDICARE	5	3.64	1.12	1.80	0.00	1	3.70	1.02	3.00	0.00	6	3.65	1.10	2.00	0.00
MEDICARE MANAGED CARE	1	4.30	1.19	5.00	0.70						1	4.30	1.19	5.00	0.70
OTHER	4	2.50	0.65	1.25	0.00						4	2.50	0.65	1.25	0.00
SELF PAY	6	2.67	0.71	0.83	0.00						6	2.67	0.71	0.83	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 1
Average Charge per Visit: 7

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. RAZI, DAVID F.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	22	**3.30**	**0.36**	**2.18**	**0.00**	**20**	**3.10**	**0.17**	**2.50**	**0.00**	**26**	**3.26**	**0.29**	**2.58**	**0.00**	**33**	**3.25**	**0.36**	**2.30**	**0.00**	**7**	**3.10**	**0.17**	**2.86**	**0.00**	**25**	**3.33**	**0.28**	**2.60**	**0.00**	**311**	**3.21**	**0.28**	**2.34**	**0.00**
COMMERCIAL	1	3.10	0.17	3.00	0.00											1	3.10	0.17	1.00	0.00	1	3.10	0.17	3.00	0.00						7	3.10	0.17	2.00	0.00
MANAGED CARE																														2	3.10	0.17	2.50	0.00
MEDI-CAL CAPITATION											1	3.10	0.17	2.00	0.00	6	3.10	0.17	2.00	0.00						3	3.10	0.17	2.67	0.00	30	3.10	0.17	2.23	0.00
MEDI-CAL MANAGED CARE	12	3.02	0.37	1.92	0.00	6	3.10	0.17	2.17	0.00	13	3.10	0.17	2.54	0.00	9	3.13	0.28	2.56	0.00	2	3.10	0.17	2.50	0.00	8	3.10	0.17	2.63	0.00	118	3.18	0.25	2.25	0.00
MEDI-CAL TRADITIONAL	9	3.71	0.38	2.44	0.00	13	3.10	0.17	2.62	0.00	12	3.45	0.43	2.67	0.00	17	3.38	0.48	2.35	0.00	4	3.10	0.17	3.00	0.00	12	3.58	0.41	2.50	0.00	149	3.27	0.32	2.44	0.00
SELF PAY						1	3.10	0.17	3.00	0.00																2	3.10	0.17	3.00	0.00	5	2.84	0.43	2.60	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 7
Average Charge per Visit: 8

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. SHENOUDA, EMILE G.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	28	**3.02**	**0.30**	**2.32**	**0.00**	**18**	**3.35**	**0.40**	**2.28**	**0.00**	**13**	**3.10**	**0.17**	**2.46**	**0.00**	**10**	**3.10**	**0.17**	**2.30**	**0.00**	**20**	**3.07**	**0.34**	**2.50**	**0.00**	**23**	**2.99**	**0.28**	**2.00**	**0.00**	**292**	**3.09**	**0.33**	**2.21**	**0.00**
COMMERCIAL						1	3.10	0.17	2.00	0.00						1	3.10	0.17	2.00	0.00										11	3.10	0.17	1.82	0.00
MANAGED CARE																														2	3.10	0.17	2.00	0.00
MEDI-CAL CAPITATION						1	3.10	0.17	2.00	0.00											1	3.10	0.17	2.00	0.00	4	2.78	0.50	1.75	0.00	24	3.02	0.37	2.33	0.00
MEDI-CAL MANAGED CARE	12	2.91	0.48	2.00	0.00	9	3.60	0.64	2.22	0.00	6	3.10	0.17	2.33	0.00	3	3.10	0.17	2.00	0.00	8	2.94	0.33	2.50	0.00	12	2.99	0.28	1.92	0.00	121	3.10	0.38	2.15	0.00
MEDI-CAL TRADITIONAL	15	3.10	0.17	2.53	0.00	7	3.10	0.17	2.43	0.00	6	3.10	0.17	2.50	0.00	6	3.10	0.17	2.50	0.00	11	3.15	0.36	2.55	0.00	7	3.10	0.17	2.29	0.00	130	3.10	0.30	2.26	0.00
SELF PAY	1	3.10	0.17	3.00	0.00						1	3.10	0.17	3.00	0.00																4	3.10	0.17	2.50	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 5
Average Charge per Visit: 7

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. SOUREHNISSANI MD, MEHRAN

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	38	**3.02**	**0.86**	**3.39**	**14.40**	**49**	**3.08**	**0.88**	**2.98**	**0.00**	**9**	**3.47**	**1.07**	**6.89**	**30.80**	**33**	**2.91**	**0.88**	**3.39**	**16.10**	**33**	**3.68**	**1.22**	**4.36**	**22.70**	**31**	**3.63**	**1.20**	**4.87**	**38.50**	**433**	**3.28**	**1.00**	**3.58**	**128.50**
COMMERCIAL	2	2.75	0.78	3.50	1.50	3	2.23	0.68	1.33	0.00						3	2.90	1.11	4.67	5.30	1	4.40	1.08	4.00	0.00	2	3.45	0.91	3.00	0.00	24	2.98	0.91	3.58	14.50
MANAGED CARE																					1	2.80	0.74	7.00	4.20						2	6.00	2.23	9.50	7.00
MEDI-CAL CAPITATION											1	2.80	0.69	1.00	0.00	1	3.20	0.68	6.00	2.80	5	2.98	0.88	3.00	0.10	4	2.53	0.71	1.75	0.00	30	2.97	0.88	3.53	17.00
MEDI-CAL MANAGED CARE	23	2.90	0.81	3.00	2.40	23	3.05	0.85	3.39	7.90	8	3.55	1.11	7.63	32.60	18	3.07	0.92	3.50	7.80	15	3.93	1.24	4.13	3.00	16	3.23	0.96	4.00	12.30	240	3.29	0.99	3.44	34.60
MEDI-CAL TRADITIONAL	1	3.90	1.00	2.00	0.00	3	2.97	0.78	2.33	0.00						4	2.63	0.73	2.75	0.50	1	2.20	0.56	2.00	0.00						22	3.18	0.89	3.18	0.00
MEDICARE	5	3.50	1.14	2.60	0.00	10	3.73	1.07	4.20	4.70						2	2.90	1.01	3.00	0.20	5	4.30	1.85	5.20	4.50	5	6.24	2.71	12.80	32.80	56	3.79	1.28	4.27	26.80
MEDICARE MANAGED CARE	1	4.90	1.59	6.00	1.10	5	2.72	0.86	1.60	0.00						2	2.55	0.75	3.00	0.90	1	3.10	0.82	3.00	0.00	3	2.90	0.83	2.67	0.00	24	3.25	0.95	2.96	0.00
OTHER	1	2.10	0.43	2.00	0.00	3	3.57	1.06	1.00	0.00											1	4.30	1.56	4.00	0.00						6	3.67	1.16	2.67	0.00
SELF PAY	5	2.82	0.73	6.00	15.90	2	1.85	0.56	2.00	0.30						3	2.47	0.68	2.00	0.00	3	3.03	1.09	7.00	11.90	1	3.90	1.00	2.00	0.00	29	2.63	0.74	4.07	41.70

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 21
Average Charge per Visit: 17

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. TAMHANE, SHRIKANT K.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	117	**4.39**	**1.58**	**5.32**	**108.20**	**123**	**4.17**	**1.47**	**3.98**	**0.00**	**175**	**4.26**	**1.48**	**4.70**	**77.30**	**147**	**4.15**	**1.37**	**3.61**	**0.00**	**132**	**4.18**	**1.43**	**4.71**	**69.70**	**150**	**4.74**	**1.70**	**4.73**	**0.00**	**1771**	**4.26**	**1.47**	**4.46**	**357.00**
CHAMPUS											1	3.80	0.98	2.00	0.00																1	3.80	0.98	2.00	0.00
COMMERCIAL	3	2.03	0.60	1.00	0.00	4	5.65	2.16	6.50	3.40	5	3.20	1.23	6.60	17.00	6	3.72	1.05	2.67	0.00	6	3.63	1.11	3.17	0.00	4	4.18	1.47	4.50	1.30	56	3.96	1.35	4.05	5.30
MANAGED CARE	1	2.00	0.70	2.00	0.00						2	3.55	1.13	5.00	2.90	1	4.30	1.41													10	2.75	0.83	2.60	0.00
MEDI-CAL CAPITATION	1	2.00	0.62	1.00	0.00	1	4.80	2.31	2.00	0.00	5	3.44	1.02	1.60	0.00	11	3.52	1.02	2.36	0.00	10	3.73	1.15	3.40	0.00	7	5.43	2.12	3.86	0.00	88	3.64	1.16	2.58	0.00
MEDI-CAL MANAGED CARE	41	3.53	1.12	3.05	0.00	40	3.18	1.02	3.88	27.90	62	3.68	1.29	3.79	6.60	38	3.59	1.10	2.84	0.00	32	3.45	1.13	3.44	0.00	38	3.39	1.04	2.76	0.00	502	3.52	1.11	3.48	0.00
MEDI-CAL TRADITIONAL	22	6.07	2.59	12.32	137.40	18	6.05	2.48	6.22	3.10	25	4.78	1.82	6.24	36.60	20	5.03	1.97	5.10	1.40	26	3.93	1.25	5.54	41.90	28	5.26	2.09	6.11	23.70	295	4.88	1.81	6.26	408.80
MEDICARE	36	5.08	1.85	5.28	7.30	45	4.42	1.53	3.64	0.00	66	4.89	1.67	4.97	5.00	57	4.55	1.53	4.39	0.00	46	4.71	1.67	5.37	30.40	58	5.42	1.99	5.86	25.60	648	4.86	1.72	4.97	73.70
MEDICARE MANAGED CARE	3	4.10	1.34	3.67	0.00	7	3.84	1.31	2.71	0.00	3	3.77	1.27	10.00	18.70	7	3.66	1.07	2.57	0.00	5	4.90	1.75	4.60	0.00	5	5.42	1.99	2.80	0.00	49	4.40	1.49	4.82	20.60
OTHER	3	3.10	0.91	2.67	0.00	1	3.10	0.82	2.00	0.00	3	3.17	1.03	3.67	1.50						1	3.80	1.00	3.00	0.00	5	4.10	1.23	4.80	3.50	32	3.43	1.04	4.34	29.40
SELF PAY	7	3.01	0.73	1.57	0.00	7	2.91	0.76	1.43	0.00	3	3.00	0.99	3.00	0.00	7	3.24	0.99	1.43	0.00	6	5.98	2.59	7.00	6.10	5	3.72	1.03	2.20	0.00	88	3.35	1.07	2.51	0.00
WORKERS COMPENSATION																														2	3.30	1.47	7.50	8.40

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 188
Average Charge per Visit: 30

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. VIDAL MD, MARTHA G.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	29	**2.79**	**0.84**	**3.07**	**8.20**	**22**	**2.56**	**0.76**	**2.91**	**7.60**	**35**	**2.65**	**0.77**	**2.74**	**3.20**	**21**	**2.67**	**0.78**	**2.86**	**4.00**	**21**	**2.61**	**0.78**	**3.05**	**9.10**	**24**	**2.55**	**0.76**	**2.67**	**2.90**	**355**	**2.56**	**0.75**	**2.74**	**63.80**
COMMERCIAL																					1	2.90	0.86	4.00	1.10	1	2.60	0.79	2.00	0.00	6	2.72	0.83	2.33	0.00
MEDI-CAL CAPITATION																										1	2.10	0.58	2.00	0.00	2	2.10	0.55	3.00	1.80
MEDI-CAL MANAGED CARE	1	3.80	1.22	7.00	3.20	1	2.90	0.86	3.00	0.10	2	2.90	0.86	3.00	0.20						3	1.93	0.60	2.33	1.20	1	1.60	0.65	1.00	0.00	21	2.36	0.73	2.62	5.40
MEDI-CAL TRADITIONAL	28	2.75	0.82	2.93	5.00	20	2.60	0.76	2.90	6.10	33	2.64	0.77	2.73	3.00	21	2.67	0.78	2.86	4.00	17	2.72	0.81	3.12	6.80	20	2.64	0.78	2.75	2.30	319	2.58	0.75	2.75	55.30
SELF PAY						1	1.60	0.65	3.00	1.40																1	2.10	0.58	4.00	1.90	7	2.34	0.80	2.86	3.60

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 16
Average Charge per Visit: 5

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. WALLACE MD, OKULEMI A.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	26	**4.49**	**1.49**	**8.31**	**99.30**	**12**	**4.22**	**1.29**	**6.25**	**24.40**	**18**	**3.62**	**1.01**	**6.33**	**48.90**	**17**	**4.75**	**1.60**	**7.88**	**53.30**	**19**	**7.11**	**3.15**	**12.21**	**97.00**	**18**	**6.18**	**2.29**	**8.28**	**37.70**	**190**	**4.65**	**1.60**	**7.61**	**562.20**
COMMERCIAL	1	4.50	1.18	6.00	1.50																									2	3.95	1.10	5.00	2.10
MEDI-CAL MANAGED CARE	10	3.80	1.17	6.30	25.00	4	4.00	1.09	7.25	13.00	5	2.66	0.72	6.80	20.70	5	3.56	1.14	6.60	15.20	1	3.40	1.02	5.00	1.60	2	16.70	8.12	19.00	4.60	54	4.05	1.34	6.98	158.30
MEDI-CAL TRADITIONAL	5	4.08	1.17	12.00	39.60	3	4.30	1.23	5.33	3.10	3	4.27	1.23	8.67	13.20	3	7.20	2.91	9.33	6.40	5	12.44	6.61	26.60	70.80	6	4.37	1.24	6.00	9.80	40	5.39	2.04	10.58	207.50
MEDICARE	9	5.57	2.11	9.33	33.90	5	4.34	1.49	6.00	8.30	9	4.06	1.14	5.89	16.50	9	4.59	1.43	8.11	31.70	13	5.34	1.98	7.23	24.60	10	5.17	1.75	7.50	23.30	88	4.71	1.59	6.84	187.30
MEDICARE MANAGED CARE	1	3.70	0.92	3.00	0.00						1	2.50	0.70	1.00	0.00															6	4.50	1.43	5.67	7.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 27
Average Charge per Visit: 21

Memorial Hospital of Gardena

PHYSICIAN REPORT CARD

For Dr. YOON MD, SAM H.

	06-2013					05-2013					04-2013					03-2013					02-2013					01-2013					Rolling YTD				
	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier	# Pt	GMLOS	CMI	Actual LOS	Outlier
	16	**2.79**	**0.57**	**1.75**	**0.00**	**23**	**3.06**	**0.27**	**2.30**	**0.00**	**33**	**2.99**	**0.32**	**2.27**	**0.00**	**21**	**3.08**	**0.38**	**2.38**	**0.00**	**22**	**2.86**	**0.41**	**2.27**	**0.00**	**20**	**2.99**	**0.35**	**2.15**	**0.00**	**296**	**3.07**	**0.36**	**2.23**	**0.00**
CHAMPUS																										1	1.80	1.50			2	2.45	0.83	1.50	0.00
COMMERCIAL	3	2.67	0.61	1.67	0.00						2	3.10	0.17	2.50	0.00															11	3.36	0.58	2.00	0.00
MANAGED CARE						1	3.10	0.17	3.00	0.00																				1	3.10	0.17	3.00	0.00
MEDI-CAL CAPITATION											1	3.10	0.17	1.00	0.00						2	3.10	0.17	1.50	0.00	2	3.10	0.17	2.50	0.00	21	3.04	0.23	2.33	0.00
MEDI-CAL MANAGED CARE	2	2.45	0.84	1.00	0.00	13	3.02	0.35	2.08	0.00	8	3.10	0.17	2.75	0.00	12	3.04	0.46	2.25	0.00	9	2.67	0.61	2.11	0.00	7	3.14	0.32	2.29	0.00	112	3.08	0.39	2.22	0.00
MEDI-CAL TRADITIONAL	10	2.87	0.54	1.80	0.00	9	3.10	0.17	2.56	0.00	22	2.94	0.40	2.14	0.00	9	3.13	0.28	2.56	0.00	11	2.98	0.29	2.55	0.00	10	2.97	0.30	2.20	0.00	145	3.06	0.35	2.25	0.00
SELF PAY	1	3.10	0.17	3.00	0.00																									4	3.10	0.17	2.00	0.00

MHG-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**636**	**3.64**	**1.12**	**3.77**	**81.30**
MEDICARE	**144**	**4.46**	**1.57**	**4.63**	**23.80**

Hospitalist-Report Card 06-2013 to 06-2013

	# Pt	GMLOS	CMI	A-LOS	Outlier
MHG	**348**	**3.91**	**1.32**	**4.19**	**95.80**
MEDICARE	**108**	**4.34**	**1.52**	**4.30**	**(4.90)**

Utilization Resources

Average Charge per Day: 4
Average Charge per Visit: 7

Medical Denial Rate

Memorial Hospital of Gardena - Performance Scorecard for June 2013

Production: July 31, 2013

Indicator	Comparison Source	Expected	Apr	May	Jun	YTD	Previous Year
Volume Indicators							
Adjusted Patient Days	Budget		2,357	2,291	2,226	14,433	62,210
	Budget - Monthly & YTD		2,278	2,249	2,201	14,097	
Average LOS (Acute)	Budget		3.86	4.36	4.01	4.29	7.17
	Budget - Monthly & YTD		3.85	4.01	3.43	3.95	
Acute Medicare GLOS	Budget		4.35	4.29	4.44	4.89	4.90
	Budget - Monthly & YTD						
Acute Medicare Case Mix Index	Budget		1.56	1.61	1.66	1.79	1.72
	Budget - Monthly & YTD		1.54	1.49	1.6	1.78	
MediCal Denial Rate	Budget	5%	4.00%	DNA	DNA	4.71%	
	Budget - Monthly & YTD						
Patient Experience							
Pt Satisfaction Score (Mean Score)	Press Ganey	80.5%	72.9	77.4	79.2	75.8	78.5
HCAHPS Score (Top Box Rate Hospital)	Press Ganey	63.0%	60.0%	65.5%	55.6%	57.7%	58.0%
ED Patient Satisfaction	Press Ganey	79.0%	76.7	83.9	81.9	74.3	74.9
Clinical Performance							
Inpatient Mortality Rate	Paragon	3.0%	2.0%	1.7%	1.6%	2.8%	3.0%
Readmission Rate (not risk adjusted)			4.7%	DNA	DNA	DNA	
Appropriate Care Measures (Total)	Truven	90.0%	97.7%	95.5%	97.2%	94.4%	91.0%
AMI Perfect Care Score	Truven	90.0%	83.3%	75.0%	85.7%	86.7%	87.0%
CHF Perfect Care Score	Truven	90.0%	100%	91.7%	88.9%	90.7%	92.0%
Pneumonia Perfect Care Score	Truven	90.0%	100%	100%	100%	98.6%	89.0%
SCIP Perfect Care Score	Truven	90.0%	100%	90%	100%	93.1%	93.0%
Stroke Perfect Care Score	Truven	90.0%	50%	60%	NEC	45.5%	
VTE Perfect Care Score	Truven	90.0%	100%	50%	60.0%	80.8%	
Outpatient SCIP Care Score	Truven	90.0%	100%	100%	100%	100.0%	83.0%
Outpt ED Perfect Care Score	Truven	90.0%	0.0%	0.0%	5.3%	1.9%	
Outpt Pain Mgmt Perfect Care Score	Truven	90.0%	NEC	NEC	NEC	NEC	
Outpt Chest Pain Perfect Care Score	Truven	90.0%	NEC	NEC	NEC	100.0%	
Outpt Stroke Perfect Care Score	Truven	90.0%	NEC	NEC	NEC	NEC	
Hospital Acquired Ventilator PN Rate (per/1000 vent days) - Poss & Prob	NHSN	0.00	0.0	0.0		3.8	0.80
Central Line Associated Blood Stream Infection Rate (per 1000 device days)	NHSN	0.00	0.0	0.2		0.7	0.40
Catheter Associated UTI rate	NHSN	0.00	0.2	0.0		0.3	0.90
Financial Performance							
Pre-Tax Income	Budget		$ (148,280)	$ 1,991,546	$ 1,096,436	$ 5,710,168	$ 5,710,168
	Budget - Monthly & YTD		$ 897,000	$ 1,032,000	$ 888,000	$ 5,881,000	
Medical Record Delinquency Rate	TJC	50.0%	54.0%	54.0%	47.0%	55.0%	40.0%
Workforce							
1st Year Turnover (Annualized)	Internal	22.0%	11.6%	11.9%	13.9%	28.1%	16.7%
Overall Turnover (annualized)	Internal	17.0%	5.5%	6.1%	7.9%	15.8%	14.1%
Contract Labor FTE's	Budget		29.51	27.14	26.21	25.22	29.4
	Budget - Monthly & YTD		19	28	26	15.33	
Worked FTE's per Occupied bed	Budget	3.36	3.5	3.48	3.56	3.44	4.28
Community Benefit							
Saturation (Diversion) Hours (ED)	Internal	*	0	0	0	90.25	125
Left Without Being Seen (ED)	Internal	2.0%	5.7%	5.4%	5.2%	7.0%	6.2%

NEC - No Eligible Cases
DNA - Data Not Available

Purpose of Short-Term Acute Care
Program for Evaluating Payment Patterns Electronic Report

Visit PEPPERresources.org

050468 MEMORIAL HOSPITAL OF GARDENA

Data Report Through Q2 FY 2013

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data for Medicare diagnosis-related groups (DRGs) and discharges at high risk for improper payments.

Please refer to the **Short-Term Acute Care PEPPER User's Guide** at **PEPPERresources.org** for guidance using the report. If you need assistance, please contact TMF by visiting **PEPPERresources.org** and clicking on the “Help/Contact Us” tab.

This is ST PEPPER version Q2FY13
Jurisdiction: J 1 Palmetto GBA (01001)

PEPPER was developed by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS).

TMF Health Quality Institute

Definitions for ST PEPPER Target Areas

ST Target Area	ST Target Area Definition
Stroke ICH	N*: count of discharges for DRGs 061 (acute ischemic stroke with use of thrombolytic agent with MCC), 062 (acute ischemic stroke with use of thrombolytic agent with CC), 063 (acute ischemic stroke with use of thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC) D*: count of discharges for DRGs 061, 062, or 063, 064, 065, 066, 067 (nonspecific CVA and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069 (transient ischemia)
Resp Inf	N: count of discharges for DRGs 177 (respiratory infections and inflammations with MCC), 178 (respiratory infections and inflammations with CC) D: count of discharges for DRGs 177, 178, 179 (respiratory infections and inflammations w/o CC/MCC), 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC), 195 (simple pneumonia and pleurisy without CC/MCC)
Simp Pne	N: count of discharges for DRGs 193, 194 D: count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC), 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC), 193, 194, 195
Septicemia	N: count of discharges for DRGs 870 (septicemia or severe sepsis with mechanical ventilation 96+ hours), 871 (septicemia or severe sepsis without mechanical ventilation 96+ hours with MCC), 872 (septicemia or severe sepsis without mechanical ventilation 96+ hours without MCC) D: count of discharges for DRGs 689 (kidney & urinary tract infections with MCC), 690 (kidney & urinary tract infections without MCC), 870, 871, 872
Unrel OR Px	N: count of discharges for DRGs 981 (extensive OR procedure unrelated to principal diagnosis with MCC), 982 (extensive OR procedure unrelated to principal diagnosis with CC), 983 (extensive OR procedure unrelated to principal diagnosis without CC/MCC), 987 (non-extensive OR procedure unrelated to principal diagnosis with MCC), 988 (non-extensive OR procedure unrelated to principal diagnosis with CC), 989 (non-extensive OR procedure unrelated to principal diagnosis without CC/MCC) D: count of all discharges for surgical DRGs
Med CC MCC **(Note: see ST PEPPER User's Guide Appendix 1 for listing of Medical DRGs included in this target area)**	N: count of discharges from medical DRGs in groups 1, 2 or 3** with a CC or MCC D: count of discharges from medical DRGs in groups 1, 2 or 3
Surg CC MCC **(Note: see ST PEPPER User's Guide Appendix 2 for listing of Surgical DRGs included in this target area)**	N: count of discharges from surgical DRGs in groups 1, 2 or 3 with a CC or MCC, excluding discharges from DRGs 005 (liver transplant with MCC or intestinal implant), 023 (craniotomy with major device implant/acute complex CNS principal diagnosis with MCC or chemo implant), 029 (spinal procedures with CC or spinal neurostimulators), 041 (peripheral/cranial nerve and other nervous system procedure with CC or peripheral neurostimulator), 129 (major head and neck procedures with CC/MCC or major device), 237 (major cardiovascular procedures with MCC or thoracic aortic aneurysm repair), 246 (percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents), 248 (percutaneous cardiovascular procedure with non-drug-eluting stent with MCC or 4+ vessels/stents), 490 (back and neck procedures except spinal fusion with CC/MCC or disc device/neurostimulator) (note: these DRGs are structured such that they may be assigned on the basis of a procedure being performed). D: count of all discharges for surgical DRGs with or without CC/MCC, excluding discharges for DRGs 005, 023, 029, 041, 129, 237, 246, 248, 490

Source: Medicare PPS Inpatient Hospital Discharge Data

Definitions for ST PEPPER Target Areas

ST Target Area	ST Target Area Definition
Single CC or MCC *(New target area as of Q1FY13)*	N: count of discharges with one CC or MCC coded on the claim D: count of discharges with one or more CCs or MCCs coded on the claim
Excis Deb	N: count of discharges for 43 DRGs (46 DRGs prior to FY 2012) affected by procedure code 86.22 that have procedure code 86.22 coded on the claim D: count of discharges for the 43 (46 DRGs prior to FY 2012) DRGs (see Appendix 3)
Vent Sup	N: count of discharges for DRGs 003 (ECMO or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth and neck with major OR procedure), 004 (tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth and neck without major OR procedure), 207 (respiratory system diagnosis with ventilator support 96+ hours), 870 (septicemia or severe sepsis with mechanical ventilation 96+ hours), 927 (extensive burns or full thickness burns with mechanical ventilation 96+ hours with skin graft), 933 (extensive burns or full thickness burns with mechanical ventilation 96+ hours without skin graft), with procedure code 96.72 (ventilator support 96+ hours) on the claim D: count of discharges for DRGs 003, 004, 207, 208 (respiratory system diagnosis with ventilator support < 96 hours), 870, 871 (septicemia or severe sepsis without mechanical ventilation 96+ hours with MCC), 872 (septicemia or severe sepsis without mechanical ventilation 96+ hours without MCC), 927, 928 (full thickness burns with skin graft or inhalation injury with CC or MCC), 929 (full thickness burns with skin graft or inhalation injury without CC or MCC), 933, 934 (full thickness burn without skin graft or inhalation injury)
TIA	N: count of discharges for DRG 069 (transient ischemia) D: count of discharges for DRGs 061 (acute ischemic stroke with use of thrombolytic agent with MCC), 062 (acute ischemic stroke with use of thrombolytic agent with CC), 063 (acute ischemic stroke with use of thrombolytic agent without CC/MCC), 064 (intracranial hemorrhage or cerebral infarction with MCC), 065 (intracranial hemorrhage or cerebral infarction with CC), 066 (intracranial hemorrhage or cerebral infarction without CC/MCC), 067 (nonspecific CVA and precerebral occlusion without infarct with MCC), 068 (nonspecific CVA and precerebral occlusion without infarct without MCC), 069
COPD	N: count of discharges for DRGs 190 (chronic obstructive pulmonary disease with MCC) 191 (chronic obstructive pulmonary disease with CC), 192 (chronic obstructive pulmonary disease without CC/MCC) D: count of all discharges for medical DRGs in MDC 04 (respiratory system) (DRGs 175 through 208)
PTCA	N: count of discharges for DRGs 246 (percutaneous cardiovascular procedure with drug eluting stent with MCC or 4+ vessels/stents), 247 (percutaneous cardiovascular procedure with drug eluting stent without MCC), 248 (percutaneous cardiovascular procedure with non-drug eluting stent with MCC or 4+ vessels/stents), 249 (percutaneous cardiovascular procedure with non-drug eluting stent without MCC) D: count of discharges for DRGs 246, 247, 248, 249 plus outpatient claims with CPT code 92980 (transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) or with HCPCS code G0290 (transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel)
Syncope	N: count of discharges for DRG 312 (syncope and collapse) D: count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)
Circ Sys Dx	N: count of discharges for DRGs 314 (other circulatory system diagnoses with MCC), 315 (other circulatory system diagnoses with CC), 316 (other circulatory system diagnoses without CC/MCC) D: count of discharges for medical DRGs in MDC 05 (circulatory system) (DRGs 280 through 316)

Source: Medicare PPS Inpatient Hospital Discharge Data

Definitions for ST PEPPER Target Areas

ST Target Area	ST Target Area Definition
Dig Sys Dx	N: count of discharges for DRGs 393 (other digestive system diagnoses with MCC), 394 (other digestive system diagnoses with CC), 395 (other digestive system diagnoses without CC/MCC) D: count of discharges for medical DRGs in MDC 06 (digestive system) (DRGs 368 through 395)
Med Back	N: count of discharges for DRGs 551 (medical back problems with MCC), 552 (medical back problems without MCC) D: count of all discharges for medical DRGs in Major Diagnostic Category (MDC) 08 (Musculoskeletal System and Connective Tissue) (DRGs 533 through 566)
Spinal Fusion	N: count of discharges that have any of the following spinal fusion procedure codes on the claim: 81.00, 81.01, 81.02, 81.03, 81.04, 81.05, 81.06, 81.07, 81.08 D: count of discharges that have any of the following procedure codes on the claim: 03.01 through 03.29, 03.32 through 03.79, 03.93, 03.94, 03.97 through 03.99, 80.50, 80.51, 80.53 through 80.59, 81.00 through 81.08, 81.30 through 81.39, 81.65, 81.66, 84.59, 84.60 through 84.69, 84.80, 84.82, 84.84, (see Appendix 4 in the Short-Term Acute Care Hospital PEPPER User's Guide at PEPPERresources.org for complete listing and description of numerator and denominator procedure codes)
3-Day SNF	N: count of discharges to a SNF with a three-day length of stay D: count of all discharges to a SNF (identified by patient discharge status code of 03 (discharged or transferred to a SNF) or 61 (discharged or transferred to a swing bed))
Readm	N: count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital or to another short-term acute care PPS hospital for the same beneficiary (identified using the Health Insurance Claim number); patient discharge status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care); principal diagnosis code of the second admission (readmission) does not begin with “V57.” For Maryland claims only: exclude claims if the second admission has a psychiatric principal discharge diagnosis code (ICD-9-CM codes 290-319), and if the index admission has a patient discharge status code of 65 (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital), and if the readmission occurred during the same day as or the day following the index admission discharge. D: count of all discharges excluding patient discharge status 20
Readm Same	N: count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the same hospital for the same beneficiary (identified using the Health Insurance Claim number); patient discharge status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care); principal diagnosis code of the second admission (readmission) does not begin with “V57.” For Maryland claims only: exclude claims if the second admission has a psychiatric principal discharge diagnosis code (ICD-9-CM codes 290-319) and if the index admission has a patient discharge status code of 65 (discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) and if the readmission occurred during the same day as or the day following the index admission discharge. D: count of all discharges excluding patient discharge status 20
2DS Vasc Px	N: count of discharges for DRGs 252 (other vascular procedures with MCC), 253 (other vascular procedures with CC), 254 (other vascular procedures without CC/MCC) with a LOS of less than or equal to 2 days, excluding patient discharge status codes 02, 20, 07 D: count of discharges for DRGs 252, 253, 254
2DS HF	N: count of discharges for DRGs 291 (heart failure and shock with MCC) , 292 (heart failure and shock with CC), 293 (heart failure and shock without CC/MCC) with a LOS of less than or equal to 2 days, excluding patient discharge status codes 02, 20, 07 D: count of discharges for DRGs 291, 292, 293

Source: Medicare PPS Inpatient Hospital Discharge Data

Definitions for ST PEPPER Target Areas

ST Target Area	ST Target Area Definition
2DS Card Arrhy	N: count of discharges for DRGs 308 (cardiac arrhythmia and conduction disorders with MCC), 309 (cardiac arrhythmia and conduction disorders with CC), 310 (cardiac arrhythmia and conduction disorders without CC/MCC) with a LOS of less than or equal to 2 days, excluding patient discharge status codes 02, 20, 07 D: count of discharges for DRGs 308, 309, 310
2DS Eso Gastro	N: count of discharges for DRGs 391 (esophagitis, gastroenteritis, and miscellaneous digestive disorders with MCC), 392 (esophagitis, gastroenteritis, and miscellaneous digestive disorders without MCC) with a LOS of less than or equal to 2 days, excluding patient discharge status codes 02, 20, 07 D: count of discharges for DRGs 391, 392
2DS Nutri Meta	N: count of discharges for DRGs 640 (nutritional and miscellaneous metabolic disorders with MCC) and 641 (nutritional and miscellaneous metabolic disorders without MCC) with a LOS of less than or equal to 2 days, excluding patient status codes 02, 20, 07 D: count of discharges for DRGs 640, 641
2DS Renal Fail	N: count of discharges for DRGs 682 (renal failure with MCC), 683 (renal failure with CC), 684 (renal failure without CC/MCC) with a LOS of less than or equal to 2 days, excluding patient discharge status codes 02, 20, 07 D: count of discharges for DRGs 682, 683, 684
2DS Kidney UTI	N: count of discharges for DRGs 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC) with a LOS of less than or equal to 2 days, excluding patient status codes 02, 20, 07 D: count of discharges for DRGs 689, 690
1DS Excl Trans	N: count of discharges with length of stay less than or equal to one day excluding patient discharge status of 02, 07 or 20 and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours D: count of all discharges excluding patient discharge status 02
1DS Med DRGs	N: count of discharges for medical DRGs with length of stay less than or equal to one day excluding patient discharge status of 02, 07 or 20 and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours D: count of all discharges for medical DRGs
1DS CP Athero	N: count of discharges for DRGs 302 (atherosclerosis with MCC), 303 (atherosclerosis without MCC), 313 (chest pain) with length of stay less than or equal to one day excluding patient discharge status of 02, 07, or 20, and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours D: count of discharges for DRGs 302, 303, 313

*N = Numerator, D = Denominator
**In the MS-DRGs, there are three "groups" of DRGs with CCs and/or major CCs (MCCs). These are as follows:
Group 1: MS-DRGs broken out into three tiers: with MCC, with CC, without CC or MCC
Group 2: MS-DRGs broken out into two tiers: with MCC, without MCC
Group 3: MS-DRGs are broken out into two tiers: with CC or MCC, without CC or MCC

Short-Term Acute Care PEPPER
Compare Targets Report of Q2 FY 2013 Data
050468 - MEMORIAL HOSPITAL OF GARDENA

Visit PEPPERresources.org

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospital's target area percent compares to the target area percents for all hospitals in the respective comparison group. For example, if a hospital's jurisdiction percentile (see below) is 80.0, 80% of the hospitals in the Medicare Administrative Contractor (MAC)/Fiscal Intermediary (FI) comparison group have a lower percent value than that hospital. The hospital's state percentile (if displayed) and the hospital national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for coding-focused target areas indicate that the hospital may be at a higher risk for improper Medicare payments (outlier status). The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Number of Target Dischs	Percent	Hospital Jurisdict. %ile	Hospital State %ile*	Hospital National %ile	Sum of Payments
Simple Pneumonia	Proportion of discharges with DRG equal to 193 (simple pneumonia & pleurisy w/ MCC), 194 (simple pneumonia & pleurisy w/ CC), to discharges with DRG equal to 190 (chronic obstructive pulmonary disease w/ MCC), 191 (chronic obstructive pulmonary disease w/ CC), 192 (chronic obstructive pulmonary disease w/o CC/MCC), 193, 194, 195 (simple pneumonia & pleurisy w/o CC/MCC)	**19**	*33.3%*	**11.8**	**11.7**	**15.8**	**$227,409**
Septicemia	Proportion of discharges with DRG equal to 870 (septicemia or severe sepsis w/ mechanical ventilation 96+ hours), 871 (septicemia or severe sepsis w/o mechanical ventilation 96+ hours with MCC), 872 (septicemia or severe sepsis w/o mechanical ventilation 96+ hours w/o MCC), to discharges with DRG equal to 689 (kidney & urinary tract infections w/ MCC), 690 (kidney & urinary tract infections w/o MCC), 870, 871, 872	**64**	**74.4%**	**29.5**	**28.1**	**56.5**	**$1,650,265**
Medical DRGs with CC or MCC	Proportion of discharges of Medical DRGs with complication or comorbidity (CC) or major CC (MCC), to discharges of Medical DRGs with or without CC or MCC	**260**	**70.3%**	**59.7**	**57.5**	**79.5**	**$3,504,332**
Surgical DRGs with CC or MCC	Proportion of discharges of Surgical DRGs with complication or comorbidity (CC) or major CC (MCC), to discharges of Surgical DRGs with or without CC or MCC	**30**	**88.2%**	**97.6**	**97.3**	**99.6**	**$852,485**
Single CC or MCC	Proportion of discharges with one CC or MCC coded on the claim, to discharges with one or more CCs or MCCs coded on the claim	**93**	**24.9%**	**32.4**	**34.4**	**11.3**	**$951,975**

* State %tile is not reported when there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target discharges.

Source: Medicare PPS Inpatient Discharge Data

PEPPER

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Target	Description	Number of Target Dischs	Percent	Hospital Jurisdict. %ile	Hospital State %ile*	Hospital National %ile	Sum of Payments
Ventilator Support	Proportion of discharges with DRG equal to 003 (ECMO or trach w/ mech vent 96+ hrs or pdx exc face, mouth & neck w/ major OR), 004 (trach w/ mech vent 96+ hrs or pdx exc face, mouth & neck w/o major OR), 207 (respir syst dx w/ vent support 96+ hrs), 870 (septicemia or severe sepsis w/ mech vent 96+ hrs), 927 (extensive burns or full thickness burns w/ mech vent 96+ hrs w/ skin graft), 933 (extensive burns or full thickness burns w/ mech vent 96+ hrs w/o skin graft) with procedure code 96.72 (vent support 96+ hours) on the claim, to discharges with DRG equal to 003, 004, 207, 208 (respir syst dx w/ vent support < 96 hrs), 870, 871 (septicemia or severe sepsis w/o mech vent 96+ hrs w/ MCC), 872 (septicemia or severe sepsis w/o mech vent 96+ hrs w/o MCC), 927, 928 (full thickness burns w/ skin graft or inhal inj w/ CC or MCC), 929 (full thickness burns w/ skin graft or inhal inj w/o CC/MCC), 933, 934 (full thickness burn w/o skin graft or inhal inj)	**24**	**29.3%**	**83.9**	**85.6**	**83.0**	**$1,692,565**
Chronic Obstructive Pulmonary Disease	Proportion of discharges with DRG equal to 190 (chronic obstructive pulmonary disease w/ MCC), 191 (chronic obstructive pulmonary disease w/ CC), 192 (chronic obstructive pulmonary disease w/o CC/MCC), to discharges for medical DRGs in MDC 04 (DRGs 175 through 208)	**33**	**34.4%**	**77.1**	**76.8**	**71.1**	**$319,427**
Three-day Skilled Nursing Facility-qualifying Admissions	Proportion of discharges with patient discharge status code of 03 (transfer to SNF) or 61 (transfer to swing bed) and length of stay equal to three days, to all discharges with transfer to SNF or swing bed	**24**	**19.0%**	**38.9**	**38.5**	**43.5**	**$227,051**

* State %tile is not reported when there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target discharges.

Source: Medicare PPS Inpatient Discharge Data

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Compare Targets Report of Q2 FY 2013 Data
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The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospital's target area percent compares to the target area percents for all hospitals in the respective comparison group. For example, if a hospital's jurisdiction percentile (see below) is 80.0, 80% of the hospitals in the Medicare Administrative Contractor (MAC)/Fiscal Intermediary (FI) comparison group have a lower percent value than that hospital. The hospital's state percentile (if displayed) and the hospital national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for coding-focused target areas indicate that the hospital may be at a higher risk for improper Medicare payments (outlier status). The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Number of Target Dischs	Percent	Hospital Jurisdict. %ile	Hospital State %ile*	Hospital National %ile	Sum of Payments
30-Day Readmissions to Same Hospital or Elsewhere	Proportion of index (first) admissions for which a readmission occurred within 30 days to the same hospital or elsewhere with the same Health Insurance Claim (HIC) number and patient discharge status code of the index admission is not equal to 02 (transfer to another short-term general hospital) and the patient was not readmitted for rehabilitation and the patient was not readmitted for psychiatric care (MD claims only), to all discharges excluding patient status code 20 (expired)	**100**	**22.3%**	**86.8**	**85.4**	**92.9**	**$1,392,626**
30-Day Readmissions to Same Hospital	Proportion of index (first) admissions for which a readmission occurred within 30 days to the same hospital with the same Health Insurance Claim (HIC) number and patient discharge status code of the index admission is not equal to 02 (transfer to another short-term general hospital) and the patient was not readmitted for rehabilitation and the patient was not readmitted for psychiatric care (MD claims only), to all discharges excluding patient status code 20 (expired)	**52**	**11.6%**	**42.0**	**40.1**	**35.1**	**$698,588**
One-day Stays Excluding Transfers	Proportion of discharges with length of stay less than or equal to one day excluding patient discharge status code of 02 (transfer to another short-term general hospital), 07 (left against medical advice), or 20 (expired), and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours, to all discharges excluding patient status 02	**16**	**3.5%**	**6.9**	**7.8**	**2.5**	**$108,938**

* State %tile is not reported when there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target discharges.

Source: Medicare PPS Inpatient Discharge Data

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The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospital's target area percent compares to the target area percents for all hospitals in the respective comparison group. For example, if a hospital's jurisdiction percentile (see below) is 80.0, 80% of the hospitals in the Medicare Administrative Contractor (MAC)/Fiscal Intermediary (FI) comparison group have a lower percent value than that hospital. The hospital's state percentile (if displayed) and the hospital national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for coding-focused target areas indicate that the hospital may be at a higher risk for improper Medicare payments (outlier status). The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Number of Target Dischs	Percent	Hospital Jurisdict. %ile	Hospital State %ile*	Hospital National %ile	Sum of Payments
One-day Stays for Medical DRGs	Proportion of discharges for medical DRGs with length of stay less than or equal to one day excluding patient discharge status code of 02 (transfer to another short-term general hospital), 07 (left against medical advice), or 20 (expired), and excluding one-day stays that have prior observation (revenue code 760 or 762) of greater than 24 hours, to all discharges for medical MS-DRGs	**16**	**3.8%**	**8.3**	**8.9**	**4.4**	**$108,938**

* State %tile is not reported when there are fewer than 11 hospitals in the jurisdiction's state or when there are no hospitals with at least 11 target discharges.

Source: Medicare PPS Inpatient Discharge Data

National High Outlier Ranking Report

050468, MEMORIAL HOSPITAL OF GARDENA

The National High Outlier Ranking report provides a comparison to all other short-term acute care hospitals in the nation. Your hospital's national percentile is used to determine high outlier status. All the quarters for which your hospital is at or above the national 80th percentile are added up for all the target areas. The hospital with the greatest total number of high outliers is assigned a rank of '1.' The hospital with the second greatest number is assigned a rank of '2' and so on. See the table below for your hospital's details.

Ranking: 340 out of a total of 3,465

Target Area	Q3 FY 2010	Q4 FY 2010	Q1 FY 2011	Q2 FY 2011	Q3 FY 2011	Q4 FY 2011	Q1 FY 2012	Q2 FY 2012	Q3 FY 2012	Q4 FY 2012	Q1 FY 2013	Q2 FY 2013	Total
Stroke Intracranial Hemorrhage		0											**0**
Respiratory Infections	1	1	1	1			0	1					**5**
Simple Pneumonia				0			0	0	0	0	0	0	**0**
Septicemia	1	1	1	1	1	1	1	1	0	0	0	0	**8**
Unrelated OR Procedure													**0**
Medical DRGs with CC or MCC	1	1	1	1	1	1	1	1	1	1	1	0	**11**
Surgical DRGs with CC or MCC	1	1	1	1	1	1	1	1	1	1	1	1	**12**
Single CC or MCC	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Excisional Debridement													**0**
Ventilator Support	0	0	0	0	0	0	0	1	0	1	0	1	**3**
Transient Ischemic Attack													**0**
COPD	0	0	1	1	0	1	0	0	0	0	0	0	**3**
Syncope													**0**
Other Circulatory System Diagnoses										1			**1**
Other Digestive System Diagnoses													**0**
Medical Back Problems													**0**
Spinal Fusion													**0**
3-Day SNF-qualifying Admissions	0	0	0	0	0	0	0	0	0	0	0	0	**0**
30-Day Readm to Same or Elsewhere	0	1	1	1	0	1	1	1	1	1	1	1	**10**
30-Day Readm to Same Hospital	0	0	0	0	0	0	0	1	0	0	0	0	**1**
2DS Other Vascular Procedures													**0**
2DS Heart Failure and Shock													**0**
2DS Cardiac Arrhythmia													**0**
2DS Esophagitis Gastroenteritis													**0**
2DS Nutritional Metabolic													**0**
2DS Renal Failure													**0**
2DS Kidney and Urinary Tract Inf													**0**
1DS Excluding Transfers	0	0		0	0	0	0		0	0	0	0	**0**
1DS Medical DRGs	0	0		0	0	0	0		0	0	0	0	**0**
1DS Chest Pain and Atherosclerosis													**0**
Total	**4**	**5**	**6**	**6**	**3**	**5**	**4**	**7**	**3**	**5**	**3**	**3**	**54**

Notes: A **1** indicates high outlier, 0 indicates low or non-outlier, and a blank cell indicates no reportable data (fewer than 11 discharges). A hospital may be identified as an outlier as compared to nation but not as compared to jurisdiction, and vice versa.

Memorial Hospital of Gardena 2013 Medi-Cal TAR Summary by MD

Admitting MD (Last Name, First Initial)	Data	TAR Approved Month January-13	February-13	March-13	April-13	May-13	June-13	Grand Total
Adetola, A	TAR Days Requested	13	1	28	9	24	4	**79**
	Denied Days	4	1	8	0	8	0	**21**
	Denial Rate (%)	30.8%	100.0%	28.6%	0.0%	33.3%	0.0%	**26.6%**
Allen, G	TAR Days Requested		8		3	4		**15**
	Denied Days		0		0	0		**0**
	Denial Rate (%)		0.0%		0.0%	0.0%		**0.0%**
Balette, L	TAR Days Requested						2	**2**
	Denied Days						0	**0**
	Denial Rate (%)						0.0%	**0.0%**
Beverly, S	TAR Days Requested						1	**1**
	Denied Days						0	**0**
	Denial Rate (%)						0.0%	**0.0%**
Cepeda, P	TAR Days Requested		10	4	2			**16**
	Denied Days		0	0	0			**0**
	Denial Rate (%)		0.0%	0.0%	0.0%			**0.0%**
Chang, D	TAR Days Requested	11	84	11	6	26	19	**157**
	Denied Days	0	5	0	0	0	1	**6**
	Denial Rate (%)	0.0%	6.0%	0.0%	0.0%	0.0%	5.3%	**3.8%**
Chegounchi, M	TAR Days Requested	9	38	17	20	118	24	**226**
	Denied Days	0	2	0	1	2	0	**5**
	Denial Rate (%)	0.0%	5.3%	0.0%	5.0%	1.7%	0.0%	**2.2%**
Essilfie, W	TAR Days Requested			16				**16**
	Denied Days			0				**0**
	Denial Rate (%)			0.0%				**0.0%**
Essilifie, W	TAR Days Requested					26		**26**
	Denied Days					0		**0**
	Denial Rate (%)					0.0%		**0.0%**
Fox, A	TAR Days Requested		2	2		6		**10**
	Denied Days		0	0		0		**0**
	Denial Rate (%)		0.0%	0.0%		0.0%		**0.0%**
Furoy, D	TAR Days Requested				1			**1**
	Denied Days				0			**0**
	Denial Rate (%)				0.0%			**0.0%**
Golbari, A	TAR Days Requested	13	15	3	49	18		**98**
	Denied Days	1	7	1	1	0		**10**
	Denial Rate (%)	7.7%	46.7%	33.3%	2.0%	0.0%		**10.2%**
Hakimian, N	TAR Days Requested				3	4		**7**
	Denied Days				0	0		**0**
	Denial Rate (%)				0.0%	0.0%		**0.0%**
Kovacs, G	TAR Days Requested				5			**5**
	Denied Days				0			**0**
	Denial Rate (%)				0.0%			**0.0%**
Kumar, A	TAR Days Requested	20	95	92	8	46	119	**380**
	Denied Days	0	0	0	0	4	0	**4**
	Denial Rate (%)	0.0%	0.0%	0.0%	0.0%	8.7%	0.0%	**1.1%**

Memorial Hospital of Gardena 2013 Medi-Cal TAR Summary by MD

Admitting MD (Last Name, First Initial)	Data	TAR Approved Month January-13	February-13	March-13	April-13	May-13	June-13	Grand Total
McKillop, H	TAR Days Requested	41	31					72
	Denied Days	0	0					0
	Denial Rate (%)	0.0%	0.0%					0.0%
Metry, A	TAR Days Requested					10		10
	Denied Days					0		0
	Denial Rate (%)					0.0%		0.0%
Moossazadeh, F	TAR Days Requested				3	4		7
	Denied Days				0	0		0
	Denial Rate (%)				0.0%	0.0%		0.0%
Noorian, B	TAR Days Requested		13					13
	Denied Days		0					0
	Denial Rate (%)		0.0%					0.0%
Plut, J	TAR Days Requested					3		3
	Denied Days					0		0
	Denial Rate (%)					0.0%		0.0%
Sehdeva, P	TAR Days Requested		2	1				3
	Denied Days		0	1				1
	Denial Rate (%)		0.0%	100.0%				33.3%
Sekhon, R	TAR Days Requested				4			4
	Denied Days				0			0
	Denial Rate (%)				0.0%			0.0%
Sourehnissani, M	TAR Days Requested		10	3	11	5		29
	Denied Days		1	2	1	1		5
	Denial Rate (%)		10.0%	66.7%	9.1%	20.0%		17.2%
Tamhane, S	TAR Days Requested	90	152	96	147	182	59	726
	Denied Days	1	8	6	4	5	0	24
	Denial Rate (%)	1.1%	5.3%	6.3%	2.7%	2.7%	0.0%	3.3%
Udoh, N	TAR Days Requested	7	2		3	13		25
	Denied Days	0	0		0	0		0
	Denial Rate (%)	0.0%	0.0%		0.0%	0.0%		0.0%
Vidal, M	TAR Days Requested		4	5	4	1		14
	Denied Days		3	0	3	1		7
	Denial Rate (%)		75.0%	0.0%	75.0%	100.0%		50.0%
Wallace, O	TAR Days Requested	10	114	94	8	36	22	284
	Denied Days	1	3	0	1	4	4	13
	Denial Rate (%)	10.0%	2.6%	0.0%	12.5%	11.1%	18.2%	4.6%
Total TAR Days Requested		**214**	**581**	**372**	**286**	**526**	**250**	**2229**
Total Denied Days		**7**	**30**	**18**	**11**	**25**	**5**	**96**
Total Denial Rate (%)		**3.3%**	**5.2%**	**4.8%**	**3.8%**	**4.8%**	**2.0%**	**4.3%**

Memorial Hospital of Gardena | **MEDI-CAL TAR LOG 2013** | Printed: 7/10/2013

SITE	MEDI-CAL TAR Number	Patient Account Number	Patient Name	Admit Date	Discharge Date	Admitting MD (Last Name, First Initial)	Review Date	Expected Medi-Cal Payments (based on LOS)	Actual Medi-Cal Approved Payments	Denied Dollars	Denial %	Days Requested	Days Approved	Days Denied	TAR Approved Month	Discharge Month	TAR Approved Quarter
MHG	65723354	1000024560	RODRIGUEZ, TERESA	12/31/12	$41,275	Beverly, S	6/7/2013	$1,125	$1,125	$0	0%	1	1	0	13-Jun	13-Jan	Q2 2013
MHG	65723313	1000041760	HENRY, DONALD	05/18/13	$41,418	Chang, D	6/7/2013	$6,750	$6,750	$0	0%	6	6	0	13-Jun	13-May	Q2 2013
MHG	65723355	1000041591	SANCHEZ, NORBERTO	05/17/13	$41,412	Chang, D	6/7/2013	$1,125	$1,125	$0	0%	1	1	0	13-Jun	13-May	Q2 2013
MHG	65723289	1000043738	WILLIAMS, DELORES	06/05/13	$41,433	Kumar, A	6/7/2013	$3,375	$3,375	$0	0%	3	3	0	13-Jun	13-Jun	Q2 2013
MHG	65504089	1000032936	FALCETTA, THOMAS T.	03/06/13	$41,403	Kumar, A	6/7/2013	$4,500	$4,500	$0	0%	4	4	0	13-Jun	13-May	Q2 2014
MHG	65504091	1000032936	FALCETTA, THOMAS T.	03/06/13	$41,403	Kumar, A	6/7/2013	$33,750	$33,750	$0	0%	30	30	0	13-Jun	13-May	Q2 2015
MHG	65504090	1000032936	FALCETTA, THOMAS T.	03/06/13	$41,403	Kumar, A	6/7/2013	$33,750	$33,750	$0	0%	30	30	0	13-Jun	13-May	Q2 2016
MHG	65504154	1000035889	GONZALES, MARIA S.	03/29/13	$41,387	Kumar, A	6/7/2013	$28,125	$28,125	$0	0%	25	25	0	13-Jun	13-Apr	Q2 2016
MHG	65723365	1000041573	HARRIS, MARY	05/17/13	$41,413	Kumar, A	6/7/2013	$2,250	$2,250	$0	0%	2	2	0	13-Jun	13-May	Q2 2013
MHG	65723303	1000043093	AGUIRRE, TERESA	05/30/13	$41,425	Tamhane, S	6/7/2013	$1,125	$1,125	$0	0%	1	1	0	13-Jun	13-May	Q2 2013
MHG	65723321	1000041257	GUERRERO, MIRNA	05/14/13	$41,412	Tamhane, S	6/7/2013	$4,500	$4,500	$0	0%	4	4	0	13-Jun	13-May	Q2 2013
MHG	65723356	1000040054	HERNANDEZ, ALBA	05/04/13	$41,402	Chang, D	6/10/2013	$4,500	$3,375	$1,125	25%	4	3	1	13-Jun	13-May	Q2 2013
MHG	65723314	1000041684	SALAZAR, MICHAEL	05/17/13	$41,425	Tamhane, S	6/10/2013	$15,750	$15,750	$0	0%	14	14	0	13-Jun	13-May	Q2 2013
MHG	65723326	1000041030	SEGURA, GUILLERMO	05/13/13	$41,417	Tamhane, S	6/10/2013	$11,250	$11,250	$0	0%	10	10	0	13-Jun	13-May	Q2 2013
MHG	65723358	1000029560	ALLEN, AMELIA	03/08/13	$41,371	Tamhane, S	6/10/2013	$33,750	$33,750	$0	0%	30	30	0	13-Jun	13-Apr	Q2 2013
MHG	65723345	1000040472	ALVAREZ, TERESA	05/08/13	$41,426	Chegounchi, M	6/18/2013	$27,000	$27,000	$0	0%	24	24	0	13-Jun	13-Jun	Q2 2013
MHG	65723299	1000043341	MOORE, EQUILLA	06/01/13	$41,430	Adetola, A	6/20/2013	$4,500	$4,500	$0	0%	4	4	0	13-Jun	13-Jun	Q2 2013
MHG	65504085	1000040631	MEJIA, BABY KAREN	05/09/13	$41,408	Balette, L	6/20/2013	$2,250	$2,250	$0	0%	2	2	0	13-Jun	13-May	Q2 2013
MHG	65723317	1000041696	SANCHEZ, LAURA	05/18/13	$41,414	Chang, D	6/20/2013	$2,250	$2,250	$0	0%	2	2	0	13-Jun	13-May	Q2 2013
MHG	65723352	1000040041	LEWIS, ISAAC	05/04/13	$41,401	Chang, D	6/20/2013	$3,375	$3,375	$0	0%	3	3	0	13-Jun	13-May	Q2 2013
MHG	65504086	1000040065	ROBERTSON, WILBUR	05/04/13	$41,401	Chang, D	6/20/2013	$3,375	$3,375	$0	0%	3	3	0	13-Jun	13-May	Q2 2013
MHG	65504146	1000013882	MONROY, FERNANDO	10/02/12	$41,209	Kumar, A	6/20/2013	$28,125	$28,125	$0	0%	25	25	0	13-Jun	12-Oct	Q2 2013
MHG	65723245	1000038534	JONES, DOROTHY J.	04/21/13	$41,393	Wallace, O	6/20/2013	$9,000	$7,875	$1,125	13%	8	7	1	13-Jun	13-Apr	Q2 2013
MHG	65723302	1000043157	JONES, DOROTHY J.	05/30/13	$41,430	Wallace, O	6/20/2013	$6,750	$3,375	$3,375	50%	6	3	3	13-Jun	13-Jun	Q2 2013
MHG	65723312	1000042139	JONES, DOROTHY J.	05/21/13	$41,423	Wallace, O	6/20/2013	$9,000	$9,000	$0	0%	8	8	0	13-Jun	13-May	Q2 2013

Memorial Hospital of Gardena

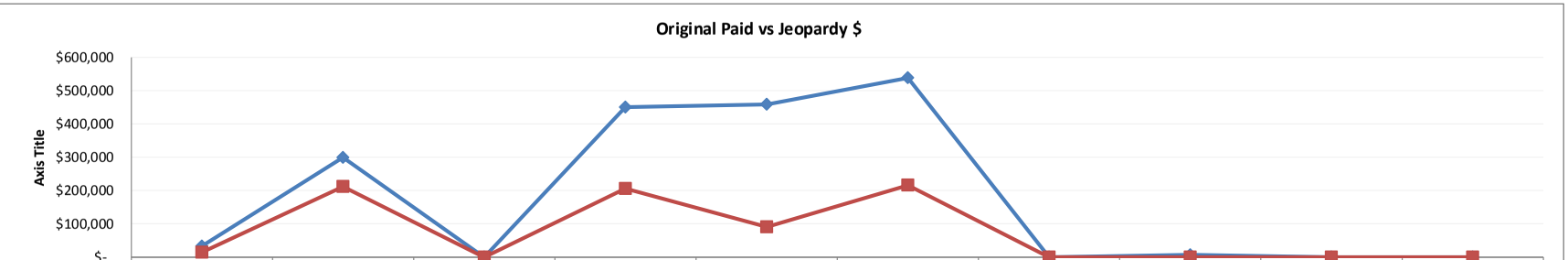
June 2013 MediCal TAR Log Summary

Date	Number of TARs Reviewed	Number of Days Reviewed	ALOS	Expected Medi-Cal Payments	Number of Approved Days	Actual Medi-Cal Approved Payments	Number of Denied Days	Sum of Denied Dollars	Denial Rate (%)
6/7/2013	11	107	9.73	$120,375	107	$120,375	0	$0	0.00%
6/10/2013	4	58	14.50	$65,250	57	$64,125	1	$1,125	1.72%
6/18/2013	1	24	24.00	$27,000	24	$27,000	0	$0	0.00%
6/20/2013	9	61	6.78	$68,625	57	$64,125	4	$4,500	6.56%
Grand Total	**25**	**250**	**10.00**	**$281,250**	**245**	**$275,625**	**5**	**$5,625**	**2.00%**

Memorial Hospital of Gardena

(Privileged and Confidential)

	Date Request was Received	Status	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	YTD
HDI	Number of Requests		3	34		47	35	35		1			155
	Pending	1											
	Sent for Discussion	2											
	Initial Discussion - Approved	3a	2	10		25	22	10					69
			$ 18,418	$ 87,292		$ 244,136	$ 289,386	$ 252,315					$ 891,547
	Pending Chart Review by RAAWG	3b											
	Partial Retraction - Not Appealable	3c											
	Not Appealable	4a								1			1
										$ 6,868			$ 6,868
Palmetto	Sent to Legal For Appeal	4b				6	2	2					10
						$ 70,402	$ 9,607	$ 14,994					$ 95,003
	Indefensible per Legal - Case Closed	4c					2	4					6
							$ 78,361	$ 70,036					$ 148,398
	Redetermination Level - Pending	5						2					2
								$ 24,838					$ 24,838
	Redetermination - Approved	6a											
	Redetermination - Denied/Sent back to Legal	6b		3									3
				$ 27,684									$ 27,684
QIC	Reconsideration - Pending	7	1	21		15	6	12					55
			$ 14,486	$ 184,244		$ 108,612	$ 59,638	$ 134,255					$ 501,235
	Reconsideration - Approved	8a											
	Reconsideration Denied/Sent back to Legal	8b				1	3	5					9
						$ 26,777	$ 21,680	$ 41,788					$ 90,244
ALJ	Administrative Law Judge - Approved	9a											
	Administrative Law Judge - Denied	9b											
$	Original Paid		$ 32,904	$ 299,220		$ 449,926	$ 458,673	$ 538,226		$ 6,868			$ 1,785,817
	Final Retractions (3c/4a/4c/9b)						$ 78,361	$ 70,036		$ 6,868			$ 155,266
	Overturned Denials (3a/6a/8a/9a)		$ 18,418	$ 87,292		$ 244,136	$ 289,386	$ 252,315					$ 891,547
	Jeopardy $		$ 14,486	$ 211,929		$ 205,790	$ 90,925	$ 215,875					$ 739,004



	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013
Original Paid	$32,904	$299,220	$-	$449,926	$458,673	$538,226	$-	$6,868	$-	$-
Jeopardy$	$14,486	$211,929	$-	$205,790	$90,925	$215,875	$-	$-	$-	$-

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report

Percentage Summary Report

Provider: 050468

Reporting Period: Fiscal Year 2014

Data as of[1] : 07/08/2013

Total Performance Score

Facility	State	National
40.066666666667	42.670282119011	46.525704094903

Scores

Domain	Unweighted Domain Score	Weighting	Weighted Domain Score
Clinical Process of Care	40.000000000000	45%	18.000000000000
Patient Experience of Care	18.000000000000	30%	5.400000000000
Outcome	66.666666666667	25%	16.666666666667

Value-Based Percentage Payment Summary - Fiscal Year 2014

Base operating DRG payment amount reduction[2]	Value-based incentive payment percentage[3]	Net change in base operating DRG payment amount[4]	Value-based incentive payment adjustment factor[5]	Exchange function slope[6]
1.2500000000%	1.0498680720%	-0.2001319280%	0.9979986807	2.0962424066

Calculated values were subject to rounding.

See the QualityNet Reports User's Guide for report information. See the Hospital VBP page on QualityNet for an explanation of Hospital VBP Calculations.

[1] The Data As Of Date is the date of the last time data were updated for the hospital.

[2] The percent by which base operating DRG payment amounts will be reduced. This percent will be 1.25% in FY 2014 and will gradually increase over time. Note: Also called the "applicable percent."

[3] The percentage of the total base operating DRG payment amount that a hospital has earned back based on its Total Performance Score (TPS) for the fiscal year.

[4] The percent that FY 2014 base operating DRG payment amounts will be changed due to the Hospital VBP program. It is computed as the value-based incentive payment percentage minus the base operating DRG payment amount reduction. A positive number indicates that the hospital will receive higher FY 2014 base operating DRG payment amounts under the Hospital VBP Program. A negative number indicates that the hospital will receive lower FY 2014 base operating DRG payment amounts under the Hospital VBP program.

[5] The number by which the hospital's FY 2014 base operating DRG payment amount for each discharge will be multiplied under the Hospital VBP program. A value greater than 1 indicates that the hospital will have higher FY 2014 base operating DRG payment amounts under the Hospital VBP program. A value less than 1 indicates that the hospital will have lower FY 2014 base operating DRG payment amounts under the Hospital VBP program.

[6] A Linear exchange function with this slope was used to distribute the estimated available amount of value-based incentive payments to hospitals, based on their Total Performance Scores.

Clinical Process of Care Measures Detail Report

Provider: 050468

Reporting Period: Fiscal Year 2014

Baseline Period: 04/01/2010 - 12/31/2010

Performance Period: 04/01/2012 - 12/31/2012

Clinical Process of Care Measures	FY 2014 Baseline Period Totals			FY 2014 Performance Period Totals		
	Numerator	Denominator	Baseline Period Rate	Numerator	Denominator	Performance Period Rate
Acute Myocardial Infarction (AMI)	.	.	.	.	.	.
AMI-7a - Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A	N/A	-	N/A	N/A	-
AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival	N/A	N/A	-	N/A	N/A	-
Healthcare-Associated Infections (HAI)	.	.	.	.	.	.
SCIP-Inf-1 - Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	36	36	1.0000	35	36	0.9722
SCIP-Inf-2 - Prophylactic Antibiotic Selection for Surgical Patients	33	36	0.9167	35	36	0.9722
SCIP-Inf-3 - Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	30	33	0.9091	29	32	0.9063
SCIP-Inf-4 - Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose	N/A	N/A	-	N/A	N/A	-
SCIP-Inf-9 - Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2	12	14	0.8571	11	11	1.0000
Heart Failure (HF)	.	.	.	.	.	.
HF-1 - Discharge Instructions	120	141	0.8511	150	170	0.8824
Pneumonia (PN)	.	.	.	.	.	.
PN-3b - Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	140	144	0.9722	156	162	0.9630
PN-6 - Initial Antibiotic Selection for CAP Immunocompetent Patient	71	72	0.9861	49	51	0.9608
Surgical Care Improvement Project (SCIP)	.	.	.	.	.	.
SCIP-Card-2 - Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	10	12	0.8333	6	7	0.8571
SCIP-VTE-1 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	41	46	0.8913	73	74	0.9865
SCIP-VTE-2 - Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	41	46	0.8913	72	74	0.9730

Calculated values were subject to rounding.

See the QualityNet Reports User's Guide for report information. See the Hospital VBP page on QualityNet for an explanation of Hospital VBP Calculations.

**Note: "N/A" indicates no data were available or submitted for this measure.

**Note: A dash (-) indicates that the minimums were not met for calculation of the points or scores.

Clinical Process of Care Measures Detail Report

Provider: 050468

Reporting Period: Fiscal Year 2014

Baseline Period: 04/01/2010 - 12/31/2010

Performance Period: 04/01/2012 - 12/31/2012

Clinical Process of Care Measures	HVBP Metrics					
	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Measure Score	Condition/ Procedure Score
Acute Myocardial Infarction (AMI)	.	.	.	.	.	**-**
AMI-7a - Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.8066	0.9630	-	-	-	.
AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9344	1.0000	-	-	-	.
Healthcare-Associated Infections (HAI)	.	.	.	.	.	**16**
SCIP-Inf-1 - Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9807	1.0000	0	0	0	.
SCIP-Inf-2 - Prophylactic Antibiotic Selection for Surgical Patients	0.9813	1.0000	6	0	6	.
SCIP-Inf-3 - Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9663	0.9996	0	0	0	.
SCIP-Inf-4 - Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose	0.9634	1.0000	-	-	-	.
SCIP-Inf-9 - Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2	0.9286	0.9989	9	10	10	.
Heart Failure (HF)	.	.	.	.	.	**2**
HF-1 - Discharge Instructions	0.9266	1.0000	2	0	2	.
Pneumonia (PN)	.	.	.	.	.	**3**
PN-3b - Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9730	1.0000	0	0	0	.
PN-6 - Initial Antibiotic Selection for CAP Immunocompetent Patient	0.9446	1.0000	0	3	3	.
Surgical Care Improvement Project (SCIP)	.	.	.	.	.	**15**
SCIP-Card-2 - Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	0.9565	1.0000	-	-	-	.
SCIP-VTE-1 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.9462	1.0000	8	7	8	.
SCIP-VTE-2 - Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	0.9492	0.9983	7	5	7	.

Eligible Clinical Process of Care Measures: **9 out of 13**

Unweighted Clinical Process of Care Domain Score: **40.000000000000**

Weighted Clinical Process of Care Domain Score[7]: **18.000000000000**

Calculated values were subject to rounding.

See the QualityNet Reports User's Guide for report information. See the Hospital VBP page on QualityNet for an explanation of Hospital VBP Calculations.

**Note: A dash (-) indicates that the minimums were not met for calculation of the points or scores.

[7] The Weighted Clinical Process of Care Domain Score is Calculated by multiplying the Unweighted Clinical Process of Care Domain Score by a weight of 45%.

Patient Experience of Care Dimensions Detail Report

Provider: 050468

Reporting Period: Fiscal Year 2014

Baseline Period: 04/01/2010 - 12/31/2010
Performance Period: 04/01/2012 - 12/31/2012

Patient Experience of Care Dimensions	Baseline Period Rate	Performance Period Rate	Floor	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Dimension Score[9]
Communication with Nurses	63.79%	66.73%	42.84%	75.79%	84.99%	1	0	1
Communication with Doctors	70.07%	71.04%	55.49%	79.57%	88.45%	0	0	0
Responsiveness of Hospital Staff	51.43%	51.45%	32.15%	62.21%	78.08%	0	0	0
Pain Management	67.16%	68.45%	40.79%	68.99%	77.92%	1	0	1
Communication about Medicines	45.12%	54.64%	36.01%	59.85%	71.54%	3	0	3
Cleanliness and Quietness of Hospital Environment[8]	57.24%	52.81%	38.52%	63.54%	78.10%	0	0	0
Discharge Information	68.88%	72.31%	54.73%	82.72%	89.24%	1	0	1
Overall Rating of Hospital	53.54%	57.37%	30.91%	67.33%	82.55%	1	0	1

HCAHPS Base Score[10]: **7**
HCAHPS Consistency Score: **11**
Unweighted Patient Experience of Care Domain Score: **18.000000000000**
Weighted Patient Experience of Care Domain Score[11]: **5.400000000000**
HCAHPS Surveys Completed During the Performance Period: **334**

Calculated values were subject to rounding.
See the QualityNet Reports User's Guide for report information. See the Hospital VBP page on QualityNet for an explanation of Hospital VBP Calculations.
[8] The Cleanliness and Quietness of Hospital Environment HCAHPS Dimension in ***bold italic*** font was used to calculate the HCAHPS Consistency Score.
[9] Dimension Scores are the higher of the improvement and achievement points for the HCAHPS Dimensions.
[10] The HCAHPS Base Score is the sum of the HCAHPS Dimension Scores.
[11] The Weighted Patient Experience of Care Domain Score is calculated by multiplying the Unweighted Patient Experience of Care Domain Score by a weight of 30%.

Outcome Measures Detail Report

Provider: 050468

Reporting Period: Fiscal Year 2014

Baseline Period: 07/01/2009 - 06/30/2010

Performance Period: 07/01/2011 - 06/30/2012

Mortality Measures[12]	FY 2014 Baseline Period Totals		FY 2014 Peformance Period Totals		HVBP Metrics				
	Number of Eligible Discharges	Baseline Period Rate	Number of Eligible Discharges	Performance Period Rate	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Measure Score
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	8	-	15	0.8586	0.8477	0.8673	-	6	6
Heart Failure (HF) 30-Day Mortality Rate	41	0.8841	60	0.9020	0.8861	0.9042	8	8	8
Pneumonia (PN) 30-Day Mortality Rate	33	0.8947	30	0.8939	0.8818	0.9021	0	6	6

Eligible Mortality Measures: **3 out of 3**

Unweighted Outcome Domain Score: **66.666666666667**

Weighted Outcome Domain Score[13]: **16.666666666667**

Calculated values were subject to rounding.

See the QualityNet Reports User's Guide for report information. See the Hospital VBP page on QualityNet for an explanation of Hospital VBP Calculations.

**Note: A dash (-) indicates that the minimums were not met for calculation of the points or scores.

[12] The mortality measures displayed are the survival rates for each mortality measure. The Hospital Value-Based Purchasing Program utilizes the patient survival rate to measure a hospital's quality of care performance for the program.

[13] The Weighted Outcome Domain Score is calculated by multiplying the Unweighted Outcome Domain Score by a weight of 25%.

Exhibit C

Term Sheet for Joint Venture

In accordance with Section 21.1 of the Management Services Agreement to which this Exhibit C is attached (the "Original MSA"), the parties intend to transition from a management relationship to a collaboration in the operations and financial results of operations of HUH. In furtherance thereof, and subject to agreement on definitive joint venture documentation ("Definitive Agreements"), the parties have agreed to enter into a joint venture transaction for the operation of HUH on terms substantially similar to those described below (the "JV Transaction"). All capitalized terms used but not otherwise defined herein have the respective meanings ascribed to them in the Original MSA. The JV Transaction would encompass the following elements:

1. **Trigger** – Howard would be able to trigger the JV Transaction upon HUH achieving financial "Stability" based on a mutually agreed Target EBITDARM (earnings before interest, taxes, depreciation, amortization, rent and management fee) or at any time thereafter provided that EBITDARM exceeds the Target EBITDARM. The parties would use commercially reasonable efforts to enter into Definitive Agreements within one hundred twenty (120) days after the JV Transaction has been triggered.

2. **JV Structure** – Paladin Healthcare Capital, LLC ("Paladin") (through an investment affiliate controlled by Paladin, "InvestCo") will form a limited liability company ("NewCo") that would own and operate the business of HUH after transfer of HUH employees and operating assets (*excluding* the HUH real estate, personal property, and brand name, which would be leased/licensed to NewCo) and obtaining all third-party approvals.

    A. NewCo would enter into an Academic Affiliation Agreement ("AAA") through which Howard would continue its medical education and charitable activities at HUH.

    B. The JV Transaction would be structured to comply with applicable laws, including IRS regulations, and applicable contractual obligations, including bond covenants.

3. **Howard Contributions; Consideration** – Howard would contribute to NewCo HUH operating assets ("HUH Assets") excluding real estate, certain personal property and the HUH brand name (the "Retained Assets"), and NewCo would assume certain HUH liabilities and contractual obligations as agreed by the parties (the "HUH Liabilities" and together with the HUH Assets, the "Business").

    A. The scope of HUH Assets and HUH Liabilities to be acquired would be mutually agreed upon and the fair market value ("FMV") of the Business as a going concern taking into account the transactions contemplated hereby, would be determined through good faith negotiation of the parties or, if agreement could not initially be reached, through mediation with a mutually acceptable third-party consultant; and finally, if the parties are still unable to agree, by a mutually acceptable third-party valuation firm whose findings would be binding on the parties.

    B. NewCo would pay Howard a purchase price (the "Purchase Price") for the Business equal to its FMV multiplied by a percentage determined by subtracting the Howard License Fee Percentage (described below) from 100%. The Purchase Price would be paid to Howard at closing of the JV Transaction in a combination of cash and promissory notes with the actual mix of cash and notes based on a formula with the understanding that Paladin is only willing to contribute capital to the extent that it has a reasonable opportunity to achieve a 22.5% return on investment. Paladin will apply

any Success Fee (net of applicable taxes) owed by Howard to Manager under the Original MSA to offset a portion of the Purchase Price.

C. In connection with the contribution of the HUH Assets, NewCo would hire substantially all of the employees of HUH.

4. **Paladin Contributions; Consideration** – InvestCo would contribute cash and promissory notes to NewCo sufficient to fund the Purchase Price in consideration for 100% of the equity ownership of NewCo. InvestCo would provide or arrange for (at commercially competitive terms) working capital sufficient to fund NewCo's operational needs.

5. **Distributions** – NewCo will maintain such minimum liquidity as is mutually agreed to by the parties and, if applicable, NewCo's lenders, to ensure that NewCo consistently maintains sufficient working capital to operate at a level expected of premier academic medical centers. In accordance with terms and conditions to be mutually agreed upon, it is anticipated that ordinary course tax distributions will be distributed by NewCo on a quarterly basis, and Free Cash Flow (as defined in the Definitive Agreements) and ordinary course tax distributions will be distributed by NewCo on an annual basis.

6. **License** – Howard would grant NewCo a license (the "License") to use the Howard University Hospital brand name and related intellectual property that Howard continues to own (the "Licensed IP") in consideration for a "License Fee" equal to (a) $3 million (the "Base Fee"), plus (b) the Howard License Fee Percentage times NewCo's Free Cash Flow (the "Free Cash Flow Fee").

A. The Howard License Fee Percentage would be an amount selected by Howard in the range of 20% to 49%. Howard will receive a proportional amount of tax and Free Cash Flow distributions.

B. In the event that NewCo is sold to a Qualified Buyer (as defined in the Definitive Agreements) following the JV Transaction closing on terms that are fair to both Parties and with the consent of Paladin and Howard, Howard would be paid a portion of the sale proceeds equal to the Howard License Fee Percentage multiplied by the net sale proceeds received by Paladin and accordingly, the Free Cash Flow Fee would terminate upon such sale whereas the Base Fee under the License, for the use of the Howard brand name and related intellectual property, would continue if the License continues.

7. **HUH Real Estate** – Howard would retain the HUH real and personal property used in the operation of HUH (the "Retained Property Assets") which would be leased to NewCo (the "Lease"). NewCo would pay Howard a base rent of $5 million annually with a 3% annual escalator. The term of the Lease would be 15 years subject to two 10-year renewal terms upon mutual agreement. Howard would have the right to sell the Retained Property Assets subject to the Lease at any time subject to 90 days prior notice to Paladin or upon termination of the lease. The Lease would terminate upon NewCo's completion of a successor hospital facility, and certain other events.

8. **Capital Expenditures** – For so long as the Lease is in effect, Howard would agree to allocate a reasonable amount of capital per year for appropriate and feasible capital improvements relating to the Retained Assets with the uses of such capital subject to approval by the Board of NewCo based on recommendations of NewCo's management team.

9. **Management Services Agreement** – Upon execution of Definitive Agreements, the Original MSA would be replaced by a new MSA between NewCo and Paladin which would provide only for a Base Management Fee and no Incentive Fee or Success Fee. The MSA governance provisions would be consistent with the governance provisions under the JV Transaction documents.

10. **Governance** – NewCo would be governed by a Board of Managers ("Board") of three members appointed by Howard, three members appointed by Paladin. Decisions would generally be by majority vote provided that (a) certain significant items would be subject to a super-majority vote and (b) Howard would possess such additional specified authority as would be mutually agreed by the Parties, specified in the Definitive Agreements and sufficient for Howard to retain its tax-exempt status and the tax-exempt treatment of its bonds.

11. **Possible UMC Involvement** – Paladin and its affiliates are considering a management services, acquisition, or other agreement with United Medical Center ("UMC") and the parties intend to explore the potential for UMC to participate in the JV in a form and on terms that are mutually acceptable to the parties. Paladin would not enter into a joint venture or other transaction with UMC without obtaining Howard's prior consent.

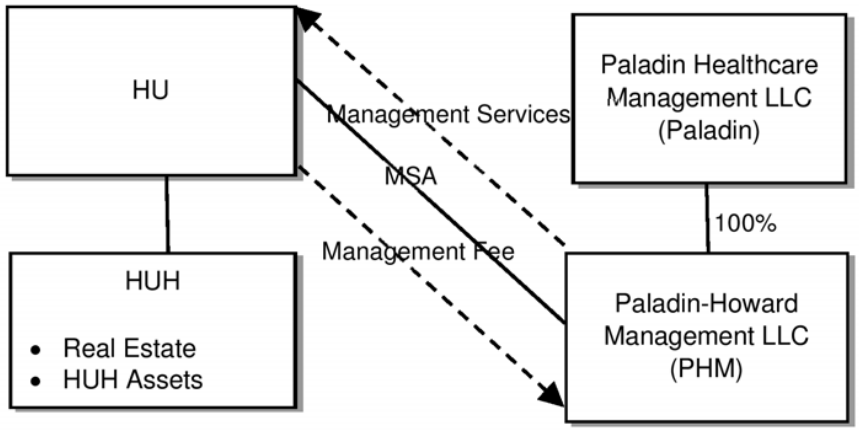
12. **Non-Compete** – Howard, Paladin and their respective affiliates would be restricted from competing with NewCo in defined ways during the term of the JV.

13. **AAA** – NewCo would have an Academic Affiliation Agreement with Howard containing customary terms.

14. **Faculty Practice** – Paladin and Howard would also work out appropriate arrangements for promotion of the faculty practice group practice in association with HUH.

15. **Definitive Agreements** – The obligation of the parties to effect the JV Transaction is subject to the execution by the Parties of Definitive Agreements containing such terms, conditions, representations, warranties and covenants as are customary and appropriate for transactions of the type contemplated, including those set forth in this Exhibit. During the term of the Original MSA, the Parties will negotiate in good faith to mutually agree on the form and substance of Definitive Agreements and any related transactions.

PHASE I – MANAGEMENT SERVICES AGREEMENT (MSA)



PHASE II – JOINT VENTURE

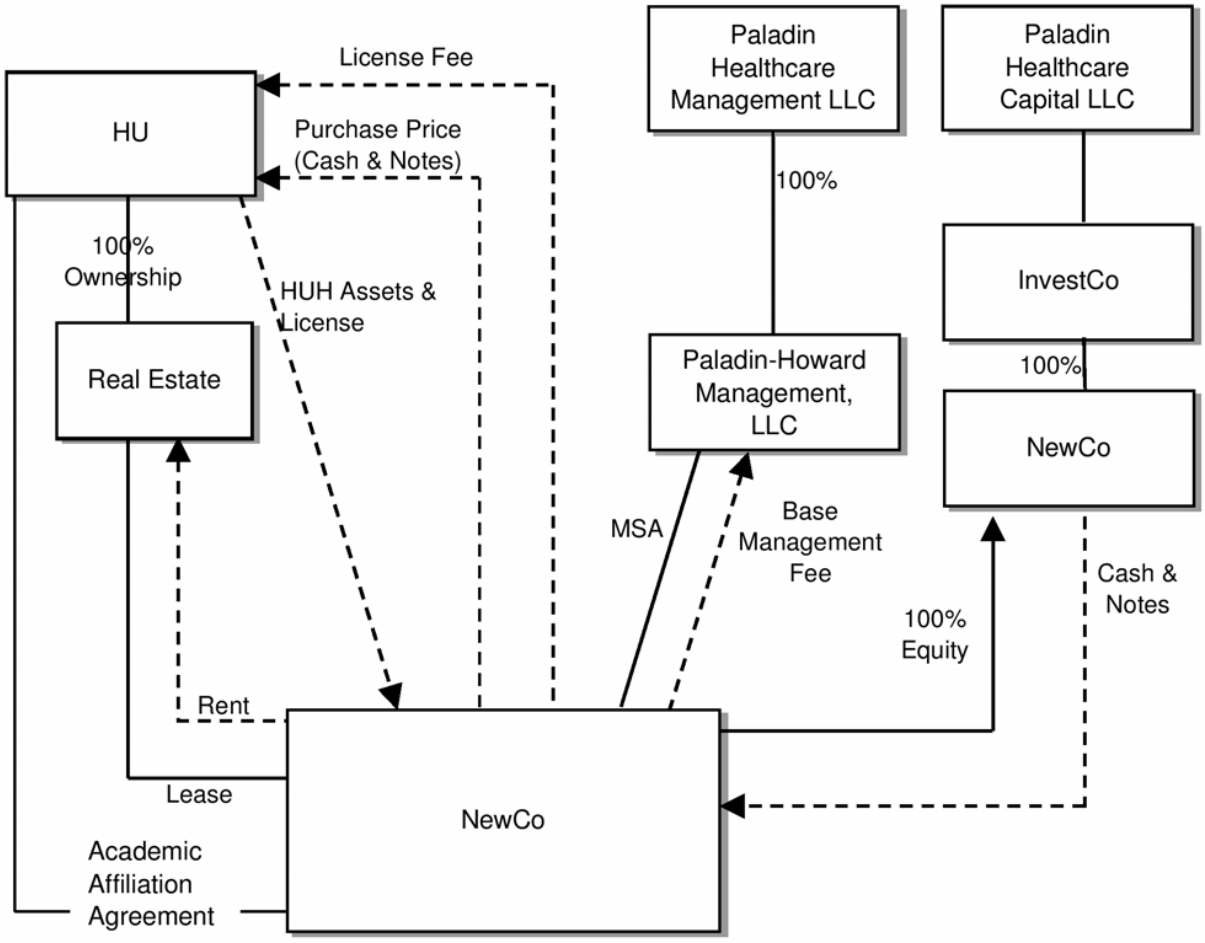


EXHIBIT D

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE ADDENDUM ("**Addendum**") is by and between Howard University (the "**Covered Entity**"), and Paladin-Howard Management, LLC (the "**Business Associate**") and will control the exchange, access, and handling of PHI, and systems that handle PHI, and related matters for all agreements that may be entered into between the parties.

The Covered Entity and the Business Associate are parties to the Management Services Agreement dated October 1, 2014 (the "**Management Services Agreement**") under which the Business Associate provides certain goods or services to the Covered Entity and, in connection with the provision of those goods or services, the Business Associate has, or will create, receive, maintain or transmit certain Protected Health Information (as defined below) that is subject to protection under the under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"). Pursuant to HIPAA, "business associates" of "covered entities" (as such terms are defined in 45 CFR 160.103) must agree in writing to certain mandatory provisions regarding the use and disclosure of Protected Health Information; and the purpose of this Addendum is to comply with the requirements of the HIPAA Rules as defined in this Addendum.

Definitions

1. **Specific definitions:**

A. HIPAA Rules. "**HIPAA Rules**" shall mean U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. Parts 160 and 164, subparts A, D and E (the "**Privacy Rule**"), 45 CFR Part 160 and 164, subparts A and E; the security standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. Parts 160, 162 and 164, subpart C (the "**Security Rule**"), 45 CFR Part 160 and 164, subparts A and C; Breach Notification Rule, 45 CFR Part 164, subpart D, and Enforcement Rules at 45 CFR Part 160, subparts C, D and E, as each is amended and supplemented by the HITECH Act. References to the HIPAA Rules or any of the individual rules shall mean each rule as it is amended from time to time.

B. HITECH. "**HITECH**" shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and all associated existing and future implementing regulations, when and as each is effective.

C. Protected Health Information. "**Protected Health Information**" or "**PHI**" shall mean PHI as defined in 45 C.F.R. 160.103, and is limited to the PHI received from, or received, maintained, created or transmitted on behalf of, the Covered Entity by the Business Associate in performance of the management services described in the Management Services Agreement.

2. **Catch-all definitions:**

A. All capitalized terms not otherwise defined in this Addendum shall have the same meaning as those terms in the HIPAA Rules, including: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic PHI, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

3. **Obligations and Activities of Business Associate**

The Business Associate agrees to:

A. Not use or disclose Protected Health Information other than as necessary to provide the services described in the Management Services Agreement and in compliance with each applicable requirement of 45 CFR 164.504(e), as expressly permitted or required by this Addendum or as Required by Law.

B. To the extent the Business Associate is to carry out one or more of the Covered Entity's obligation(s) under the Privacy Rule, comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation(s).

C. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information; and to share such agreement(s) with the Covered Entity on request.

D. Make available Protected Health Information in a Designated Record Set, in accordance with Section 3(E) below, to the Covered Entity as necessary for the Covered Entity to satisfy its obligations under 45 CFR 164.524. All Protected Health Information shall be provided in accordance with 45 CFR 164.524, including providing or sending a copy to a designated third party and providing or sending a copy in electronic format, to the extent that the PHI in the Business Associate's possession constitutes a designated record set.

E. Within ten (10) days of receiving a written request from (i) the Covered Entity, make available PHI necessary for the Covered Entity to respond to Individuals' requests for access to PHI about them; and (ii) an Individual directly, forward such request to the Covered Entity, in the event that the PHI in the Business Associate's possession constitutes a Designated Record Set.

F. Within fifteen (15) days of receiving a written request from the Covered Entity, make any amendment(s) to Protected Health Information in a Designated Record Set as directed or agreed to by the Covered Entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the Covered Entity's

obligations under 45 CFR 164.526; and will forward within fifteen (15) days to the Covered Entity any request for amendment that the Business Associate receives directly from the Individual.

G. Document and make available all information necessary for the Covered Entity to provide an accounting of disclosure. The Business Associate agrees within fifteen (15) days of receiving a written request from the Covered Entity to make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy the Covered Entity s obligations under 45 CFR 164.528 and, as of the later of the date compliance is required by final regulations or the Effective Date, 42 U.S.C. § 17935(c). If the Business Associate receives a request directly from the Individual, the Business Associate will forward such request to the Covered Entity within fifteen (15) days.

H. Make its internal practices, books, and records available to the Secretary for purposes of determining the Covered Entity's compliance with the HIPAA Rules.

I. Use appropriate administrative, physical and technical safeguards, and comply with the Security Rule with respect to Electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for by this Addendum.

J. Safeguard the PHI from tampering and unauthorized disclosures. This protection shall extend beyond the initial information obtained from the Covered Entity to any databases or collections of PHI containing information derived from the PHI. This Addendum shall be in force unless PHI is de-identified in conformance to the requirements of the Privacy Rule.

K. Use reasonable and appropriate safeguards, including information system security measures, such as software and/or policies and procedures to reasonably ensure that all transmissions of PHI are authorized and to prevent use or disclosure of PHI other than as provided for by this Addendum.

L. Not transmit PHI over the internet or any other insecure or open communication channel unless the PHI is encrypted or otherwise safeguarded with a FIPS Compliant Encryption Algorithm.

M. Within five (5) days of discovery, report to the Covered Entity any use or disclosure of Protected Health Information not provided for by this Addendum of which it becomes aware, including Breaches of Unsecured Protected Health Information as required at 45 CFR 164.410, and any Security Incident of which it becomes aware. Notices of Breaches shall include (i) the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such Breach, (ii) all other information reasonably necessary to provide notice to Individuals, the Secretary and/or the media, all in accordance with the Breach Notification Rule, and (iii) all other information required for or requested by the Covered Entity to perform

a risk assessment in accordance with 45 CFR 164.402 with respect to the incident to determine whether a Breach of Unsecured PHI occurred. The Covered Entity shall have sole responsibility for determining if a Breach occurred. Without expanding or limiting in any way Manager's indemnity obligations under the Management Services Agreement, it is agreed that Manager's indemnification of Howard may include Manager's obligation to pay, with respect to a Breach by Manager, the reasonable and actual (i) costs associated with any notifications provided to individuals, HHS and/or the media and (ii) expenses and costs incurred by Howard that arise from an investigation or any incident required to be reported under this Section 3(M).

N. Notwithstanding Section 3(C) above, ensure through written agreement that Business Associate Subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate report to the Business Associate any use or disclosure of PHI not provided for by this Addendum of which it becomes aware, including Breaches of Unsecured PHI as required at 45 CFR 164.410, and any Security Incident of which it becomes aware; and to notify the Covered Entity of such reports, and to share such agreements with the Covered Entity on request.

4. **Permitted Uses and Disclosures by Business Associate:**

The Business Associate may:

A. Use and Disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are (i) Required by Law, or (ii) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

B. Provide data aggregation services relating to the health care operations of covered entities in accordance with the Privacy Rule. The Business Associate may not disclose the PHI of one covered entity to another covered entity without the written authorization of the covered entities involved.

C. De-identify any and all PHI created or received by the Business Associate under this Addendum; provided that the de-identification conforms to the requirements of the Privacy Rule.

5. **Term and Termination**

A. Termination for Cause. The Business Associate authorizes termination of the Management Services Agreement and/or this Addendum by the Covered Entity, if

the Covered Entity determines the Business Associate has violated a material term of this Addendum. Alternatively, the Covered Entity may choose to provide the Business Associate with notice of the existence of an alleged breach and afford the Business Associate an opportunity to cure the alleged breach. In the event the Business Associate fails to cure the breach to the satisfaction of the Covered Entity within thirty (30) days, the Covered Entity may immediately thereafter terminate this Addendum and/or the Management Services Agreement.

B. Obligations of the Business Associate Upon Termination.

a. Upon termination of this Addendum and/or the Management Services Agreement for any reason, the Business Associate shall return to the Covered Entity, or, if explicitly agreed to by the Covered Entity, destroy, all Protected Health Information received from the Covered Entity, or created, maintained, or received by the Business Associate on behalf of the Covered Entity that the Business Associate still maintains in any form. The Business Associate shall retain no copies of the Protected Health Information. In the event that the Business Associate believes return or destruction is not feasible, the Business Associate shall notify the Covered Entity and, if the Covered Entity agrees, may retain such Protected Health Information provided that the Business Associate extends the protections, limitations and restrictions of this Addendum to the PHI and limits any further uses or disclosures of the PHI to the purpose(s) that make return or destruction infeasible.

b. Term. The Term of this Addendum shall be effective as of Effective Date, and shall terminate when the Management Services Agreement terminates or on the date the Covered Entity terminates for cause as authorized in paragraph (A) of this Section 6, whichever is sooner.

6. **Amendment.**

The Covered Entity and the Business Associate agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Covered Entity to comply with the requirements of the HIPAA Rules.

7. **Survival.**

Section 6(B)(a) of this Addendum shall survive the termination of this Addendum.

8. **No Third Party Beneficiaries.**

Nothing express or implied in this Addendum is intended to confer, nor shall anything in this Addendum confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

Effective Date.

This Addendum shall be effective on October 1, 2014.

The Covered Entity: Howard University

By: _____

Name: _____

Title: _____

Date: _____

Business Associate: Paladin-Howard Management, LLC

By: _____

Name: _____

Title: _____

Date: _____

EXHIBIT B

HU
HOWARD
UNIVERSITY
HOSPITAL

REVISED STRATEGIC PLAN AND FINANCIAL FORECAST

DISCUSSION DRAFT - SUBJECT TO REVISION

FEBRUARY 2015

PALADIN
HEALTHCARE
CAPITAL

DISCLAIMER

This Revised Strategic Plan has been prepared from data provided to Paladin—Howard Management, LLC and/or its affiliates (collectively, "Paladin") by Howard University ("Howard"), its Howard University Hospital division ("HUH") and its advisors, as well as public information. Paladin, including any of its principals, officers, employees, representatives, or agents, as the preparer of the document, makes no representation or warranty, express or implied, as to the fairness, accuracy of completeness of any of the contents of this document and no liability whatsoever is assumed or implied by any such person with respect thereto.

This document is provided solely for information purposes and does not purport to contain all the information that a recipient may require in evaluating the business herein presented. All expressions of opinion reflect the judgment of Paladin at the date of this document and are subject to change. The information contained herein has been obtained from sources considered reliable, but the accuracy and completeness of such information is not guaranteed. Paladin and their respective principals, directors, officers, employees, representatives or agents expressly disclaim any and all liability which may be based on such information.

The contents of this document are strictly private and confidential and are subject to the terms of a confidentiality letter entered into between Paladin and Howard. Each recipient is reminded to ensure that the terms of the confidentiality letter are strictly adhered to. Any investment in the Company is speculative, and involves a high degree of risk.

The information contained herein includes "forward-looking statements" and forecasts which can be identified by the use of forward-looking terminology such as "believes," "expects," "may," "should," or "anticipates" or the negative thereof or given that the future results covered by the forward-looking statements will be achieved. The preceding matters constitute cautionary statements identifying important factors with respect to such forward-looking statements and forecasts, including certain risks and uncertainties that could cause actual results to vary materially from the future results covered in such forward-looking statements and forecasts. Other factors could also cause actual results to vary materially from the future results covered in such forward-looking statements and forecasts. No representations are made that any of these statements or forecasts will come to pass or that any forecast will be achieved.

In furnishing this document, neither Paladin, nor any of its principals, directors, officers, employees, representatives or agents undertake any obligation to provide the recipient with access to any additional information or to update this document or additional information or to correct any inaccuracies herein which may become apparent.

Accordingly, neither Paladin, nor any of its principals, directors, officers, employees, representatives or agents shall be liable for any errors or omissions in the content provided herein or for any actions taken by recipients in reliance thereon.

HOWARD UNIVERSITY HOSPITAL STRATEGIC PLAN AND BUDGET FOR FYE 6/30/15

Pursuant to the Management Services Agreement ("MSA") between Howard University ("Howard") and Paladin, on October 6, 2014, Paladin assumed day-to-day operational responsibility (subject to certain limitations and decision-making guidelines) and has initiated a transition plan designed to transform Howard University Hospital ("HUH" or the "Hospital") into a stable and reliable provider of high-quality, cost effective acute care and outpatient services that complement the academic, scientific, and social missions of the Howard University Health Sciences Program (the "HSP") and Faculty Practice Plan (the "FPP"). The MSA included an attached Interim Strategic Plan (the "Interim Strategic Plan") but called for the development of a Strategic Plan and Budget (the "FY2015 Plan") which includes additions, modifications and improvements to the Interim Strategic Plan. Once approved by Paladin and Howard, the FY2015 Plan will serve as the operating plan for HUH through the end of the current fiscal year on June 30, 2015.

The FY2015 Plan presented herein is based on Paladin's knowledge of the business of and markets served by urban community hospitals in disadvantaged communities and is bolstered by several C-level hospital executives from Alvarez and Marsal ("A&M"), whose executives have significant prior experience operating and transitioning underperforming hospitals. It is based on preliminary due diligence over nine months and experience operating HUH for the past four months, including various discussions with Howard personnel and advisors, a review of all information that was posted to the HUH data room, and a report prepared by WeiserMazars ("Weiser"). Ongoing due diligence and collaboration with Howard, HUH and FPP leadership and other advisors should strengthen and enhance the operating plan presented herein.

Paladin's hospital operating model is tightly defined, historically successful, and portable to most hospitals. Several elements of the model can have a materially favorable impact on HUH. The model includes a wide range of clinical and operational performance improvement initiatives that can significantly enhance clinical and financial performance, as well as employee and patient satisfaction, by maintaining strong disciplines in the areas of emergency department operations, care coordination, case management, clinical documentation, recruiting and retention, staff flexing to volume, purchasing, facilities management, contracting, revenue cycle, information systems ("IS"), and capital deployment.

Paladin has developed several key strategies that, when implemented effectively, are expected to improve the operational and financial performance of HUH. Such strategies include reducing costs through the right-sizing of departmental staffs, enhancing emergency department operations, improving clinical documentation and inpatient management, IS optimization, tightening the supply chain, renegotiating and/or securing new payor contracts, rationalizing unprofitable programs, improving revenue cycle processes, optimizing bed utilization, and implanting revenue enhancement programs where applicable. Subject to Howard's financial commitment and availability of human capital, contemplated objectives include:

- Control labor costs through voluntary buyout, reduction in force, and disciplined staffing policies (to the extent permissible under existing collective bargaining agreements), while strengthening employee retention and recruitment activities;

- Improve Emergency Department ("ED") wait times and left-without-being-seen metrics, and attract increasing volumes of Paramedic runs;

- Improve efficiencies and documentation through sophisticated hospitalist and case management programs, including protocols and training programs to support HUH clinicians;

- Improve the coding, clinical, and billing documentation and compliance with governmental programs and private payor requirements (focus on denials management), so as to increase proper fee realization in accordance with applicable law;

- Increase cash collections by implementing tighter protocols and promoting discipline across the revenue cycle;

- Decrease supply chain costs by standardizing purchasing activities and establishing stringent buying protocols;

- Realign administrative infrastructure to better capitalize on system scale and to standardize best practices;

- Empower FPP physicians through clinical documentation education programs, care coordination tools and support, ambulatory infrastructure, increased patient volumes, and, to the extent possible, comprehensive physician scorecards;

- Document and optimize relationship between HUH and FPP via formal time and resource consumption studies and updated "funds flow" analysis to ensure appropriate value is obtained for the physician services that are purchased by and rendered to HUH;

- Renegotiate existing managed care agreements to ensure rates remain at market levels, develop and better manage a provider network, help ensure the consistent delivery of quality healthcare services, and generate profitable recurring revenue streams and increasing inpatient volumes;

- Improve the operating and financial management capabilities of the HUH IT system, and evaluate how best to integrate the system with that of the FPP and prospective future ambulatory and managed care operations;

- On a consistent and structured basis, collaborate with the FPP and HSP to strengthen and manage the linkage between the clinical programs and undergraduate and graduate medical education programs;

- Identify and develop strategies to implement a range of business development initiatives designed to increase patient volumes and related net revenues at HUH, while enhancing the operations and capabilities of the FPP; and

- As required, support the prospective acquisition of United Medical Center ("UMC") by a special purpose company which will be jointly owned and governed by Howard and Paladin.

The plan centers on immediately reducing labor and supply costs, driving efficiencies across the enterprise, and increasing volume, with a goal to stabilize those programs that are currently not financially viable due to a lack of scale or adequate resources. The FY2015 Plan does not contemplate removing service lines at HUH during Year One of the MSA, even if certain lines are currently not financially sustainable as currently configured. To the extent possible and with the assistance of the FPP and HSP, the FY2016 Plan will include a SWOT analysis which will quantify the contribution margin and potential of each such service line, allowing Howard and Paladin to respond accordingly in subsequent operating periods.

GOVERNANCE

Management Services Agreement

Howard and Paladin have entered into an exclusive Management Services Agreement (the "MSA"), and Paladin and A&M have entered into an exclusive agreement for A&M to provide senior executives to Howard through Paladin, whereby Paladin will administer the day-to-day operations of HUH, subject to a mutually agreed to Strategic Plan and Budget for each fiscal year. This document and the accompanying financial forecast, once approved pursuant to the MSA, will serve as the "roadmap" and criteria by which Paladin will be evaluated for the remainder of the period covered by the FY2015 Plan. The MSA defines the manner in which HUH will be governed and administered on an ongoing basis, with a requisite to safeguard HUH's ability to consistently provide quality-oriented, compassionate healthcare services, while supporting and receiving support from the FPP and HSP.

On a day-to-day basis, HUH will operate under the direction of a senior management team with Sandra Austin, RN serving as Chief Executive Officer (the "CEO"); Kathleen Millgard, RN as Chief Operating/Nursing Officer (the "CNO/COO"); and Douglas Womer, CPA as Chief Financial Officer (the "CFO"). Several Paladin and A&M professionals will provide active and ongoing support to management including Joel Freedman; Mark Bell, MD; Ravi Sharma; Irv Edwards, MD; Everett Lyn, MD; James Lally, DO; Ashok Kumar, MD; Keith Ghezzi, MD; Nicolas Orzano; Rick McKellar; and Philip Criscione. Bios for each of these professionals are provided as Appendix A to this plan.

Faculty Practice Plan

With sweeping transformations to the U.S. health sector, physicians are faced with a new paradigm of providing quality care at the lowest possible cost. There is a new demand to organize and integrate physicians into diverse, interdisciplinary teams; measure their performance based on value as opposed to volume; strategically apply financial and behavioral incentives; improve processes; and address dysfunctional cultures. Effectively engaging physicians to embrace a new paradigm for health care delivery requires strategies that provide a clear and compelling picture of the value created by participating in these efforts. The value must extend beyond financial benefits to the quality of care delivered to their patients. To this end, Paladin and the FPP and HSP leadership teams will work together to devise and implement strategies that empower physicians to provide the best possible care to patients.

A key element of Paladin's strategy for HUH is the development of strong relationships with Howard's physicians. Underpinning Paladin's efforts to engage and attract physicians are its experienced team of C-level executives and physician operators, and a firm commitment to the consistent delivery of high quality of care, properly maintained equipment and facilities, and an environment that is responsive to physicians' needs. Additionally, as Paladin continues to improve upon the efficiency and standards of the HUH emergency department (the "ED"), management expects that physician relationships will improve further, as physicians respond positively to well-trained and well-run EDs, typically resulting in more admissions for a hospital. Through these efforts, HUH will earn a reputation as a physician-friendly facility in which physicians prefer to practice. Initial initiatives may include:

- Transparent and meaningful process of information exchange, including a physician dashboard that includes relevant statistics that can be benchmarked against peers;
- FPP's active participation in strategic and operational decision making, including a monthly strategy meeting with Paladin/HUH leadership to discuss physician compensation

methodology, program development, capital budgeting, and strategic opportunities, among other topics; and

- Engagement with the FPP to coordinate professional development opportunities such as Lean/Six Sigma workshops, practice management seminars, and health care policy seminars.

Paladin management and FPP leadership will meet regularly with physicians active at HUH to review bed utilization statistics, case mix index, length of stay, patient satisfaction, claim denials, suspension days, consults per admission, queries, and other relevant information. Paladin and the FPP will work closely with physicians to educate them on proper and complete documentation to ensure patient safety and regulatory compliance, and to discuss performance and service opportunities.

Academic Affiliation Agreement

Paladin recognizes the significant and ongoing commitment the Howard's College of Medicine (the "COM") has made in the area of clinical research and healthcare disparities, particularly in the biomedical sciences arena. To the extent possible, Paladin is committed to ensuring that HUH continues to support the ongoing bioscience research studies at the COM and HSP. This support will include helping to maintain financially-viable specialty programs at HUH, whenever possible.

In support of a revised Academic Affiliation Agreement (the "AAA") between HUH and Howard, which will be initially drafted by Howard counsel and reviewed by Paladin, HUH, with the assistance of the FPP and HSP, will strive to operate at a level expected of premier academic medical centers of similar size. Whenever possible, HUH will maintain viable programs in all clinical departments necessary for the COM to maintain its accreditation by the Liaison Committee for Medical Education ("LCME"), and preserve high-quality clinical rotations for Howard's medical students. Subject to market forces and available training resources, HUH will work diligently to maintain clinical volumes to satisfy the requirements of the Accreditation Council for Graduate Medical Education ("ACGME") and the Residency Review Committees ("RRC") for graduate medical education (residency) programs. Should volume at HUH become insufficient to support these programs, HUH will work with Howard to identify academic affiliation relationships to help maintain Howard's LCME and GME accreditations and meet RRC requirements.

The FPP will provide all clinical coverage/call and assured physician staffing for HUH and help to direct and supervise residents and medical students. The FPP will be compensated as appropriate at fair market rates, subject to mutually agreed clinical, administrative, research, teaching and service agreements utilizing the "CARTS" methodology, which Paladin and Howard will work in good faith to construct on fair and reasonable basis. HUH and the FPP will also work to establish a mutually beneficial academic support program or "funds flow" that is anticipated to include, among other provisions, a market-based subsidy from HUH to the FPP based upon CARTS. Other than qualified community-based physicians or as otherwise agreed to by Howard, medical staff at HUH will hold some category of full time, clinical or voluntary faculty appointment from Howard. A methodology for sharing recruitments of department chairs, division chiefs, service chiefs, medical directors or other key physician leaders of clinical/academic programs will be mutually developed and agreed upon.

Paladin will cooperate and maintain liaisons with the executive office of the COM and HSP and assist with the management and administration of any academic affiliation agreements in effect between the University, COM and/or the HSP. If Howard deems it a priority, Paladin will allocate time and use commercially reasonable efforts to support the expansion of clinical translational research (including clinical trials, population studies and related research) at HUH.

Medical Executive Committee

In order to provide a forum for communication among representatives of the Medical Staff, it is anticipated that Paladin will continue to engage Howard's Medical Executive Committee (the "MEC") to recommend and assist with the development of policies and programs related to the clinical philosophy and objectives of Howard, including interaction with, training, support, and utilization of medical staff; research, training, and community service activities; maintenance of high standards of professional practices in and at the hospital, clinics, or other HUH-affiliated patient-care facilities; capital improvements for the Hospital; strategy, real estate development (as requested), and operations relating to an Ambulatory Network; and fundraising; among other considerations. [redacted]

REPORTING TO HOWARD

Strategic Plan and Budget

At least 30 days prior to the end of each fiscal year of the term of the MSA, Paladin will deliver a draft Strategic Plan and Budget that will set forth, among other matters:

- Operational initiatives such as profit improvement methods, cost reduction priorities, efficiency improvements, business development objectives, and synergistic opportunities;
- Strategic initiatives that are predominately targeted at growing volume and revenue;
- Operating budget setting forth an estimate of operating revenues and expenses for the next fiscal year, which operating budget shall be in reasonable detail and shall contain an explanation of anticipated changes in utilization, patient charges, payroll, and other factors differing significantly from the prior fiscal year;
- Funds flow budget outlining services purchased by HUH from and transfer of monies to FPP based upon a formal CARTS analysis (study to be funded by Howard and elements documented in writing);
- Capital expenditures ("CapEx") budget outlining a program of necessary capital expenditures for the next fiscal year, which budget shall designate capital items as either emergency, mandatory or desirable; and
- Projection of cash receipts and disbursements based upon the proposed capital expenditures and operating budgets, which projection shall contain recommendations concerning use of excess cash flow, if any.

Once finalized among Paladin, the FPP, the HSP, and Howard leadership, the plan will be presented to the Management Committee and Board for approval. This Revised Strategic Plan and Financial Forecast is intended to satisfy all related production requirements under the MSA for FY2015.

Data Deck

Turning around a hospital is an extremely complicated and sensitive process, and quality data is mission critical. Based upon readily available information from Howard, Paladin will closely track the financial and operational performance of HUH to help ensure that specific goals and targets are met. Each month, the organization will compile a "Data Deck" which will be made available to each member of the Management Committee (and other select personnel) to ensure consistent visibility into the financial and operational performance of the Hospital. To the extent that HUH's current IT and finance systems are limited in their ability to produce meaningful and accurate reports, significant effort will be made to facilitate the production of such data.

In addition to unaudited monthly financial statements, the Data Deck shall include the following:

- Quality of Care and Service Excellence Metrics — Paladin will review quality metrics on a monthly basis, including tracking those quality indicators that may relate to the pay-for-performance aspects of healthcare reform. Specific outcomes or cases that negatively impact quality scores will be reviewed and the appropriate staff educated on the correct response. Paladin will also track patient, employee and physician satisfaction scores; turnover rates; and changes to the medical staff.

- Cost and Productivity Measurements — Paladin will track expenses on an adjusted basis. Close attention will be paid to productivity measurements such as salaries, wages and benefits per adjusted occupied bed or adjusted patient day and salaries, wages and benefits as a percentage of net patient service revenue. These metrics will help to ensure that the Hospital is staffed appropriately and efficiently, subject to limitations under various collective bargaining agreements.

- ED Measurements — Paladin's ED-centric model requires a particular emphasis on indicators such as visits, left without being seen (LWOBS), LOS, and Paramedic runs. Paladin will communicate these results to the emergency physicians, which Paladin believes will result in greater diligence and efficiency in the management of patient care at HUH. HUH's ED data is currently being produced manually and on paper, which creates significant barriers to gathering meaningful data in a timely manner. In conjunction with Howard and FPP, Paladin expects to select an electronic EHR in the second part of FY2015 and implement it in the first half of FY2016.

- Patient Days, Average Daily Census (ADC), and Average Length of Stay (ALOS) — Patient days and discharges by bed type will be tracked, along with ADC and ALOS (by payor type) to illustrate patient flow on a monthly and yearly basis. Medicare geometric mean length of stay ("GMLOS") will be determined and compared quarterly. By actively sharing these statistics with HUH physicians, Paladin will require greater diligence and efficiency from the physicians, resulting in improved length of stay and, hopefully, lower costs.

- Case Mix Index — Case Mix Index (CMI) measures the level of acuity of admitted patients. Statistics are kept for Medicare CMI, with numbers greater than 1.3 generally considered in the high range and reasonably acute. Paladin will institute clinical documentation training and review practices that it believes will lead to more accurate determination of CMI and more appropriate payment for the services HUH performs.

- Revenue Management — Idiosyncrasies associated with each particular payor requires management to break down gross revenue and track monthly and yearly trends by payor class. Each month, Paladin will review the net revenue by payor class, net patient revenue per adjusted patient day against budgeted figures.

- Provider Scorecards — Paladin will work with the FPP to create Provider Scorecards to serve as user-friendly tools to enable individual physicians, physician assistants, and nurse practitioners to compare their performance at HUH with that of their peers. Provider Scorecards will include data that is designed to balance clinical efficiency with quality of care, including metrics associated with LOS by CMI versus benchmark; readmission, infection, mortality, and comorbidity rates; and other objective data that is readily available. Provider Scorecards should help to align provider accountability with organizational objectives by expanding awareness and understanding of how individual providers impact the Hospital, promoting discussions among them regarding best practices and clinical pathways, and creating numerous mentoring opportunities. [redacted]

Daily reports measuring inpatient, ED, and ambulatory volume, and weekly reports measuring collections and cash balances, among other data, will be distributed and reviewed by members of senior management and be available upon request to Howard. In addition, a monthly key performance indicator dashboard, highlighting operational, financial, quality and service, materials and facility management, on a monthly and year-to-date basis in comparison to budget or benchmarks will be distributed to all members of the management team. By monitoring these metrics and identifying trends on a daily and monthly basis, Paladin and Howard can proactively manage and control expenditures, maintain productive relationships, and ensure the highest possible levels of patient care.

THE PLAN TO TRANSITION AND STABILIZE HOSPITAL OPERATIONS

Paladin has developed various key strategies and operational tactics that, when implemented effectively and in combination, are expected to improve performance in both the quality of healthcare services and financial results at HUH. Such strategies and tactics include reducing costs through the right-sizing of departmental staffs, enhancing emergency department operations and volume, tightening the supply chain, renegotiating and/or securing new payor contracts, improving revenue cycle processes, optimizing bed utilization, and implementing revenue enhancement programs where applicable. The foundational elements of Paladin's transition plan for HUH in FY2015 are as follows:

Promote a Culture of Excellence in Care Delivery and Customer Service

The development of a culture of service excellence at HUH is essential to its sustained survival and is directly connected to the overall success of the enterprise. In order to provide a world-class patient experience, superior clinical and financial outcomes, and ultimately sustained volume growth, HUH and Howard leadership must develop and sustain a culture that is marked by the provision of information, courtesy, and responsiveness, fueled by employee and physician engagement, transparency, and accountably.

Central to this commitment is employee engagement and the development of employee loyalty at all levels of the organization. It is difficult to have an engaged and loyal patient base without first having engaged and loyal associates. Additionally, a fundamental paradigm shift must take place with all HUH leaders and associates with an organization commitment, at all levels, to protecting and enhancing the patient experience as the highest priority for all who want to remain associated with the organization.

Patients are the heart and soul of HUH, and every patient deserves a world-class service experience. Employees must be willing to do whatever it takes to serve the patients' needs and receive an employee's best effort with every interaction. Adopting this patient/customer service approach will help to deliver a hospital that is clean and friendly, with the safest most extraordinary care and outcomes in the region.

Consistent Enforcement of Tight Staffing Policies and Procedures

Paladin is committed to ensuring that HUH provides quality care on a highly efficient basis. To the extent allowable under current Collective Bargaining Agreements ("CBAs"), staff members are assigned clinical responsibilities based on education and training, applicable licensing laws and regulations, and an assessment of competence. Staffing plans for patient care departments are developed based on the scope and intensity of care to be provided, the frequency of the care to be provided, and determination of the level of staff required to provide appropriate care. The departments within each hospital operate according to a staffing plan that has been developed by management with input from Paladin professionals. The plan will be reviewed and modified at least annually based on the needs of patients, patient satisfaction surveys, performance improvement activities, changes in patient needs/expectations, and budget/resources available. Once developed, measurement tools will be utilized by management to assess the effectiveness of the staffing plans and their conformance with the budget.

Programs to promote recruitment, retention, development, and continuing education of staff members will be provided to enhance and encourage employee retention and patient care. Education and orientation of personnel is the responsibility of the department manager, with the support of the Human Resources department. An approach that customizes the staffing according to volumes, acuity, seasonality, variability of volumes by day of week and hour of day, and levels of available staff is essential. This ensures that the organization will consistently meet the needs of its customers (e.g., patients, physicians, staff, Paramedics, and visitors) by having the right number of people in the right place at the right time.

The revised staffing approach at HUH took all these factors into consideration, with each department considered individually. The current staffing configuration was indexed to volume to discern the worked hours/statistic (depending upon the department and function). This was compared to the Solucient® database for teaching hospitals, hospitals of comparable size, and hospitals within the region. Other databases were utilized to complement the Solucient® data such as the recommended California nurse-to-patient ratios, the Association of Women's Health, Obstetric and Neonatal Nurses (AWOHNN) standards, and American Association for Respiratory Care (AARC) workload measurements. A recommended/restructured staffing plan was developed with the unit management to try to achieve a staffing pattern at or better than the 50th percentile in the applicable database.

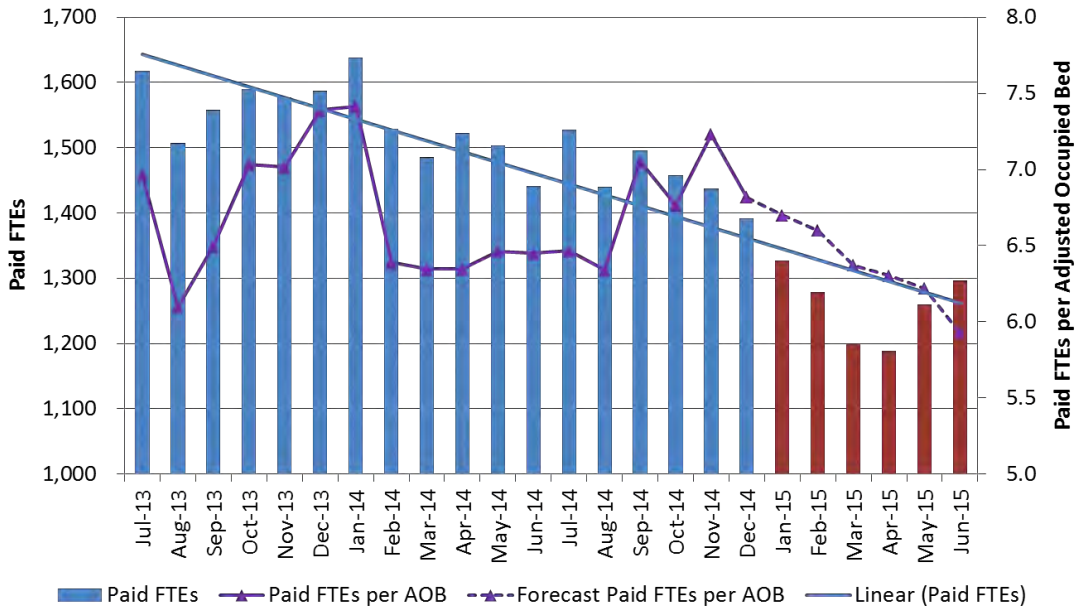
As a result of this evaluation, there were some departments that showed the need for additional staff, whereas others require a reduced staff or no changes. The current and recommended staffing plans were converted, by classification and by collective bargaining unit (each, a "CBU"), into staff increases or staff reductions, netted by the number of personnel who had already left the organization during the voluntary buy-out. In addition to evaluating the staffing levels of the departments, the span of control and levels of management were assessed. The goal was to "flatten" the organization and have an appropriate number and levels of management to facilitate effective and more rapid decision-making throughout the organization.

The span of control was also evaluated in the Finance Department and changes to its structure were included in the right-sizing of the organization. In addition to acute care operations, the strategic realignment of the hospital-based clinics was also part of this initiative. Based upon disparities in access, quality, and service, and a lack of significantly differentiated reimbursement, the decision was made to move all of the hospital-based clinics (except Dentistry) under control of the FPP.

[redacted]–The recent non-union RIF included 35.5 FTEs and yielded approximately $4.2mm of annual salary and benefit savings. RIFs for DCNA and 2094 will occur in February/March 2015. Because of the "bumping" process for union employees, final estimates of cost savings will not be available until the end of March 2015.

Ensuring that the staffing levels are appropriate given future volumes is critical. This will be achieved by actively monitoring the worked hours versus the volumes for each department based on agreed upon standards. If funding is available, a number of different monitoring tools will be developed and deployed for this purpose over the next 90 to 120 days.

Bases upon the revised staffing pattern, it is anticipated that HUH will approach more competitive staffing benchmarks by the end of FY2015, as reflected on the following graph:



Optimize Emergency Department

A particular strength and focus of Paladin's business model is ED management. Central to this model is the view that paramedics and emergency medical technicians (together, "Paramedics") are vital customers of HUH. A significant effort will be directed to establishing strong, coordinated relationships with District of Columbia Emergency Medical Services, and earn confidence that Paramedics are safely and efficiently presenting patients at a competent hospital.

After observing the ED patient flow and reviewing policies and procedures, Paladin is highly confident that its operations expertise can enable the HUH ED to become more efficient and effective. Paladin's goals include:

- Reducing "wall time" (time between a Paramedic's arrival to the ED and the patient being accepted by the Hospital such that the Paramedic can leave),
- Reducing LOS (time between a patient's arrival to the ED before being admitted or discharged),
- Reducing LWOBS (percentage of patients presenting to the ED that leave prior to receiving treatment, most often due to excessive Wait Times),
- Increasing patient and Paramedic satisfaction (often a byproduct of all of the above).

Paladin expects to achieve such objectives through a series of specific profit improvement initiatives related to the ED. Initiatives and tasks that have been identified and are in progress include:

- Paramedic Outreach — Beginning in October, Paladin's consultants and HUH management began conducting visits to the local firehouses. Monthly follow-up visits are expected to continue in order to maintain relationships. Responsibility for outreach falls on all staff within the ED and for hospital management. In addition to firehouse visits, Paramedic barbeques, and "ride-alongs" will be conducted to encourage interaction between the Hospital and Paramedics.
- Address Staffing Concerns — Currently, the ED is understaffed by approximately six-to-eight physician and nursing FTEs. A temporary staffing solution is in place and management is looking to hire appropriate personnel to meet the demands. Paladin's team is working with contacts throughout the industry to attempt to fill some of the holes, particularly on the physician side.
- Value Stream Mapping — Paladin has mapped the ED patient flow with an eye towards improving door-to-doctor times. Observations and suggested process changes have been provided to management for review and implementation. A "two-hour rule" has been recommended as the target, which would require physicians to make an admissions decision within two hours of a patient being presented to the ED. A specific work plan is being developed based upon the findings and new policies and procedures will be proposed to the physicians and ED leadership.
- Paramedic Lounge — Paladin recommended outfitting a Paramedic lounge and the revamped setting was opened in late November. Initial feedback from the Paramedics has been very positive.

- Observation Pilot Study — This program is presented in detail below. Initial results indicate a significant increase in inpatient admissions and reduction in cases inappropriately designated as observation stays.

- Electronic Medical Record — Paladin's advisors have been evaluating electronic medical record (or "EMR") solutions for the ED. To date, discussions have centered on products from MedHost and Siemens. While the consensus is that the MedHost product is superior, it has yet to be proven to fully integrate with the Hospital's current system (Sorian). Paladin and its team plan to have a recommended solution ready for the March Management Committee meeting. Implementation of this system will take time and progress on other fronts, such as implementation of Computerized Physician Order Entry "CPOE" and turnaround time for lab and radiology, will continue through this "bridge" period. Additionally, Paladin has suggested the use of scribes in the ED, both as an interim solution before the EMR system is implemented and as a continued practice post-implementation.

- Bed Capacity — There is currently a subset of beds in the ED that have been set aside for pediatric emergency needs. These beds are largely unfilled, and Paladin has recommended converting these beds to medical/surgical use. Management has begun the process of converting the beds and ensuring that adequate staffing is in place.

- Facility Improvement — A renovation plan is being developed by management to address immediate functional and cosmetic needs. Once funding is approved by the Management Committee, a cosmetic facelift of the ED will be undertaken, which is expected to improve patient and Paramedic perception of HUH's ED operations.

Additionally, there are several dynamics in the District market that could greatly favor the Hospital. Despite recent reductions in ambulance volumes at HUH, volumes across the district have been increased by an estimated 6% annually, with a disproportionate share of the growth attributed to Wards 7 & 8. However, of the approximately 151,000 DC EMS calls in 2014, Paladin estimates that only 16,740 (11%) were directed to HUH, a low figure given HUH's physical location and brand recognition. There appear to be opportunities to recapture ED traffic which was historically presented to HUH, but is being redirected to other area hospitals due to increased competition from George Washington and Washington Hospital Center, among other factors.

Paladin bases its ED management strategies on placing the success of each hospital before its own gain to ensure the community retains access to the vital services and the "safety net" that a hospital's emergency department provides. By solidifying HUH's relationships with the local Paramedic and patient populations, improving the internal flow of patients, and bolstering the medical staff with highly qualified, experienced, and caring ED providers, HUH should rebuild patient volumes. Profit improvements from optimizing the ED will take time given the construction and resource requirements that are not yet finalized. Accordingly, the estimated timeframe for completion is FY2016.

Impeccable Clinical Documentation

Paladin places a significant emphasis on accurate and comprehensive clinical documentation. Improved documentation increases charge capture, which can have an immediate and dramatic impact on the bottom line. In addition, precise documentation can increase patient safety, improve workflow, promote collaboration and improve communication among clinicians, and allow for more nurse-patient time and better utilization of physician time.

Paladin's documentation training and support program empowers physicians by enabling them to document with consistently improving levels of precision to more accurately reflect Case Mix Index ("CMI") and favorably impact clinical and financial outcomes. There is a clear disconnect at HUH between CMI and length of stay ("LOS"), indicating that physicians are leaving justifiable charges on the table, that inpatient management is sub-optimal, or a combination thereof. Paladin's preliminary assessment indicates that there are significant opportunities to improve documentation processes at HUH and capture justifiable charges, based solely on improvements to Medicare documentation.

Over the past four months, Paladin has deeply assessed the physician education and documentation process. In November 2014, Paladin's documentation experts met with hospital and physician leadership to understand the current process and identify ways to improve the query process. After gathering this initial data, Paladin made a presentation to the physician leaders that identified major issues and pointed towards the financial implications of poor documentation.

Paladin has initiated and will continue to implement a number of projects designed to improve documentation and establish ongoing policies and procedures to ensure continued commitment to strong documentation practices. Included in those projects are:

- Lectures to Residents — Dr. Lally has conducted lectures to the residents on documentation. On a quarterly basis, documentation lectures will be presented to both residents and the entire medical staff. The upcoming lecture will focus on the two-midnight rule (March 2015). Going forward, such lectures will be video recorded so that residents and physicians that were not in attendance can view.

- Review and Revision of Query Forms — Drs. Bell, Lally, and Kumar plan to formally review the query forms and present feedback to management and physician leadership in February 2015.

- Chart Review — Drs. Lally and Kumar are reviewing charts to identify opportunities to make improvements and educate related physicians. Dr. Kumar has a daily phone conference with a HUH physician who assists in review of charts. Opportunities for improvement are then relayed, daily, to the relevant physician.

- Documentation Booklet — Drs. Bell and Kumar are compiling a documentation booklet for the entire medical staff. The booklet will focus on procedures and protocols for proper documentation. On-site physician "champions" will play an integral role in ensuring compliance with related policies.

- Justification for Acute Care Admission Form — In conjunction with the observation pilot study, Drs. Bell and Lyn plan to revamp the acute care admission forms. Further details on the pilot study are included herein. In many instances, a long-term solution to documentation and processes will be the full integration of an EMR system. "Bridge" processes have been proposed, including "check-box" forms that can help physicians to more easily determine if patients meet admission criteria.

- Training around CDP (Chief Complaint/Diagnosis/Problem List) - While the CDP capability has existed in Siemens Soarian system it has not been used up to this point. This was discovered while working with residents and physicians to create the Rounding Report. Dr. Lally will incorporate the introduction and usage of this feature as part of his ongoing lectures. The potential impact of this feature on improved documentation and CMI is expected to be significant.

- Development and introduction of Siemens Rounding Report to replace DocDox, with features and capabilities that provide real time clinical data to manage patient care, as well as LOS.

- Hiring of CDI Staff — In order to perform concurrent query processes HUH needs at least three additional CDI FTEs. There is a general concern with the competitiveness of HUH's salaries. In the interim, a CDI "team" will be created to help backfill needs and eventually train the new staff.

The FPP must remain engaged in the CDI process, as it will be difficult to realize sustainable improvements without FPP support. It may be appropriate to assess the current FPP compensation plan to ensure that incentives are aligned for physicians. For example, compensation that reflects performance on completing documentation in a timely and complete manner may help to enhance results. The HUH Chief Medical Officer will work directly with the Associate Dean for Clinical Affairs to coordinate.

Accurate Designation of Inpatient Admissions

Given significant changes to CMS policies related to hospital admissions and observation stays, hospitals and physicians have struggled to keep up with the correct criteria required to admit patients as an inpatient. Medicare (and subsequently Medicaid) intends to not pay full "admission" rates for patients that require short stays in the hospital and has implemented several rules governing this process. Another change occurred in 2014 when Medicare issued a new policy, commonly referred to as the "two-midnight rule" — that establishes new criteria for inpatient admissions. The decision to admit is now based on physician expectations that admitted patients require at least two midnight stays in an acute care bed.

After analyzing historical data, it became clear that HUH's ratio of observation to inpatient stays was disproportionately high in comparison to industry benchmarks and warranted a detailed analysis. In October, Paladin physicians began an in-depth chart review of observation and inpatient cases to determine the root-cause of the historical trend of increased observation stays. This study demonstrated a significant number of cases where patients clearly met admission criteria yet were classified as an observation stay. The financial impact of misclassifying patients in this way is significant, particularly given that the hospital provides the same care and expends the same resources for patient's incorrectly classified as observation. The reimbursement difference is as much as eight times for Medicare, and six times for Medicaid managed care.

Paladin implemented a 30-day pilot program to educate physicians on the appropriate clinical classification of patients and the documentation that is required to validate that the appropriate classification was made, which is critical to collecting appropriate levels of reimbursement on the back-end (see the Clinical Documentation section above). The initial results of the pilot indicate significant progress, with the number of inpatient admissions rising relative to observation stays. In January 2015, Paladin physicians with the concurrence of the Management Committee, decided to continue the pilot before establishing the program as standard operating procedure.

- Building on the promising results resulting from the first phase of the pilot, phase two of the pilot will be extended such that a larger number of physicians — both residents and attending physicians — are trained and that the cycle all the way through to collections is successful.

- Paladin and HUH physicians will continue chart reviews to make sure the emphasis on appropriate classification is sustained and ensure that the policy does not prompt admission of patients that do not meet clinical criteria. Following phase two, Paladin will finalize protocols and institute related policies and procedures.

Efficient Inpatient Management

Paladin's hospital operating model is rooted in the belief that "efficiency is the friend of quality care" and vice versa. A key element of Paladin's strategy for HUH is the develop hospitalist and case management programs, with the significant participation of a Medical Director and COO/CNO who are familiar with and trained on both the business and operational aspects of medicine, as they are most directly involved in managing relevant aspects of hospital operations, including patient flow and quality assurance, in order to properly coordinate the clinical side of the operations with the business side.

HUH hospitalists are physicians that are or will be specially trained in inpatient care, and who take charge of patient cases upon their admission to the Hospital and act as team leaders to help coordinate the medical care patients receive throughout their stay. The hospitalists work with specialists, nurses, other health care professionals and, as appropriate, the patients' primary care physicians to ensure the delivery of quality care and the best possible outcome. As patients recover, hospitalists work with the medical staff, along with patients and their families, to develop discharge plans and discuss any follow-up care that patients may require after leaving the Hospital. HUH hospitalists should be familiar with key staff in the Hospital, including medical and surgical personnel, case managers, discharge planners, medical records, and others, to ensure a high level of quality and efficiency, and facilitate the discharge of patients without undue delay. Based on a detailed assessment by Paladin's team of physicians, a contemplated hospitalist program at HUH should improve health outcomes and enable patients to return home more quickly than they otherwise might have. This program will rely on a hospitalist that acts as a Medical Director to oversee residents and admitting physicians.

Through a series of education programs led by Dr. Lally, current and future hospitalists will be trained in the operating strategy, disciplines, practices, and overall philosophy of Paladin, which often relies on the hospitalist to convey this information to other physicians and staff at the hospital. Paladin tracks physician metrics daily and meets with hospitalists at least once a month to review current cases, successes and failures, and provide education to drive continued improvements.

In conjunction with the hospitalist, Paladin has begun to implement a Case Management to ensure that patients are admitted and transitioned to the appropriate level of care. Case Managers are responsible for the implementation of patient care plans, including communication and coordination with patients, families, and third-party providers. As a result, physicians can focus on what they do best — diagnosing patients and developing appropriate treatment plans. To support the Case Management program, a new Utilization Review/Case Management ("UR/CM") Director was recently hired and is working closely with the COO/CNO to accelerate the implementation and optimization of the program.

In support of these initiatives, Paladin's process improvement experts spent considerable time observing the current work-flow as patients move from the ED to the inpatient setting through discharge. These observations, along with historical data comparing LOS to a national benchmark, indicate significant room for improvement in inpatient management. Goals for the remainder of FY2015 include:

- Implement Hospitalist Medical Director— Recruiting a physician leader to oversee the hospitalist program is already underway. This position would have several responsibilities including rounding every morning of all patients admitted the prior day, rounding with case managers, and developing relationships with community sub-acute providers.

- Value Stream Mapping — Paladin has mapped the ED patient flow and will use the same technique for the inpatient and discharge process. This will identify key bottlenecks, such as staffing or physical layout, that can be addressed to improve inpatient management.

- Building Relationships with Post-discharge Providers — Coordinated relationships with skilled nursing facilities ("SNFs"), long-term acute care hospitals ("LTECHs"), and home care agencies ("HHAs") can be established and/or strengthened to ensure patients with continuing needs have an appropriate and safe place to go after they are discharged (see Appendix B).

The academic orientation and commitment to quality of HUH's physicians and nurses, coupled with Paladin's ability to educate and empower such clinicians, will lend to the development of effective hospitalist and case management programs at HUH. The ongoing reduction in force and upcoming renegotiation of CBAs make the financial impact of this program imprecise at this point, although tangible improvements are expected and will be quantified as soon as these uncertainties are resolved. The program will continue forward through the remainder of FY2015 and beyond, and is expected to make a highly favorable impact on patient satisfaction and quality of care for the foreseeable future.

Materials Management

As is typical of most financially distressed situations, HUH's relationships with certain vendors have become strained. Paladin has completed a preliminary analysis of all critical vendor and other contracted parties and is currently implementing a cash management program designed to preserve cash while pacifying such vendors. It is anticipated that this program will continue until HUH returns to profitability. Where appropriate, Paladin is attempting to renegotiate certain contracts on more beneficial terms.

HUH's supplies expense per occupied patient day is high relative to industry benchmarks, providing ample opportunity for profit improvement. Paladin is committed to ensuring that supply expenses are kept under efficient control through effective management, including eliminating duplication, standardizing products, purchasing less expense equivalent products where possible and efficacious, controlling inventory levels, and streamlining production distribution methods. Paladin prefers to control the allotment of supplies through electronic distribution whenever possible.

HUH's Medical Director will be instrumental in the purchasing process, and is responsible for establishing guidelines which are designed to keep supplies costs down. If an item's cost or specifications fall outside of the guidelines, it is Paladin's policy that employees must first receive approval before ordering the item or using such item in the treatment of a patient.

The supply expense reduction plan includes, among others, initiatives to address physician preference supplies and equipment, laboratory instrumentation, reprocessing supplies and office supplies. In addition, the HUH Value Analysis Committee will continue its product standardization efforts in key clinical areas such as radiology, perioperative services, and the pharmacy. Based on a comprehensive review and analysis of contractual arrangements and internal processes, Paladin is projecting that it will achieve a 10% expense reduction across the supply chain (based on current census).

An assessment of the hospital's GPO participation reveals further opportunities. The primary GPO for HUH is Novation, but the Hospital has been a member of the MedAssets GPO for well over 12 years. HUH does access MedAssets for certain services and supplies, when more favorable pricing is available. The best way to recalibrate the relationship with the existing GPOs is to initiate an RFP process, which HUH expects to benefit from in FY2016, targeting the following objectives:

- Greater contract compliance;
- Increased rebates;
- Participate in share back (% of GPOs collected administrative fees (2% - 3.5% of sales));
- Costs savings (as a result of more aggressive pricing of contracts, tier optimization, contract compliance);
- Benefit from services as a result of new membership agreement (e.g., core measures, revenue cycle, benchmarking)
- Process improvement in areas such as energy, workforce, clinical resources, supply chain, facilities, food services, bed management, patient transport;
- Maintain current or lower fees with improved service;
- Adjusting policies and procedures relating to the HUH supply cabinets to control utilization, increase inventory turns, reduce supply costs, and improve revenue capture; and
- Launching a sourcing initiative to choose a new GPO partner is expected to improve contract compliance, tier optimization, rebates, and share-back opportunities, with Paladin leveraging its existing partnership with MedAssets to ensure the best possible pricing for HUH.

Based on the various strategic cost reduction initiatives, the Supply Chain management team believes that the Hospital will experience at least a $29 supply expense per APD reduction for the six (6) month period ending June 30, 2015.

Renegotiate Managed Care Contracts

HUH receives payment for patient services from Medicare, Medicaid, managed care providers, commercial contracts, and other payors, including workers compensation and private insurance organizations. Ongoing review of managed care contracts is crucial to sustaining adequate reimbursement rates as the costs of providing care rises. Accordingly, Paladin has performed a financial analysis on each payor contract to ensure that HUH is receiving appropriate reimbursement levels. At the core of Paladin's strategy is the aim to renegotiate managed care contracts that are inherently unprofitable or below market rates, and if necessary and subject to Howard's approval, it may be appropriate to cancel unprofitable contracts in situations where the health plan/payor is unwilling to agree to reasonable reimbursement rates. Philosophically and strategically, Paladin is comfortable with volume declines from cancelled contracts, as breaking unprofitable contracts could have a positive impact on HUH's bottom line. Separately, the claims department staff must be thoroughly trained and educated in documentation, billing, and collections procedures to ensure that clean claims are submitted. This will be an ongoing process.

Building off of work performed by Weiser and the Hospital's performance over the past two quarters, three of the following agreements have been renegotiated to either improve the contract terms and rates due to HUH or to avoid a forthcoming rate reduction by becoming a non-participating provider. Two contracts are in final stages of negotiation. All rate increase values listed below assume the same volume and mix of patients as in the previous year. Total estimated annual revenue increase from renegotiated contracts based on the current census is $2.68 million.

- Aetna — Legacy ten-year Commercial agreement that was on monthly extensions since 2013 has been renegotiated from a per diem to a DRG-based reimbursement structure. Effective date of the new contract was November 1, 2014. Anticipated annual income in the first-year of new agreement will increase by 36% or approximately $728k over the previous year.

- Care First / Blue Cross — Commercial and Medicare agreement that was schedule to expire December 31, 2014. The rates have been renegotiated and an 11% overall increase became effective on January 1, 2015. The term of the contract is three years. Anticipated annual income in calendar 2015 of new agreement is anticipated to exceed the prior by approximately $817k.

- Trusted Health — Medicaid managed care contract that was at a high rate (i.e., an enhanced rate above 100% of Medicaid) was threatened to be terminated by Trusted in order to bring the payment rate down to 100% of Medicaid. Parties agreed upon reimbursement that applies new higher rates approved by the District effective October 2014, but at a lower percentage than in the original contract, enabling HUH to avoid a reduction in overall revenue from Trusted. The contract was made retroactive to May 1, 2014 and no expiration date, but has three-year escalators with renegotiation in year three.

- United Healthcare — HUH is in the final stages of contract negotiations with United for its commercial membership and, are anticipated to be completed by March 15, 2015, yielding an annual increase during the first year of the new agreement of approximately $536k or 30% over the prior year based on historical volumes. The negotiations were successful in changing HUH's reimbursement to a DRG based methodology.

- Cigna — Commercial contract that has not provided a rate increase since 2012. Proposals have gone back and forth over the past several months, but Cigna had been hesitant to grant any increases above 3% without knowing whether they would become the health plan for employee health coverage at Howard and HUH. Since Howard is self-insured, HUH proposed two rates — a lower set of rates for the Howard health plan beneficiaries and a higher rate for all other beneficiaries. HUH is awaiting a response from Cigna regarding this proposal. Recent discussions appear favorable and could result in a 7% rate increase that would yield approximately $600k of additional net revenue based on historical volumes. The terms of the contract have not yet been finalized. Howard recently awarded the employee health contract to Cigna, who has been contacted by HUH to finalize the agreement.

Billing and Collections

The suboptimal performance of HUH's billing and collections systems has had a dramatic impact on the financial performance, profitability, and cash flow of the Hospital. A root cause analysis has revealed deficiencies along the entire revenue cycle, including insufficient or inaccurate collection, inaccurate recording and verification of patient and payor information by the Admitting department, incomplete or inaccurate payor tables, incomplete clinical documentation, late submission of billings to payors, and a failure to appropriately respond to otherwise reversible denials.

Accurate and efficient billing and collections systems have a direct correlation to minimizing claims denials and optimal cash collections. During the due diligence process, Paladin assessed the quality of existing billing and collections functions in relation to best practices and believes there significant opportunities to dramatically improve cash flow through the implementation of efficient systems managed by competent employees. Ultimately, Paladin intends to install a range of new processes and protocols for inpatient and outpatient admissions and coding, and admissions error reporting and feedback for the Admitting department.

The first key initiative being implemented by the Revenue Cycle team is an aggressive program to minimize the current state of denials incurred at HUH. The first six months of FY2015 generated in excess of $37mm in denied claims, of which 69% or approximately $29mm were from DC Medicaid. These inpatient denials resulted from non-authorized care, authorized observation then denied due to patient admission, unnecessary care, and/or poor/lack of documentation. In addition to lost collections, denials produce significant rework and prevent Revenue Cycle staff from working on other important tasks.

The Revenue Cycle team instituted a Denials Management Steering Committee that commenced on January 29, 2015. The Committee estimates that reductions in denials will yield a $1mm increase in Net Patient Revenue in FY2015 and $4.4 million in FY2016. To ensure that these targets are met, the following actions have been implemented and are ongoing:

- Relocated a denial management staff member from the Business Office to the Utilization Management department to assist with “front-end” clinical review, documentation, and authorization processes, as well as coordinating requests from payors for additional information to clear claims and receive reimbursement.

- Conducted training sessions regarding a range of payor-based software (including DC Medicaid) to improve compliance with payor authorization procedures. Additional training programs are contemplated on a regular basis.

- 3M ARMS product “go-live” on February 1, 2015. This enables manual edits performed on the "back-end” business office for entering of modifiers to be replaced by an automated process at front-end clinical areas. This reduces discharged not final billed (DNFB) days, improves “clean” claim submission, and enhances cash acceleration. Training was completed on January 27, 2015.

- Implementation of Soarian Scheduling Advance Beneficiary Notice (ABN) Module is slated for February 16, 2015. This software will automatically prompt registration/admitting staff to execute an ABN for Medicare patients. HUH has not historically completed ABNs.

Other Revenue Cycle initiatives that are underway or slated for FY2016 include:

- Focus on “Propensity to Pay” analysis of Self-Pay and Patient Balance after Insurance financial classes.

- Automation of manual processes in Soarian, which should result in better productivity, less human intervention, increase in “clean claims” and faster payments. Most of the automated processes had been turned off previously.

- Re-training and focus on accurate identification of patient insurance carrier at time of registration and admission.

- Timely authorization capture and updating authorization if patient treatment or status changes.

- One time cash acceleration through decreasing bill hold times, due to lack of charge capture or documentation.

- Automated manual workflow processes such as changing account financial classes, account status and payment postings. These and other automations should increase staff productivity and help to ensure that all accounts move through the claims adjudication process in a timely and efficient manner.

- HUH currently has 7.5 FTE openings for certified coder positions. The lack of certified coders negatively impacts HUH's ability to file claims in an expeditious manner, due to back logs in coding of medical records for submission of claims to payors thereby extending DNFB days and delaying cash receipts. HUH has successfully negotiated with Local 2094 to contract with outside resources to provide this function on an ongoing basis until HUH can recruit and employ certified coders (or secure an outsourcing solution). Local 2094 agreed to allow this function (while performed by outside resources) to fall outside the CBA.

ADDITIONAL OPERATING INITIATIVES

To date, Paladin has identified a number of prospective profit improvements, before addressing the CBAs. There are numerous additional operational levers that can be pulled to drive incremental performance improvements to quality and/or financial performance that, in aggregate, can add up to a considerable amount of EBIDA improvements. Some of the opportunities identified to date include:

Near-Term Opportunities

- Employee Health Plan — Howard recently re-awarded the employee health plan to Cigna. HUH was not involved in the negotiations and has not been informed of any changes, savings, plan design, costs, or employee shared costs.

- Eliminate Pediatric Coverage — The volume of pediatric patients seen in the ED is very low (about five per day}. After consultation with the Chairs of Emergency Medicine and Pediatrics, HUH management was able to eliminate pediatrician call coverage after 5:00 pm for an annual savings of about $450,000.

- Transfer Specialty Clinics to FPP — In performing a review of the hospital-based clinics, it became apparent that the management of the specialty and family medicine clinics was not in alignment with its primary strength; that is, running hospital operations. HUH leadership explored the possibility of moving the specialty and family practice clinics to the FPP. The evaluation was positive and such clinics, with the exception of the Dentistry clinic, will be operated under the FPP in the coming weeks. Transferring specialty and primary care clinics to FPP impacts about 25 FTE's and is expected to save HUH approximately $1.6 million annually.

- Adding Key Staff Members — Permanent employees will be recruited to replace interim managers and directors in the following departments: Quality, Utilization Review/Case Management, Emergency Department and Surgical Services. The recruiting process will start in FY2015; however, candidates are unlikely to start until FY2016 and ~~substantial~~ savings should be realized at that time.

Additional Near-Term Opportunities Not Yet Quantified:

- Cell Phone Usage – Management is reviewing the distribution and usage of cell phones throughout the entire campus. Management is looking to limit cell phone access to critical members of the hospital staff and/or have HUH reimburse employees in need of cell phone access a flat fee of $40 per month. Conflicts with any CBAs are also being reviewed and management plans to resolve cell phone distribution and reimbursement within 90 days.

- Meaningful Use – Several items remain incomplete with respect to HUH's achieving Meaningful Use Stage 2 (MU2) compliance. Although recent comment by CMS indicates the MU2 reporting period will be reduced to 90 days from the previously approved 365 days, this change has not been finalized. Given HUH's current state of readiness, the Hospital should capitalize on the recent visibility created at the Executive Director's meeting to fully engage operational leaders in implementing processes required to achieve MU2, in particular those related to patient engagement, such as patient use of the patient portal. Significant financial impact exists in terms of incremental revenue and penalty avoidance should HUH achieve and maintain Meaningful Use compliance. Although incremental revenue is based on patient volumes during the measurement period, initial financial projections related to MU, as identified by a third party consulting firm previously were as follows:

HOWARD UNIVERSITY HOSPITAL
EHR INCENTIVE PAYMENTS
ESTIMATES FOR FY 13 - FY 16

Based on Meaningful Use Attestion for Medicare in FY13

	FY 13	FY 14	FY 15	FY16	Total
Aggregate EHR Amount - Medicaid*	$3,013,627	$2,410,902	$602,725	$0	$6,027,255
Aggregate EHR Amount - Medicare	$1,324,217	$974,062	$637,070	$312,589	$3,247,938
Total	**$4,337,844**	**$3,384,964**	**$1,239,795**	**$312,589**	**$9,275,193**

Based on Meaningful Use Attestion for Medicare in FY14

	FY 13	FY 14	FY 15	FY16	Total
Aggregate EHR Amount - Medicaid*	$3,013,627	$2,410,902	$602,725	$0	$6,027,255
Aggregate EHR Amount - Medicare	$0	$974,062	$637,070	$312,589	$1,923,721
Total	**$3,013,627**	**$3,384,964**	**$1,239,795**	**$312,589**	**$7,950,976**

*Medicaid incentive payments will be distributed over 3 years at 50%, 40%, 10% increments

- Peri-Operative Services – Cost reductions are available through improvements in OR turnaround, case times, supply chain, and more efficient scheduling of appropriate cases in the operating rooms. Management changes in the OR may be necessary to achieve the desired results.

- Staff Scheduling – Some efficiencies and additional cost reductions should be available through adjustments to staff scheduling, even under the current CBAs. Other initiatives, such as the ability to flex staff are appropriate, yet constrained by current provisions in the CBAs. Additional opportunities are tied to better management at the department level (e.g., telemetry, radiology, laboratory, respiratory therapy) and/or updating certain pieces of equipment.

- HRIS and Time and Attendance Systems — Currently there are no reliable HRIS and limited time and attendance systems. The absence of these rudimentary payroll tools is impairing the ability of front line managers to control and monitor labor costs. Enforcing existing policies should yield some financial improvement in the interim.

- Management Span of Control and Training — There exists a great degree of variation in the talents, motivation, and discipline among front line managers, some of whom were terminated in the reduction in force (RIF). Remaining managers will benefit from training, tighter management and controls, and improved processes and systems; and new managers will need to be developed or recruited to replace interim executives. Other management changes may be necessary after all departments are reviewed in further detail.

- Human Resources — HR can be improved in all facets, which would have a ripple effect across every element of the business and potentially yield favorable results in recruiting, retention, productivity, staffing, training, labor arbitration, and other critical areas. The new HR Director will be developing a comprehensive action plan for the department, as soon as the current RIFs are concluded.

- Monitoring and Controlling Contract Labor — Improved processes and controls, and better management of full time staff will help to control the use of contract labor, which will lower relative costs and increase productivity. However, some departments (i.e. OR, NICU, L&D and ED) have been extremely challenging to hire and contract needs in these area will continue for some period of time. Additional efforts include better control of overtime and eventual modifications to CBAs which would allow additional part-time positions.

Mid-Term Opportunities

- Physical Plant — In addition to safety and/or regulatory related improvements, certain cosmetic and/or structural improvements to the physical plant can provide a return. Management has begun a face lift of the public area of the hospital, and now that nursing management is in place for the ED, will be proposing a limited redesign and refreshing of this “front door” to the Hospital.

- Physician Recruitment — Complement and mix of physicians whose practice is dedicated to HUH appears to limit growth and delay follow-up in certain specialties. This area requires detailed analysis and further investment, with recruitment likely in the areas of primary care, advanced practice nursing, and other targeted specialties. A comprehensive physician manpower plan should be considered by Howard for the COM, FPP and HUH.

- Clinic Wait Times and No-Show Rates — Waiting time for clinic appointments and no-show rates are having a direct effect on productivity, teaching, reputation, and financial performance. Management believes that improvements to industry standards can yield near-term savings and is accomplishing this through transfer of the hospital-based clinics to control of the FPP.

- Physician Productivity and Funds Flow — Management has not yet formally assessed this area but believes that there are a range of opportunities to improve productivity and lower costs to the Hospital. A formal “CARTS” analysis should be performed in order to determine what services the Hospital needs to purchase from the FPP and how funds flow should be adjusted.

- Process Redesign and Productivity Standards — By establishing tighter productivity standards, improvements in efficiency may be achieved across the enterprise, especially in clinical ancillary areas and the nursing units, accounts payable, receivable, admitting and customer service. Additional resources will be required to help implement a better productivity system.

- Benefits — Employee benefits such as health insurance, retirement and tuition reimbursement should be evaluated vis-s-vis all major competitors and adjusted (if possible) during renegotiation of the CBAs later this year.

- Contracts — Perform a comprehensive review of all major vendor contracts such as laundry, linen, equipment maintenance, etc. to identify opportunities to lower costs, especially as they come due for contract renewal. One example is offsite record storage and destruction. This contract has been recently renegotiated and is awaiting legal department approval. Estimated annual savings for this initiative are estimated to approach $100,000.

- Lease Revenue — Management is working with the HSC Foundation who is considering relocating their free-standing pediatric long-term acute care hospital (LTACH) to the vacated HUH pediatric floor. The LTACH would lease space and purchase selected clinical services from HUH at a market rate.

- Environmental Services — Management is strongly considering insourcing these services and confidentially soliciting options. A formal recommendation with estimates of cost savings and pros/cons of insourcing will be completed and presented to the Management Committee prior to the end of FY2015.

REVENUE ENHANCING STRATEGIES

It is not uncommon for operationally- and financially-challenged hospitals to experience a poor public perception and reputation, which often prompts area physicians, payors, Paramedics, and ancillary service providers to resist normal patterns of referring patients and leads patients to question the hospital's commitment to its community and/or ability to deliver quality care. Critical to the successful rehabilitation of a hospital's image is its ability to deliver quality healthcare services in a clean, well maintained environment, which can then be promoted to the community and other key constituents. Paladin's business development strategy centers on restoring the image and reputation of HUH by working with the FPP to ensure that adequate and consistent quality metrics are consistently achieved and the Hospital environment meets high standards for cleanliness, customer service and professionalism.

Local and state governments, as well as regulatory agencies and accreditation organizations play a key part in a hospital's livelihood, and must be considered as well. Exemplary reports resulting from surveys by state health agencies and accreditation organizations can be strong tools to support the marketing efforts of HUH and the FPP.

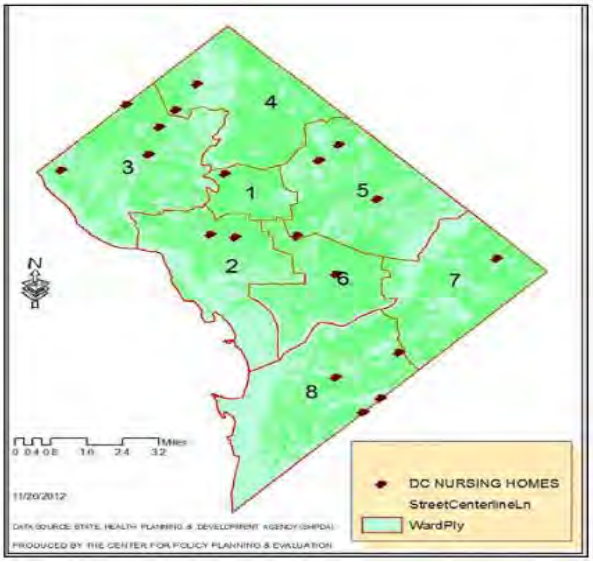
Once these objectives are achieved, HUH management will collaborate with the FPP and HSP to develop a comprehensive plan to promote positive community relations and reestablish the hospitals historically strong reputation, highlighting the new management, quality of service, and commitment to the community, and introducing new outreach programs such as health screenings for targeted chronic disease populations. Such strategies will include the development and distribution of new hospital collateral that reflects the strength of the organization under new leadership; coordination and implementation of community support programs such as scholarships, health festivals, toy fairs, education programs, and others; and the strategic use of print, radio and television media. Requests to fund these marketing efforts will be presented as part of the FY2016 budget process.

Prior to the implementation of more conventional and/or grass-root promotional and community outreach campaigns, management has identified several opportunities that offer the potential to increase admissions and FPP volumes. To that end, Paladin has already implemented a number of immediate operational initiatives that will drive revenue in FY2015 and beyond, improving the accuracy of clinical documentation, driving ED volumes via outreach to Paramedics, and appropriate classification of patients as inpatient versus observation status. These initiatives are described above in detail. Preliminary data suggests that tangible progress has already been made in these areas.

Paladin and HUH have also made significant progress identifying medium and long-term opportunities to revenue enhancement. While the prospective impact of such initiatives cannot yet be quantified, they appear to offer significant potential, although the success each respective initiative will depend, in large part, on a close and productive collaboration between Paladin, FPP, HSP and Howard leadership. Many of the below-listed initiatives will be assessed and/or initiated in FY2015. However, the current forecast does not include any impact from such opportunities. Subject to further due diligence, they are anticipated to be included in the FY2016 Budget.

Partnerships with Pre- and Post-Acute Providers

Pre- and post-acute providers can be critical partners in driving patient volumes and reducing unnecessary hospitalizations and readmissions. Paladin anticipates expanding HUH's working relationships with areas providers by establishing coordinated working relationships with SNFs, LTACHs, HHAs, and other providers that agree to meet quality standards, share data, provide certain services, and work with HUH to deliver comprehensive and accessible quality care on a coordinated and cost-effective basis. The hope is that such provider partners will share Howard's vision of a comprehensive community-centric integrated healthcare delivery system. Such relationships can also have a dramatic and favorable impact on hospital admissions. A list of District facilities is attached as Appendix B.

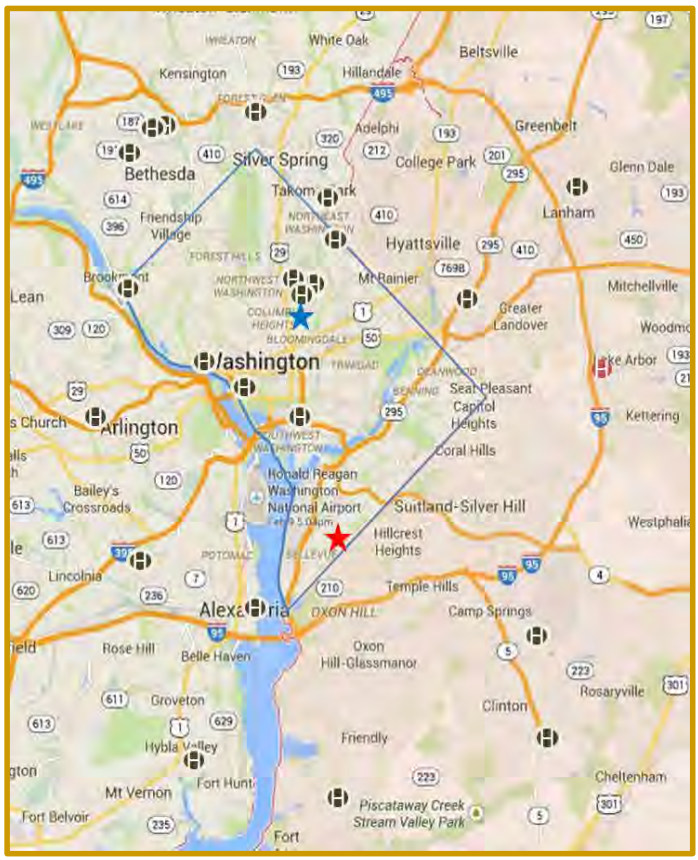


Of the 19 skilled-nursing facilities in the District of Columbia, it appears that only four have entered into coordinated partnerships with competing medical centers. Many of the LTACs and HHAs are also seeking affiliation. By establishing coordinated working relationships with such providers, HUH should benefit from better and tighter access to an ambulatory and post-acute network. More importantly, this organizational initiative will enable HUH nurses and physicians to work closely with their staff to continuously improve lines of communication and discharge protocols, such that each facility will have all of the necessary information to provide the best level of care to every patient being presented to or discharged from HUH. This will also enable HUH management to work with management teams from those facilities to possibly create higher acuity care units, develop enhanced clinical protocols and care pathways, mine EHR data to provide the necessary preventive treatment to at-risk patients, and effectively track discharged patients through each episode of post-discharge care. Dr. Feseha Woldu has been identified to champion outreach strategies with targeted providers, with support from Dr. Frederick, Jeanette Gibbs, Sandra Austin, and Joel Freedman. It is also anticipated that an experienced business development professional will be hired to ensure a consistent and professional presence in the market.

To further remove any barriers that SNFs, LTACs, and HHAs may face in admitting their patients to HUH, a HUH physician should be made available to serve as a facility Medical Director, with support being provided from an assigned care team that will include a Case Manager and one or more allied professionals to support the ongoing needs of the facility and their patients. If an opportunity does not exist to place a FPP physician as Medical Director, HUH will seek to establish a strong relationship with the current Medical Director, including support from a care team. As part of this organizational strategy, A 1-(800) call center may be established as the sole point of contact if a patient needs to be admitted to HUH or if services are required from an FPP physician. A candidate with an RN qualification has already been identified to lead the call center.

Expansion into Prince George's County

Prince George's County ("PGC") represents a very exciting market opportunity as it borders Wards 4, 5, 7 and 8 and has a fragmented hospital market. It is often referred as "Ward 9". PGC residents face a severe lack of access to primary care (University of Maryland School of Public Health, "Transforming Health in Prince George's Count, Maryland"). There are far fewer primary care physicians in the area compared to surrounding jurisdictions, especially in the part immediately bordering on Wards 4, 5, 7 and 8. Given the lack of access and some insurers not covering local providers, many residents seek care outside of PGC. Compounding the shortage is a very real and tangible need for services for the residents of PGC. These needs are comparable to those faced by HUH's patient population, with chronic diseases such as asthma, diabetes, and heart disease resulting in an exceptionally high rate of ED visits compared to other counties in Maryland. The rate of ED visits for diabetes, for instance, was 80% higher in PGC than in neighboring Montgomery County, with a significant disparity in rates for black residents. PGC is predominately black (65.1%) with a significant foreign-born population (20.2%) (See demographic overview below). Howard has a strong presence in and relationship with PGC, as many residents and government officials are Howard graduates.



There are five acute care hospitals in the county, of which the largest, Prince George's Hospital Center, has had significant financial difficulty in the past several years. This facility accounts for almost half of the licensed beds in PGC and is part of the Dimensions Health System ("DHS"), a government-owned entity that also owns Bowie Health Center, which operates as a hospital-level ED and ambulatory surgery center. Due to financial pressures, there has been significant discussion about closing Prince George's Hospital Center, although the facility remains open today. Preliminary review of emergency data suggests that the facility lost as much as 30% of its volume to United Medical Center ("UMC") over the last several years. In part to combat this trend, there is a plan to replace the facility with a new 250+ bed hospital ("Regional Medical Center") in Largo Town Center, approximately a 25 minute drive east of HUH (see map of DC and surrounding areas). This facility is slated to break ground late spring or early summer of 2015 but requires funding from the Maryland government, which may lead to significant additional delays. The other facilities lie farther into PGC, providing a tangible opportunity to obtain patient volume from this adjoining area.

The fragmented and struggling hospital network, geographic proximity to HUH and UMC, similar patient population, strong evidence of an insufficient ambulatory presence (especially primary care), and broad and favorable recognition of the Howard brand present an excellent opportunity to expand the Howard footprint and gain a patient base that desperately needs the care. Moreover, PGC is a "beacon for middle-class African Americans" and has seen a tremendous influx from neighboring areas as well as nationally, with an expectation that the area will continue to grow into the foreseeable future (Washington Post, Wiggens, Morello and Keating). Gaining a foothold in the short term can not only increase patient volumes, but also help to gain traction with a growing population of commercially insured residents. Accordingly, in addition to initiating significant outreach to these communities, Paladin will look to the FPP to help guide the expansion of clinics and physician practices in appropriate locations, perhaps as part of the ambulatory investment commitment made by Paladin. Moving aggressively into the market will require a thorough understanding of Maryland's all-payer hospital reimbursement system, the state's movement to a fully capitated payment structure, and how services to Maryland residents who receive care outside the state are reimbursed.

Demographic Overview (2013 Census)			
Category	**PG County**	**Maryland**	**DC**
Population	**890,081**	**5,928,814**	**646,449**
% Black	**65.1%**	**30.1%**	**49.5%**
% White	**26.6%**	**60.5%**	**43.4%**
% Other	**8.3%**	**9.4%**	**7.1%**
Foreign Born	**20.2%**	**14.0%**	**13.8%**
High School Graduate or Higher	**85.5%**	**88.7%**	**88.4%**
Bachelor's Degree or Higher	**29.8%**	**36.8%**	**52.4%**
Median Household Income	**$73,623**	**$73,538**	**$65,830**

Service Line Development

Paladin envisions developing multiple service lines to target low-acuity outpatient opportunities, which will help to increase volume and attract physicians and patients who may not have sought care at HUH otherwise. Hospitals across the country continue to report flat or even declining inpatient growth, and some of the competing hospitals in the District are widely recognized for their expertise in providing high-acuity and high-risk care. However, there is a strong market for low-acuity services by a recognized provider such as HUH. An example of these service lines may include occupational medicine, outpatient oncology, and a maternal-child health center.

Occupational Medicine. In pursuing this market opportunity, a multi-disciplinary healthcare team would be developed to serve as the regional experts in the prevention, diagnosis, and treatment of workplace injuries and illnesses. The team could include physicians, nurse practitioners, industrial hygienists, ergonomists, social workers and benefits specialists, who provide comprehensive patient-centered services. The goal would be to partner with employers and labor unions to assess and reduce risk factors in work environments and to establish comprehensive occupational health and safety programs designed to encourage a safe, healthful, and productive workplace. Once these programs and protocols are established, the HUH occupational medicine team would be the professionals designated to provide medical services to their employees and members, and will be the liaison between the employee, HUH providers, and the employer. This will ensure that protocols are followed when any work-place injuries occur, and that employees receive cost-effective care that decreases time away from work. Additionally, partnerships with medical providers in the area will be developed, which providers would be encouraged to consult with the Howard team when injuries and illnesses may be work related. Treatments may include pre-placement medical evaluations, periodic medical evaluations, and episodic medical evaluations, such as job transfers, illnesses affecting work performance, and job fitness evaluations. With a focus on prevention, the goal of the Howard Occupational Medicine program will be to keep workers healthy and their workplaces safe.

Oncology Services. The overall demographic in the US is aging, as a larger percentage of the population is over age 65. It is estimated that 18% of Americans will be over the age of 65 by 2020 and are naturally more prone to illnesses and diseases common amongst the elderly such as cancer. As new therapies facilitate the earlier detection of cancer, the number of cancer survivors needing monitoring and follow-up care will grow significantly. Therapies such as stereotactic body radiotherapy can better facilitate cancer treatment in the outpatient setting. If such therapies are coupled with an institutional emphasis on care coordination and service integration, HUH and the FPP can reduce the need of high-acuity inpatient cancer care. This coordination should begin at screening, with ongoing assistance to patients through diagnosis, treatment, and into survivorship. This could be coordinated by leveraging mid-level providers specializing in cancer care. By recruiting the right resources, developing a new physical environment for the provision of cancer services, and acquiring appropriate medical technology, HUH could provide comprehensive oncology services in an outpatient setting such that it will no longer necessitate the large specialty centers developed by competitors. A new HUH cancer center can specifically focus on the treatment of breast, lung, and colon cancers, and be partially funded by receiving grants from national payers looking to develop models of coordinated cancer care.

Women's and Children's Services. It is readily apparent that a new generation is moving into the areas surrounding HUH, creating a vibrant neighborhood full of young millennials. In order to meet their needs of tomorrow, HUH could develop a maternal child service that offers comprehensive services addressing a comprehensive set of needs before, during, and after birth. From the time that young couples are beginning to start a family, HUH can be their destination of care for all of their healthcare needs. Upon investing in cosmetic upgrades, the women's and children's services could offer an extraordinary patient experience that is comfortable and luxurious. A decision will need to be made reasonably soon as to whether these services will stay at HUH or move to a combined program located at UMC.

Monetize Unfilled Beds

Several years of declining inpatient volume have led to a significant number of unutilized inpatient bed rooms. Even with projected volume growth driven by the ED and outreach programs, the Hospital is unlikely to utilize its full capacity of 482 licensed beds. There may be opportunities to reposition such unused beds to generate cash flow for HUH. While the monetization of unused beds is still in an exploratory phase, there are several potential avenues. One method is to lease space to another provider organization that can operate a "hospital within a hospital." The partner organization would be responsible for its own operational performance and pay market-based rent and compensation for HUH-provided services (e.g., housekeeping, food service) which can yield significant revenue with little operational risk on the part of Howard. Initial conversations with a long-term pediatric care provider in the market have generated interest, although this is a significant move that will require much more diligence and input from many stakeholders. HUH could also relicense such excess beds to another acute or non-acute designation, for which there is unmet market demand in the surrounding areas. Alternative uses may include psychiatric, geriatric psychiatric, sub-acute, rehabilitation, behavioral health, and skilled nursing, among other possibilities.

The first step in this process is for Paladin and Howard (FPP and Real Estate Department) to co-develop a real estate strategy that fully complements the Hospital's operating objectives. By converting an under-performing asset into a profit center, HUH could reduce occupancy costs, manage taxable uses, and enhance cash flow.

Supporting FPP to Expand Ambulatory Care Network

Paladin will work diligently to assist in developing in an expanded ambulatory care infrastructure as identified by the FPP. To pursue this goal, and be more accessible to the patients treated by HUH, Paladin and its real estate partner, Stanton Road Capital, intend to fund the establishment of a network of multi-specialty clinics and health centers within the markets served by HUH, with an emphasis on Wards 7 & 8 (and possibly PGC). As currently envisioned, this would involve the acquisition of underutilized medical office facilities that will be transformed into vibrant ambulatory operations.

Physician Recruiting

A key element of Paladin's growth strategy and marketing efforts is to work with the FPP to attract and retain quality physicians that can implement Paladin's efficient patient care model, including graduates of the COM. HUH management and FPP leadership are committed to developing and implementing well-architected physician recruitment strategies, an initiative that will be fueled by the planned establishment of an ambulatory infrastructure and prospective acquisition of UMC. Acquisitions of physician practices may also be considered.

Partnering with Local Community Hospitals

Declining reimbursement, acceleration towards performance-based and risk-based payment, and increasing competitive pressure from large systems threatens the ongoing viability of stand-alone hospitals like HUH. Benefits of scale and rationalization of service lines through hospital partnerships can drive both financial success and higher quality patient care and teaching opportunities. These relationships must be mutually beneficial and carefully assessed to ensure a collaborative, productive relationship. Relationships are currently being pursued with UMC and Providence Hospital, an Ascension facility, each of which share a commitment to serving the underrepresented communities of the District of Columbia yet are far enough away to mitigate concerns regarding market saturation. Paladin and Howard are currently under contract with the District to acquire UMC through a joint venture. Paladin believes UMC offers significant growth potential as it is the only non-specialty hospital in the District that is located in Wards 7 and 8 and is in need of support from Howard specialists.

With respect to UMC, it will be possible to consolidate many of the administrative and operational functions with HUH, which can quickly reduce each hospital's operating costs, while improving the efficacy of critical functions. Opportunities include consolidating and standardizing purchasing to reduce supply costs, including pharmaceuticals; consolidating the central business offices and introducing a number of revenue cycle management initiatives; creating a unified charge master; implementing joint contracting to garner additional leverage and negotiate more favorable arrangements; consolidating service lines to ensure scale and financial viability; and/or adding service lines to better meet community needs; among others. Obtaining input from the physicians of both Howard and UMC is a critical next step to determining how the two facilities can best support one another.

Providence Hospital is a 408-bed acute care facility that appears to offer significant synergy with HUH. Leadership at both Providence and Ascension has indicated initial interest in discussions about future partnerships. Paladin, with assistance from the FPP and Howard leadership, will continue to explore this relationship and the possibility of partnerships in the near future.

Integrated, Modern, and Patient-Centered Managed Care Platform

The trend towards risk-based reimbursement, such as shared-savings, episode based payments, and global capitation, continues to push large provider networks to focus on integration and building systems that can assess and manage patient risk. However, success under these models requires control of a full spectrum of providers, significant data analytics capabilities, and confidence that patients will stay in network. In concert with UMC and other District providers, Paladin will continue to evaluate the opportunity to engage in risk-sharing arrangements as the HUH clinical network evolves and will stay in-tune to changes in CMS payment initiatives to make sure Howard is prepared to succeed under future payment models. In addition to adding primary care services and an ambulatory network, Paladin will consider the addition of ancillary services such as: diagnostic services such as audiology, radiology, pulmonary testing and clinical lab services; therapeutic services such as physical therapy, occupational therapy, speech therapy, radiation therapy, nutrition therapy, and weight management; and custodial ancillary services focus on hospice, home health, and skilled nursing facility (SNF) care, and durable medical equipment, among others. Many of these services can be provided at HUH-branded facilities, with gaps filled at other provider locations.

Risk will not be taken lightly, particularly in a rapidly-evolving reimbursement environment. As the Howard integrated healthcare delivery system takes effect across the District, it may attract patients that have had insufficient access to quality healthcare and which, in aggregate, represent a disproportionately high-risk population. Early on, forthcoming reimbursement models may not accurately account for these necessary types of geographic-centric risk adjustments. Such a dynamic can lead to substantial and rapid losses. In order to ensure that appropriate and manageable risks are accepted, it is critical to establish a stringent underwriting policy that includes comprehensive actuarial analysis rooted in quality data, and to have a clear understanding of the organization's operational ability to manage targeted patient populations. In order to develop confidence in rates, we plan to build a relationship with the District and explore partnership opportunities, including the possibility of taking on Medicaid beneficiaries in a shared-risk contract with the District. At this time, no such initiatives are taking place, and it is difficult to determine at what point they will be initiated. Suffice to say, Paladin and Howard will remain cognizant of market conditions and respond accordingly.

HUH FY2015 Financial Forecast

The Paladin team took over the management of HUH on October 5, 2014 under difficult financial conditions. EBIDA losses for the prior fiscal year (ended June 30, 2014) were ($37.3mm) with net losses of ($62.0mm). The losses for the first quarter of FY2015 (July 1, 2014 through September 30, 2014) showed only a slight improvement, with EBIDA losses of ($4.7mm) and net losses of ($13.0mm). Faced with limited capital, a challenging relationship with HUH's union leadership, and ongoing losses, it became apparent that stabilizing the business and eliminating the cash burn was immediately necessary for HUH to continue operating. Less than one month after taking over, Paladin began implementing immediate initiatives focused on expense reductions, primarily through a voluntary buy-out and reduction in force and near-term opportunities capture additional revenue. While Paladin is committed to developing strategies that grow patient volume long-term, the immediate needs were to right-size and stabilize the financial performance of the organization.

In addition to inheriting a significant loss, there were two significant reductions in revenue unrelated to HUH performance subsequent to October 5th. In late October, it was learned that Medicaid DSH funding for the federal fiscal year beginning October 2014 would be $25.7mm; prior fiscal year funding was $38.3mm. Also, in January 2015 it was learned that Federal Appropriation funding for the federal fiscal year beginning October 2014 would be $26.9m; prior fiscal year funding was $28.8mm.

Despite the aforementioned pressures on revenue, the management team has instituted performance improvement initiatives that are anticipated to bring the hospital to break-even EBIDA (on a run rate basis) by the end of FY2015.Based on the limited time available, Paladin is providing a "top down" financial forecast (and therefore not a "bottom up" budget) for the final six months of FY2015. The forecast is based upon historical trends and key assumptions which are outlined below. The bulk of the forecast improvement over the Howard Board-approved FY2015 budget occurs in expense reduction, although a number of revenue enhancement activities are included and should begin to yield results.

Because of "noise" which management found in purchased services, with many "one time" and unique journal entries from earlier in FY2015, this forecast remains subject to revision until January results are available and the document is approved by the Management Committee in March 2015.

	YTD-Dec	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FY15
Operating Revenue								
Net Patient Revenues	$105,426	$ 16,373	$ 15,907	$ 17,363	$ 17,232	$ 18,221	$ 19,198	$209,719
Federal Appropriation	14,417	2,082	2,082	2,082	2,082	2,082	2,082	26,906
Other Operating Revenues	3,437	586	586	586	586	586	586	6,953
Total Operating Revenues	**123,279**	**19,041**	**18,574**	**20,030**	**19,900**	**20,889**	**21,865**	**243,578**
Operating Expenses								
Salaries, Wages and Benefits	80,255	12,519	10,725	11,386	10,861	11,798	11,593	149,138
Professional Fees & Purch. Svcs.	27,021	4,348	4,370	4,351	4,350	4,448	4,506	53,394
Supplies, Drugs & Other Op. Exp.	30,207	4,766	4,792	4,939	4,989	5,228	5,356	60,277
Total Operating Expenses	**137,484**	**21,633**	**19,888**	**20,676**	**20,200**	**21,474**	**21,455**	**262,809**
EBIDA	**$(14,205)**	**$ (2,592)**	**$ (1,313)**	**$ (646)**	**$ (300)**	**$ (585)**	**$ 410**	**$(19,231)**
EBIDA Margin	**(11.5%)**	**(13.6%)**	**(7.1%)**	**(3.2%)**	**(1.5%)**	**(2.8%)**	**1.9%**	**(7.9%)**
Depreciation and Amortization	(8,024)	(1,346)	(1,346)	(1,346)	(1,346)	(1,346)	(1,346)	(16,099)
Interest Expense	(2,446)	(389)	(389)	(389)	(389)	(389)	(389)	(4,782)
Restructuring	(8,496)	(50)	(1,104)	(3,545)	(50)	(50)	(50)	(13,345)
Extraordinary Items	(5,704)	-	-	-	-	-	-	(5,704)
Net Income (Loss)	**$(38,875)**	**$ (4,377)**	**$ (4,153)**	**$ (5,926)**	**$ (2,086)**	**$ (2,370)**	**$ (1,375)**	**$(59,162)**
Net Income Margin	**(31.5%)**	**(23.0%)**	**(22.4%)**	**(29.6%)**	**(10.5%)**	**(11.3%)**	**(6.3%)**	**(24.3%)**

Notes and Assumptions to the FY 2015 Financial Forecast

The forecast for FY2015 was developed by predicting a baseline scenario that incorporates trended historical information and then adding the impact of performance improvement initiatives described above. The baseline forecast represents that which is expected to occur in the absence of the performance improvement initiatives (a "do nothing" scenario). Specifically, the baseline was constructed with the following assumptions:

- Baseline inpatient and outpatient volume were based on YTD variance through November-2014 vs. prior year. This variance percent was then applied to prior year volume to account for seasonality. Other than the shift from Observation to Inpatient cases, FY2015 volumes to-date are similar to prior year.

- Baseline inpatient average length of stay was estimated to remain at the current November-2014 YTD levels of 4.6. This value, which is low compared to the average LOS over the previous two years, is the best-available estimate of forecasted LOS because it encompasses the most recent case mix and inpatient processes in place at HUH.

- Baseline inpatient and outpatient payor mix was forecast based on FY2014 actual experience. The data currently available on FY2015 payor mix, shows a mix that is not significantly different from prior year. It is important to note that the final payor mix is not known until a few months after the end of the period as it is learned whether Medicaid applications are either denied or accepted.

- Baseline inpatient case mix was forecast to remain at the current November-2014 YTD levels of 1.207. The CMI has decreased from prior years, which, as noted above, is a major factor in the decrease in average LOS.

- Federal Appropriation and DSH revenue were forecast with the latest available information. The Federal Appropriation amount is determined by the Consolidated and Further Continuing Appropriations Act of 2015 and is for the federal fiscal year beginning October 1, 2014. The Medicaid DSH revenue is also based on the federal fiscal year beginning October 1, 2014; however, the amount is subject to change as the allocation of DSH funds by the DC Medicaid office is subject to review.

- Operating expenses were forecast at the year-to-date run-rate through November-2014 with adjustments to variable expenses forecast for changes in volumes. It is important to average expenses over a long period to eliminate the impact of monthly fluctuations in expenses. As baseline volumes are anticipated to increase (due to seasonality) over the final months of FY2015, it is important to increase the baseline expense projection to account for those expenses that are variable.

Changes from Prior Version of Forecast presented to the Management Committee

- Federal Appropriation for Federal FY2015 was previously assumed to be $28.8mm; however, in January 2015, it was learned that the annual amount will instead be $26.9mm.

- [redacted]

- [redacted]

- [redacted]

- [redacted]

Major Assumptions for the Performance Improvement Initiatives

Managed Care Rate Negotiations

- Calculates impact on net revenue of percentage increase of contract terms based on prior year volumes.

Clinical Documentation Integrity

- Assumes a 0.05 (4%) increase in Medicare and Medicaid CMI from February 2015 to June 2015. CMI directly impacts both Medicare and Medicaid reimbursement, which are paid on a prospective DRG basis with higher reimbursement for higher acuity cases. The CDI initiative is expected to yield $1.0mm in FY2015, with an annualized run rate of $4.9mm.

Denials Management

- Based on the first six months of FY2015, annualized Medicaid denials are $71.5mm in gross revenue. 30% of those initial denials are eventually overturned, so there is no opportunity to increase revenue on such cases. Medicaid net-to-gross rates for inpatient and outpatient services average 41.0% and 7.6%, respectively, resulting in a total opportunity of $17.4mm if all Medicaid denials were eliminated. The annual opportunity is assumed to be 25% of the total opportunity or $4.4mm annually.

Voluntary Separation Plan

- In November and December-2014, 89 FTEs accepted an early retirement package. The annual salary of such employees is $6.7mm, with associated benefits of $2.0mm.

Reduction in Force

- The non-Union RIF was executed on January 30, 2015. 35.5 FTEs were terminated, deriving an annualized savings of $4.3mm (including $1.0mm of associated benefits).

Materials Management

- There are 16 individual initiatives within the Materials Management heading. Each of these initiatives is individually calculated with specific timing.

Accurate Classification of Inpatient and Observation Cases

- Observation rates are assumed to be $1,432 based on FY2014 accounts. Inpatient rates are assumed to be $10,693 based on FY2014 accounts at an average CMI of 1.207. Inpatient short-stay rates are assumed to be $8,862 at an average CMI of 1.000. It is further assumed that 25% of the short-stay inpatient accounts will be denied by the payor. This initiative is estimated to yield an additional one discharge per day in the three months ending February 2015, and two discharges per day in the period between March 2015 and June 2015.

Transfer Specialty Clinics to FPP

- Hospital cost-accounting data was used to determine the direct cost, indirect cost and payments for all clinic visits. It is assumed that all payments will be eliminated, fifty percent of indirect costs will be eliminated and all of the direct costs will be eliminated. Additionally, it is assumed that DSH will be reduced by $1.0mm due to the loss of this service.

	FY2015 Yield	*Annualized Run Rate*
Cost Management Initiatives		
Voluntary Separation Plan	*$ 5,080,833*	*$ 8,710,000*
Reduction in Force - Non Union	*2,012,736*	*4,565,395*
Reduction in Force - Union 2094	*2,316,641*	*4,554,418*
Reduction in Force - Union DCNA	*1,828,531*	*2,666,205*
Materials Management	*1,272,406*	*2,006,812*
Eliminate Pediatric Coverage	*150,000*	*450,000*
Revenue Cycle Initiatives		
Clinical Documentation	*995,329*	*4,907,791*
Denials Management	*922,662*	*4,359,338*
Admissions Criteria	*1,741,625*	*3,754,399*
Managed Care Rate Negotiations	*833,333*	*1,910,000*
Programmatic Initiatives		
Transfer Specialty Clinics to FPP	*551,567*	*1,654,702*
Other		
EBIDA	**$ 17,705,664**	**$ 39,539,059**

	FY2015 Yield	*Annualized Run Rate*
Cost Management Initiatives		
Voluntary Separation Plan	*$ 5,080,833*	*$ 8,710,000*
Reduction in Force - Non Union	*2,012,736*	*4,565,395*
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Reduction in Force - Union DCNA	*1,828,531*	*2,666,205*
Materials Management	*1,272,406*	*2,006,812*
Eliminate Pediatric Coverage	*150,000*	*450,000*
Revenue Cycle Initiatives		
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Denials Management	*922,662*	*4,359,338*
Admissions Criteria	*1,741,625*	*3,754,399*
Managed Care Rate Negotiations	*833,333*	*1,910,000*
Programmatic Initiatives		
Transfer Specialty Clinics to FPP	*551,567*	*1,654,702*
Other		
EBIDA	$ 17,705,664	$ 39,539,059

The forecast impact of each of the major initiatives for the remainder of FY2015.A comparison of key elements of the FY2015 Plan to the preliminary Strategic Plan that was attached to the MSA will identify a discrepancy in projected LOS reductions, as such LOS had already fallen below the baseline originally assumed by Paladin. Based upon needs to bolster department management and recruit additional physicians and nurses, ED initiatives are not assumed to yield meaningful results until FY2016. All initiatives have been divided between those that manage costs lower and those that improve performance of the revenue cycle.

	Revised Plan	*Preliminary Plan*
Cost Management Initiatives		
Voluntary Separation Plan	*$ 8,710,000*	
Reduction in Force - Non Union	*4,565,395*	
Reduction in Force - Union 2094	*4,554,418*	*7,723,996*
Reduction in Force - Union DCNA	*2,666,205*	
Materials Management	*2,006,812*	*2,163,422*
Eliminate Pediatric Coverage	*450,000*	
Reduce ALOS		*8,435,929*
Employee Health & Cell Phone		*1,700,000*
Subtotal Cost Management	*22,952,830*	*20,023,347*
Revenue Cycle Initiatives		
Clinical Documentation	*4,907,791*	*5,631,199*
Denials Management	*4,359,338*	*4,902,035*
Admissions Criteria	*3,754,399*	*6,988,193*
Managed Care Rate Negotiations	*1,910,000*	*2,250,000*
Increase ED Visits		*1,039,479*
Subtotal Revenue Cycle	*14,931,528*	*20,810,906*
Programmatic Initiatives		
Transfer Specialty Clinics to FPP	*1,654,702*	*3,000,000*
EBIDA Improvement	*$ 39,539,059*	*$ 43,834,253*

	FY15			Pro Forma Annualized	
	Base	Initiatives	Base + PIPs	Initiatives	Base + PIPs
Operating Revenue					
Net Patient Revenues	$ 206,508	$ 3,211	$ 209,719	$ 11,570	$ 218,078
Federal Appropriation	26,906	-	26,906	-	26,906
Other Operating Revenues	6,953	-	6,953	-	6,953
Total Operating Revenues	**240,367**	**3,211**	**243,578**	**11,570**	**251,937**
Operating Expenses					
Salaries, Wages and Benefits	160,782	(11,644)	149,138	(23,741)	137,042
Professional Fees & Purchased Services	53,877	(483)	53,394	(1,434)	52,443
Supplies, Drugs & Other Operating Expenses	61,757	(1,480)	60,277	(2,795)	58,963
Total Operating Expenses	**276,416**	**(13,607)**	**262,809**	**(27,969)**	**248,447**
EBIDA	**$ (36,049)**	**$ 16,818**	**$ (19,231)**	**$ 39,539**	**$ 3,490**
EBIDA Margin	**(15.0%)**		**(7.9%)**		**1.4%**
Depreciation and Amortization	(16,099)	-	(16,099)	-	(16,099)
Interest Expense	(4,782)	-	(4,782)	-	(4,782)
Restructuring	(8,796)	(4,549)	(13,345)	-	-
Extraordinary Items	(5,704)	-	(5,704)	-	-
Net Income (Loss)	**$ (71,431)**	**$ 12,269**	**$ (59,162)**	**$ 39,539**	**$ (17,391)**
Net Income Margin	**(29.7%)**		**(24.3%)**		**(6.9%)**

	FY15			Pro Forma Annualized	
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Capital Budget and Personnel Needs

In order to fully implement the FY2015 Plan, both financial and human resources will be required. The following outlines a number of resources that will be required in order to support implementation.

Financial Capital

Management has divided requested Capex into three categories:

- Patient Safety – Items identified internally by nursing, which are required for the safe and effective care of patients.
- Regulatory – Items previously identified by external regulators in surveys and site visits.
- Emergency Department – Items needed to improve the efficiency, environment and patient/family/Paramedic perception of this "front door" to the Hospital.

Summary schedules for each category are presented below.

PATIENT SAFETY		ESTIMATED COST
Replace Tunnel Washer in SPD	$	75,000
Replace EO sterilizer in SPD (Steris)		425,000
Replace patient chairs throughout Hospital		30,000
Replace NICU mattresses		1,000
Replace Adult mattresses		25,000
Replace windows, electrical outlets, etc. throughout Hospit		100,000
Purchase hypothermia warming system for OR		50,000
Repair/replace wheelchairs		25,000
Purchase hand-held metal detectors (ED and Psych)		1,000
Purchase ED badge readers (3)		10,000
Subtotal	**$**	**742,000**

REGULATORY	ESTIMATED COST
Purchase patient lift systems (5)	5,000
Replace floor tiles (throughout Hospital)	20,000
Replace patient privacy curtains throughout Hospital	37,500
Replace window film	75,000
Repair/replace air curtain at ED entrance	20,000
Repair/replace doors with penetrations	20,000
Subtotal	**$ 177,500**

EMERGENCY DEPARTMENT		ESTIMATED COST
Create two additional Triage rooms	$	400,000
Replace lobby chairs		60,000
Purchase dopplers		12,000
Purchase portable ultrasound		26,000
Purchase EKG maching		12,000
Purchase EZIO set		4,000
Purchase ventilator		26,000
Purchase ENT intubation sets (2)		60,000
Purchae Trauma stretchers with scales (2)		16,000
Purchase infusion chairs (10)		30,000
Purchase surgical lights for Code rooms (3)		60,000
Purchase Armstrong Carts (5)		5,000
Purchase hypothermia warming system		50,000
Convert discharge lounge; miscellaneous paint		40,000
Subtotal	**$**	**801,000**

INFORMATION TECHNLOGY/ ELECTRONIC MEDICAL RECORD	ESTIMATED COST
ICD 10 Conversion/ 3M Grouper	$ 275,000
Laboratory Upgrade/ Loinc migration	125,000
Lawsom Upgrades/ Enhancements	75,000
Financial System Upgrades	150,000
Security Enhancements/ Upgrades	250,000
Virtualization/ Storage	75,000
Devices/ Equipment	350,000
Network Switches	85,000
Data Network Closet Work-Optimazation	50,000
Fiber Optic Cabling Installation	75,000
Siemens/ Allscripts MPI alignement, Inbound Registration and Orders to HUH	75,000
Subtotal	**$ 1,585,000**

It is anticipated that purchase of an Emergency Department Information System ("EDIS") is long overdue and will be presented to the Management Committee for approval in March 2015, with a targeted implementation to begin before the end of FY2015.

Human Capital

Analytical Assistance from Phil Criscione

Although not contemplated in the MSA, access to competent, experienced analytical and decision support resources are crucial to the success of HUH and are not currently available at the Hospital. Until capable permanent personnel are hired, these resources are necessary to produce weekly cash reports and financial forecast requested by Howard, assist with production of the data deck and numerous ad hoc requests for data, and to help manage the FY2016 budget process. Without this resource available on an ongoing basis, all of these initiatives will be delayed or not occur. The estimated cost is $56,000 per month.

Consulting Assistance for productivity, process improvement and service line assessment from [redacted]-Todd [redacted] RN

Sandra Brown has been engaged on a consulting basis to develop productivity tools by nursing unit and clinical service (e.g., ICU, respiratory therapy) in order to dynamically and properly flex staffing to volume. She is also evaluating processes and management of surgical services in order to improve efficiency/flow and decrease turnover time in these critical areas. She is also performing service line profitability analyses for cardiovascular, obstetrics, oncology and trauma. Until capable permanent personnel are hire, it is anticipated that she will assist in implementing changes that have already been identified or will result from her and Paladin's analysis. The estimated cost is $64,000 per month.

Consulting Assistance for HUH and FPP - Van House and Associate

Paladin feels the following items should be addressed in preparation for the FY2016 HUH budget:

- Determine the Clinical, Administrative, Research, Teaching and Service needs (i.e. "CARTS") for HUH to purchase from FPP and the funding source for same (i.e. "funds flow")

- Jointly develop Faculty Performance Score Cards with FPP

The following items were identified by FPP leadership as additional priorities for assistance:

- Develop Clinical Chair evaluation criteria, including facilitating Chairs' meetings regarding governance and non-clinical/operational issues, and updating performance expectations and standards for Chairs.

- Develop facility plan (improve/move/construct) for less desirable buildings/clinics.

- Evaluate physician productivity and compensation by physician and department through a formal assessment of time spent and resource consumption (CARTS).

- Evaluate management structure and make recommendations relative to organization, positions, and span of control.

- Develop strategies/tactics to market Howard clinical and hospital services to employees and commercial market.

- Identify potential acquisition/affiliations with community-based physicians, evaluate fit and assist with on-boarding process (medical records, systems, etc. – perhaps cultural integration).

Gary Van House, a leading physician [redacted]-practice management executive (who would be supported by an Associate), is available to help implement these objectives at an estimated cost of $130,000 per month. FPP revenue cycle performance represents another improvement opportunity, but would need to be scoped and priced separately.

Business Development and Outreach Professional

As outlined in the MSA, revenue growth of the FPP and HUH is dependent upon developing referral relationships with physicians, hospitals, Federally Qualified Health Centers ("FQHCs"), HHAs and SNFs. A professional with deep experience outreaching to such providers in markets that are comparable to those served by HUH would be highly valuable and establish a consistent presence in the market. This position would primarily be responsible for marketing and outreach to include these above referral sources, as well as establishing tighter linkages to primary care physicians and selected specialists. The role does not currently exist at HUH, and a formal position description will need to be developed. The estimated cost is $125,000 per year.

APPENDIX A

THE PALADIN MANAGEMENT TEAM

The management team that has been assembled to oversee and transform the operations of Howard University Hospital is comprised of numerous industry leaders, most of whom have more than 25 years of experience in their respective areas of knowledge. The team provides broad collective strengths and proven track records in the areas of hospital operations, physician group operations, payer operations, regulatory compliance, managed care, real estate, and finance. Key members of the Paladin — Howard management team includes:

Joel Freedman — Member, Management Committee

Joel Freedman currently serves as President of Paladin Healthcare Capital and Paladin Healthcare Management. He recently served as President and co-founder of Avanti Hospitals LLC, which acquired, turned around, and continues to own and operate four highly successful community hospitals in South and East Los Angeles, among the most disadvantaged and underrepresented communities in the US.

Prior to establishing Avanti, Mr. Freedman served as Managing Partner of Paladin Capital, a corporate finance advisory firm, where he completed more than 175 transactions, including $800 million in the healthcare sector. In 2004, he co-founded CompWest Insurance Company, an innovative workers compensation insurance company that was sold in 2007 to a subsidiary of Blue Cross and Blue Shield of Michigan.

Mr. Freedman is a founding member of the Healthcare Policy Advisory Council for Harvard Medical School and Chairman of its Healthcare Markets and Regulatory Lab, which is deeply involved in the transformation of the healthcare system at both a federal and state level. He is also a member of the Board of the Leonard D. Schaeffer Center for Health Policy and Economics at the University of Southern California, which seeks to measurably improve value in health through evidence-based policy solutions, research excellence, transformative education, and private and public sector engagement. He also serves on the Boards of Children's Bureau, one of the largest investors in child abuse prevention in the US; and the Foundation for AltaMed Health Services, the largest independent Federally Qualified Community Health Center operator in the country, serving more than 140,000 community members through 43 clinics in underserved communities throughout Los Angeles and Orange Counties.

Mark Bell, MD — Member, Management Committee and Advisor, Hospital Operations

Dr. Mark Bell currently serves as President and Founder of Emergent Medical Associates, a leading provider of Emergency Department and Inpatient management services. He is a co-founder and current Chief Medical Officer of Avanti Hospitals, which acquired, turned around, and continues to own and operate four acute care hospitals in South and East Los Angeles. As a leading provider of emergency and episodic care management services to patients, communities, physician groups, and hospitals throughout California. EMA's proven physicians, proprietary methods, management techniques, and uncompromising standards allow EMA to create "Hospitals of Excellence" for its acute care clients. EMA currently operates 20 emergency departments caring for 550,000 patients annually, along with a high-performance hospitalist program. EMA brings unparalleled emergency department and hospitalist operations expertise to the Paladin team.

Dr. Bell's expertise is particularly strong in ED efficiencies, hospitalist programs, customer service, strategic planning, quality, Core Measures, and business development. He frequently lectures on many topics including Nuclear Biological and Chemical Warfare, EMTALA, and toxicology, among others. He is a Diplomat of the American Board of Emergency Medicine and Fellow of the American College of Emergency Physicians.

Sandra Austin — Chief Executive Officer

Sandra Austin is a Managing Director with Alvarez & Marsal Healthcare Industry Group, specializing in executive leadership, operations, human resources, compliance, and financial management. She excels at leading high performing management teams and improving overall organizational performance.

Ms. Austin previously served as the Chief Executive Officer for the LSU Interim Public Hospital in New Orleans, where she managed day-to-day operations and led a transition that yielded significant cost reductions and operational improvements, while maintaining or enhancing service lines. She also served as Chief Responsible Officer (with CEO responsibilities) of Grady Health System in Atlanta, where she led the development and implementation of a comprehensive operational turnaround and financial restructuring plan. In addition, she led the development and implementation of a turnaround business plan for the University of Southern California, Keck School of Medicine, which resulted in substantial operating savings and operational improvement at its faculty practice plan, USC Care.

Ms. Austin has held several other leadership positions with major healthcare companies, including President of a $400 million homecare subsidiary of Caremark, a $2.5 billion healthcare services company; Chief Operating Officer of the University of Chicago Medical Center; President of Huron Road Hospital in Cleveland; Senior Vice President and General Manager of Medicine, Surgery and Psychiatry at University Hospitals of Cleveland; and Chief Executive Officer of two leading physician practice management firms, PhyServ and Sedona Healthcare Group.

Ms. Austin has also served on numerous corporate boards, including National City Corporation, Ferro Corporation, Cancer Treatment Centers of America, Gambro AB, and NCCI Holdings.

Kathleen Millgard, RN — Chief Operating Officer and Chief Nursing Officer

Kathleen Millgard is a Senior Director with the Alvarez & Marsal Healthcare Industry Group, specializing in hospital operations, process re-design, case management, regulatory compliance, clinical resource management, physician practice management, spatial analysis and planning, process re-design, and cross-cultural settings. Her managerial experience began as a clinic department head and progressed to the level of CEO/COO. Her experience includes acute care, psychiatric, and academic teaching facilities in both domestic and international settings in facilities/systems up to 1,000 beds in both the public and private sector.

Ms. Millgard served as Chief Executive Officer for a rural hospital system managed by Quorum Health Resources; and as Chief Operating Officer for several underperforming hospitals, including the University of Michigan Health System (Ann Arbor), Oak Hill Hospital (Joplin); and Maricopa Medical Center (Phoenix), where she achieved consistent successes in the areas of operational efficiencies, quality, safety, clinical resource management, staff productivity, cost containment, and new markets/product offerings.

Ms. Millgard began her career as a staff nurse in Critical Care and Emergency Services and later in Maternal/Child Services. She maintains her status as a Registered Nurse and is also Certified Professional in Healthcare Quality.

Douglas Womer, CPA — Chief Financial Officer

Doug Womer is a Senior Director with the Alvarez & Marsal Healthcare Industry Group, specializing in financial reporting, strategic planning, managed care contracting, revenue cycle management, project management, turnarounds, and due diligence for mergers, acquisitions and debt restructuring. He recently served as Chief Financial Officer for a two-hospital system affiliated with LSU Shreveport, which he helped to transition from public to private ownership, operationally redesigned all finance and accounting functions, established new banking relationships, created financial processes and policies for all aspects of finance, enhanced revenue cycle operations, and redesigned the supply chain. He also was responsible for the implementation of pre-transition plans, negotiations with an affiliated Medical School for physician services, and creation/execution of a 100 Day Plan to stabilize the hospital operations.

Mr. Womer previously served as the Chief Financial Officer for West Penn Allegheny Health System ($1.7B in net patient revenue, 750 employed physicians), where he established analytical tools through decision support to enhance Net Revenue, improved accounts receivable recovery and rate reimbursement accuracy, and developed a comprehensive performance improvement program which identified and quantified more than $75mm of operational improvements. He previously served as the Chief Financial Officer for Cardiovascular Consultants, a 55-physician cardiology practice in Phoenix, Arizona; and has held Corporate-level positions at Sound Inpatient Systems, the Johns Hopkins Medical Services subsidiary of the Johns Hopkins Health System, EPIC Healthcare Group (a 43-hospital system), Sisters of Charity, Christus Health, and Incarnate World Health Care System.

Keith Ghezzi, MD — Senior Advisor, Strategy

Dr. Keith Ghezzi is a Managing Director with Alvarez & Marsal Healthcare Industry Group, specializing in operational and financial turnarounds, performance improvement and interim management. His primary areas of focus include integrated health care systems, academic medical centers, large community hospitals and physician group practices. With more than 20 years of healthcare management experience, he has successfully led academic hospitals and community systems and has served as senior adviser to the management and Boards of private and public companies regarding business strategy, mergers and acquisitions, operational improvements and physician integration.

Dr. Ghezzi recently served as Interim Chief Executive Officer and President of the West Penn Allegheny Health System in Pittsburgh, Pennsylvania, and led the system through a successful turnaround and restructuring transaction with Highmark, Inc. He previously served as President and CEO of Forum Health, where he led the three-hospital system from near insolvency to financial stability; and as Chief Operating Officer of Inova Fairfax Hospital and Vice President of the Inova Health System. Under his leadership, Inova Fairfax was named a magnet hospital for nursing, Top 100 hospital by HCIA / Mercer, and Best in Cardiology / Cardiac Surgery, Oncology, and Pulmonary by U.S. News and World Report.

Dr. Ghezzi also served as Chief Operating Officer and Medical Director of George Washington University Hospital, which he helped return to profitability and prepare for sale. He also served as a Director of the George Washington University Health Plan, inaugural Director of the Ronald Reagan Institute of Emergency Medicine, and Associate Professor of Emergency Medicine and Surgery at the George Washington University School of Medicine and Health Sciences. He is board certified in emergency medicine and a Fellow of the American College of Emergency Physicians. He also serves on the Board of Washington & Jefferson College, where he chairs the Academic Affairs Committee.

Irv Edwards, MD — Advisor, Hospital Operations

Dr. Irv Edwards currently serves as Chairman and Founder of Emergent Medical Associates, a leading provider of Emergency Department and Inpatient management services. He is a co-founder and active board member of Avanti Hospitals, which acquired, turned around, and continues to own and operate four acute care hospitals in South and East Los Angeles. His expertise includes emergency department operations, inpatient management (including hospitalist and case management programs), care coordination, and clinical documentation. Working closely with Dr. Mark Bell, Emergent has spent considerable time analyzing Emergency Department Operations and developed a proprietary business model which consistently transforms underperforming departments into Departments of Excellence that are more efficient, deliver improved quality, and attract increased Paramedic volumes and associated admissions.

Dr. Edwards is responsible for managing the emergency departments at Chino Valley Medical Center, Tarzana Regional Medical Center, La Palma Intercommunity Hospital, Mission Community Hospital, Montclair Hospital Medical Center, Sherman Oaks Hospital, Centinela Freeman Hospital Medical Center, Valley Presbyterian Hospital, West Hills Medical Center, Alvarado Medical Center, and several others.

Dr. Edwards is a Diplomat of the American Board of Emergency Medicine and American Board of Quality Assurance & Utilization Review, and a Fellow of the American College of Emergency Physicians.

Everett T. Lyn, MD, Advisor, Emergency Department Operations

Dr. Everett Lyn currently serves as an executive with Emergent Medical Systems, a leading provider of Emergency Department management services. He specializes in operational efficiencies, clinical pathways, quality measures, high-risk population care management, and fiscal management. He recently served as Chairman of the Department of Emergency Medicine for Partners HealthCare in Boston, where he led the turnaround of several emergency departments. He previously held several positions with Brigham and Women's Hospital, including Director of Medical Education, Director of Academic and Faculty Affairs, and Director of Clinical Affairs, among others. He has served on numerous industry boards, and been the recipients of several awards and research grants.

Ashok Kumar, MD — Advisor, Clinical Documentation

Dr. Kumar is Medical Director for the hospitalist program at Avanti Hospital in Gardena, California where he assists the hospital in focusing on quality inpatient care and proper documenting the severity of illnesses. Dr. Kumar has been a hospitalist since 1998, and in 2001, Dr. Kumar formed a hospitalist group in which he provided cost effective, high quality medical care and developed a post-hospitalization community case management program to coordinate post-hospitalization care and reduce re-admission rates. Due to the success of the program, ACE Medical Group provides hospitalist services to multiple IPA's in the South Bay. Dr. Kumar also oversees the core measure program at Memorial Hospital of Gardena. As the leader of the core measure team, he has been able to improve the core measures from less than 30% to above 90%.

James Lally, DO — Advisor, Inpatient Management

Dr. Lally, President & Chief Medical Officer, Chino Valley Medical Center, is recognized in the local community as a charitable and giving physician, who leads by example. Board certified in Family Practice, with certificates of added qualification in Sports Medicine and Geriatrics, he is responsible for the day to day operations of the hospital and also serves as director of medical education for an internship, family practice residency, geriatrics & sports medicine fellowship. Chino Valley Medical Center has been recognized as a Truven Top 100 Hospital for 2012, 2013, and 2014. He serves as team physician for the USA Shooting Team as well as its President for the second time and is Chairman of the Medical Committee of the International Shooting Sports Federation and sits as a member of the International Olympic Medical Committee. He serves on the Board of Trustees for Chino Valley Medical Center and Montclair Hospital Medical Center.

Ravi Sharma — Senior Advisor

Ravi Sharma currently serves as the Chief Technology Officer for Paladin. He is among the healthcare industry's leading information technology experts, including a deep understanding of transformational technologies across the healthcare spectrum that offer the potential to increase efficiency, improve quality, decrease costs, enhance decision making, and engage patients. He has a thorough understanding of hospital operations and the various enterprise and ancillary solutions which support the industry. Mr. Sharma formerly led the largest division of GE Healthcare, was handpicked to be the first Global Director of GE's Six Sigma business, and led the development of GE's Customer Relationship Management (CRM) initiative, GE Cares. He also served as the Director of US Operations for Toshiba America Medical Systems; and as CEO for three early-stage healthcare technology companies, each of which he built into successful operations providing progressive solutions in clinical integration to a wide range of cloud-based healthcare companies.

Nicholas Orzano — Advisor, Real Estate and Data Deck

Nick Orzano currently serves as a principal of Paladin Healthcare Capital. He previously served as Vice President of Finance and is a co-founder of Avanti Hospitals, LLC, where he played a key role in Avanti's several acquisitions and recapitalizations, and led the highly-successful transformation of Avanti's supply chain and revenue cycle operations. Nick has been involved in the implementation of more than $500mm of transactions, including more than $400mm of healthcare transactions. He is also a certified real estate broker and principal of Stanton Road Capital, a real estate private equity firm, and PalCap Realty Advisors, a real estate brokerage.

APPENDIX B

District of Columbia Providers

Skilled Nursing Facilities		
Facility Name	**Address**	**Ward**
Stoddard Baptist Nursing Home	1818 Newton St., NW Washington, DC 20010	1
Unique Residential Care Center	901 First St. NW Washington, DC 20001	2
Lisner Louise Home	5425 Western Ave., NW Washington, DC 20015	3
Ingleside Presbyterian Retirement Home	3050 Military Rd., NW Washington, DC 20015	3
Brinton Woods Health and Rehabilitation Center at Dupont Circle	2131 O St., NW Washington, DC 20037	2
Health and Rehabilitation Center at Thomas Circle	1330 Massachusetts Ave., NW Washington, DC 20005	2
Sibley Memorial Hospital -The Renaissance Unit	5255 Loughboro Rd., NW Washington, DC 20016	3
The Methodist Home of the District of Columbia	4901 Connecticut Ave., NW Washington, DC 20008	3
The Washington Home	3720 Upton St., NW Washington, DC 20016	3
Jeanne Jugan Residence	4200 Harewood Rd., NE Washington, DC 20017	5
Washington Center for Aging Services	2601 18th St., NE Washington, DC 20018	5
Carroll Manor Nursing and Rehabilitation Center	725 Buchanan St., NE Washington, DC 20017	5
Knollwood HSC	6200 Oregon Ave., NW Washington, DC 20015	6
Capitol Hill Nursing Center	700 Constitution Ave., NE Washington, DC 20002	6
Deanwood Rehabilitation and Wellness Center	Fire Inspection 5000 Nannie Helen Burroughs Ave., NE Washington, DC 20019	7
Specialty Hospital of Washington- Hadley Skilled Nursing Facility	4601 MLK Jr. Ave., SW Washington, DC 20032	8
Carolyn Boone Lewis Health Care Center	1380 Southern Ave., SE Washington, DC 20032	8
Washington Nursing Facility	2425 25th St., SE Washington, DC 20020	8
United Medical Nursing Center	1310 Southern Ave., SE Washington, DC 20032	8

Primary Care Centers		
Site name	Address	Ward
Andromeda Transcultural Health	1400 Decatur Street NW Washington, DC 20011	4
Bread for the City	1525 Seventh Street NW Washington, DC 20001	2
Bread for the City	1640 Good Hope Road SE Washington, DC 20020	7
Carl Vogel Center	1012 14th Street NW Suite 700 Washington, DC 20005	2
Children's National Medical Center (CNMC) - Adams Morgan Clinic at Dorchester House	1630 Euclid Street NW Washington, DC 20009	1
CNMC - Adolescent Health Center- CHC	111 Michigan Avenue NW Washington, DC 20010	5
CNMC -Children's Health Center Good Hope Road	2501 Good Hope Road SE Washington, DC 20020	8
CNMC - Children's Health Center at Martin Luther King Jr Ave	3029 Martin Luther King Jr Ave. SE Washington, DC 20032	8
CNMC - Children's Health Center at Shaw	2220 11th Street NW Washington, DC 20001	1
CNMC - THE ARC	1901 Mississippi Avenue SE Washington, DC 20002	8
Community of Hope - Marie Reed	2250 Champlain Street NW Washington, DC 20009	1
Community of Hope - Family Health and Birth Center	801 17th Street NE Washington, DC 20002	5
Family and Medical Counseling Services	2041 MLK Jr. Ave SE, Suite 300 Washington, DC 20020	8
Howard Family Health Center	2139 Georgia Avenue NW Washington, DC 20001	2

Home Health Agencies		
Facility Name	**Address**	**Wards**
MedStar Visiting Nurse Association	4455 Connecticut Avenue, NW Washington, DC 20008	3
Nursing Enterprises, Inc.	5101 Wisconsin Avenue, NW # 250 Washington, DC 20016	5
Tender Loving Health Care	1212 New York Avenue, NW Room 200 Washington, DC 20005	2
Health Management, Inc.	1025 Vermont Avenue NW Suite 810 Washington, DC 20005	4
Ideal Nursing Services	820 Upshur Street, NW Washington, DC 20011	4
VMT	4201 Connecticut Avenue, NW Washington, DC 20008	3
Nursing Unlimited	1328 G Street, SE Washington, DC 20003 313 8th Street, NE Washington, DC 20002	8 6
Tri-State Home Care	6210A Chillum Place, NW Suite 101 Washington, DC 20011	4
Community Care Services	6031 Kansas Ave., NW Suite 201 Washington, DC 20011	6
Professional Health Care Resources	1010 Wisconsin Avenue, NW Suite 300 Washington, DC 20007	2
Premium Select	5513 Illinois Avenue, NW Suite 411 Washington, DC 20011	2
ASAP Service Corp.	201 15th Street, SE Washington, DC 20003	2

Home Health Agencies (Continued)		
Facility Name	**Address**	**Wards**
Human Touch Home Health Care Agency Inc.	1416 9th Street, NW Washington, DC 20001	2
Berhan Home Health Care Agency, Inc.	7826 Eastern Avenue, NW Suite LL16 Washington, DC 20012	4
Alliance Health Care and Equipment Services	7826 Eastern Avenue, NW Suite 406 Washington, DC 20012	4
Americare in Home Nursing	4000 Abermarle Street, NW Suite 210 Washington, DC 20016	3
ABA Home Health Care, Inc.	821 Kennedy Street, NW Washington, DC 20011	4
T & N Reliable Nursing Care	3500 18th Street, NE Washington, DC 20018	5
Maxim Health Services, Inc.	6856 Eastern Avenue, NW Suite 220 Washington, DC 20012	4
KBC Nursing Agency & Home Health Care Inc.	7506 Georgia Avenue, NW Washington, DC 20012	4
Immaculate Health Care Services, Inc.	2512 24th Street, NE Washington, DC 20018	5
Speqtrum Home Health	3019 Georgia Avenue, NW Washington, DC 20028	1
J.D. Nursing and Management Services, Inc.	7826 Eastern Avenue, NW Suite LL18A Washington, DC 20012	4
Linac Service Inc.	6856 Eastern Avenue, NW Suite 320A Washington, DC 20012	4
Premier Health Services, Inc.	7600 Georgia Avenue, NW Suite 323 Washington, D.C. 20012	4
Capitol View Home Health Care Agency	1618 7th Street, NW Washington, DC 20001	2
HSC Home Care LLC	1731 Bunker Hill Road, NE Washington, DC 20017	5

Federally Qualified Health Centers		
Facility Name	**Address**	**Ward**
Community of Hope	2250 Champlain St NW Washington , DC 20009	1
Community of Hope	801 17th Street NE Washington , DC 20002	5
La Clinica Del Pueblo	1470 Irving Street NW Washington , DC 20010	1
Unity Health Care	1500 Galen St SE Washington , DC 20020	8
Unity Health Care	1201 Brentwood Rd NE Washington , DC 20018	6
Unity Health Care	1660 Columbia Rd NW Washington , DC 20009	7
Unity Health Care	3720 Martin Luther King Jr Ave SE Washington , DC 20032	8
Unity Health Care	123 45th St NE Washington , DC 20019	7
Unity Health Care	4130 Hunt Pl NE Washington , DC 20019	7
Unity Health Care	3924 Minnesota Ave NE Washington , DC 20019	7
Unity Health Care	850 Delaware Ave SW Washington , DC 20024	6
Unity Health Care	3240 Stanton Ave SE Washington , DC 20020	8
Unity Health Care	3020 14th St NW Washington , DC 20009	1
Unity Health Care	1900 Massachusetts Ave SE Washington , DC 20003	6
Unity Health Care	40 Patterson St NE Washington , DC 20002	6
Mary's Center for Maternal & Child Care	2333 Ontario Rd NW Washington , DC 20009	1
Mary's Center for Maternal & Child Care	3912 Georgia Ave NW Washington , DC 20011	4
Whitman Walker Clinic	1701 14th St NW Washington , DC 20009	2
Whitman Walker Clinic	2301 Martin Luther King Jr Ave SE Washington , DC 20009	8
Elaine Ellis Center of Health	1605 Kenilworth Ave NE Washington , DC 20019	7
Family and Medical Counseling Services	2041 Martin Luther King Jr Ave SE Washington , DC 20020	8

EXHIBIT C

Richard Wier Jones

Certified Public Accountant
70 Grandview Boulevard
West Lawn, Pennsylvania 19609
(M) 504-782-9512
E-mail: jones1rw@earthlink.net

Florida certificate number 16219, issued October 3, 1985 – inactive status

EXPERIENCE

Reading Health System
West Reading, Pennsylvania

Corporate Chief Financial Officer September 2010 – October 2014

Reading Health System, West Reading, Pennsylvania – serving as **Corporate Chief Financial Officer** –since June 2010, initially as a Managing Director of FTI Consulting and later as an employee of Reading Health System. $900 million net revenue integrated health care delivery system which includes: 560 bed acute care teaching facility, 112 bed skilled nursing/rehab facility and 40 bed psych facility; 345 employed physicians (primary care, specialists and hospital based); 13 remote imaging centers; remote Ambulatory Surgery Center (Hospital – Physician joint venture); The Highlands at Wyomissing – a licensed Continuing Care Retirement Community 290 independent/assisted living apartments/cottages and 80 skilled nursing beds; and The Reading Hospital School of Health Sciences which includes a school of nursing and training programs for OR techs, radiology techs, paramedics and clinical pastoral care. Initially performed financial and operational assessment for the organization's Board of Directors, resulting in FTI receiving a 20 month performance improvement / management engagement and being appointed to serve as Corporate Chief Financial Officer during the engagement.

- Hired as Reading Health System Corporate CFO in January 2012
- Refinanced $470 million of the system's 610 million outstanding debt through public bond offerings and privately placed bank debt,
- Improved Standard & Poor's bond rating from "AA" with negative outlook to "AA" with "Stable" outlook,
- Improved Moody's bond rating from "Aa3" with negative outlook to "Aa3" with "Stable" outlook,
- Developed a shared risk arrangement with the second largest employer in the market for its employees' health care coverage,
- Submitted an application to participate in Medicare bundled payments,
- Serve on the steering committee to develop and implement the organization's clinical integration strategy,
- Serve on the steering committee responsible for selecting and overseeing the implementation of the EPIC healthcare information system for inpatient and physician practices,
- $47.6 million Net Revenue improvement fiscal year over year,
- $21.1 million Operating EBITDA improvement fiscal year over year (includes $15 million of one-time restructuring costs),
- $35.4 million Net Income improvement fiscal year over year,
- Increased Days Cash on Hand by 54.5 to 505.0,
- Improved hospital Net Days in Accounts Receivable from 50.7 to 45.0,
- Reduced acute Medicare average length of stay from 5.94 to 5.05 by restructuring Care Management and Social Services, engaging hospitalists and other physicians along with the development and implementation of a comprehensive Care Management program,
- Restructured financial accounting and reporting, and
- Implemented financial internal controls.

FTI Healthcare – FTI Consulting

Brentwood, Tennessee

Managing Director — June 2007 – December 2011

Senior leadership position responsible for identifying, planning and implementing turn around, performance improvement, interim management and litigation support solutions for healthcare clients, their credit holders and law firms. Clients and services provided include:

- **Reading Health System**, West Reading, Pennsylvania – served as **Corporate Chief Financial Officer** – eighteen month engagement.

- **Boca Raton Community Hospital**, Boca Raton, Florida – served as **Corporate Chief Financial Officer** – eighteen month engagement.

  $350 million net revenue integrated health care delivery system,
  - ♦ $110 million year over year Net Income and EBIDA improvement,
  - ♦ $120 million two year Net Income and EBITDA improvement,
  - ♦ Improved bond rating outlook from "Watch negative" to "Stable" from Fitch Ratings,
  - ♦ $30 million year over year Net Patient Revenue improvement,
  - ♦ Improved Net Collectable Revenue by $1,076 per adjusted admission over 18 months resulting from improved revenue cycle processes, renegotiated managed care contracts, improvements in clinical documentation and charge master improvements,
  - ♦ Reduced Bad Debts as a percent of Net Patient Revenue from 10 percent to 4.5 percent,
  - ♦ Reduced Days in Accounts Receivable from 59 to 39,
  - ♦ Reduced Medicare average length of stay from 6.04 to 5.22 by restructuring Case Management and Social Services along with the development and implementation of a comprehensive Case Management program,
  - ♦ Reduced FTE's by 267,
  - ♦ Initiated BocaCare primary care network of employed primary care physicians which will include two dozen employee primary care physicians,
  - ♦ Restructured financial accounting and reporting,
  - ♦ Implemented financial internal controls,
  - ♦ Received no management letter comments or recommendations from external auditor, and
  - ♦ Opened two remote imaging centers bringing the total to three remote imaging centers.

- **Brooklyn Queens Healthcare of New York**, New York City, New York – served as **Corporate Chief Financial Officer** – eleven month engagement.
  $600 million net revenue integrated health care delivery system.

  - ♦ Implemented Meditech information systems for revenue cycle and financial accounting in three hospitals,
  - ♦ Standardized financial accounting and reporting for the three hospitals and the system,
  - ♦ Implemented internal and financial controls for the system, and
  - ♦ Implemented system policies, procedures and practices revenue cycle, financial accounting and reporting, materials management accounts payable and information systems.

- **Methodist Hospitals**, Gary, Indiana – Conducted review of Revenue Cycle, Managed Care contracts, Information Systems plan and Early Retirement plan.

- **Memorial Health**, Savannah, Georgia – Operations Assessment, resulting in a performance improvement project.

- **General Health System**, Baton Rouge, Louisiana – Litigation Support.

- **Locke Lord Bissell & Liddell LLP**, Dallas, Texas – Litigation Support.

- **Roseland Community Hospital**, Chicago, Illinois – Interim Management, **Chief Financial Officer** – six month engagement.

Consultant – Independent Contractor March 2007 – June 2007

Financial management consultant responsible for providing turn around support to clients' senior management team. Client: **Roseland Community Hospital**, Chicago, Illinois, reporting to the Hospital's Chief Executive Officer, subcontracted through FTI Healthcare.
Activities included:

- Serving as interim Chief Financial Officer,
- Restructuring revenue cycle processes in order to accelerate cash flow,
- Perform analysis of information system functionality and utilization,
- Development and implementation of productivity monitoring procedures,
- Negotiate discount payment terms with vendors,
- Coordinate external audits, and
- Provide regular reports to the Hospital's Board Finance Committee

USC University Hospital / USC Norris Cancer Hospital, Tenet Healthcare Corporation
Los Angeles, California

Chief Financial Officer August 2006 – February 2007

Senior financial executive for USC University Hospital / USC Norris Cancer Hospital (the Hospital) reporting to the Hospital's Chief Executive Officer (CEO) and indirectly to the Tenet California Region Vice President, Finance. Direct reports include the Assistant Chief Financial Officer, the Directors of Case Management/Social Services, Contracting, Health Information Management, Information Systems, Managed Care, Materials Management, Patient Access and Patient Financial Services. Duties include: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis for the Hospital and its clinics, managed care contract negotiations, coordination of external and internal audits and information systems implementations and management.

USC University Hospital was a 267-bed for profit tertiary teaching hospital serving as the principle teaching hospital the USC Keck School of Medicine. The USC Norris Cancer Hospital was a 60-bed for profit National Cancer Institute designated Comprehensive Cancer Center. The combined annual volumes of the two hospitals are approximately 11,500 inpatient admissions, 80,000 patient days and 470,000 outpatient visits.

The following is a list of accomplishments while at USC University Hospital / USC Norris Cancer Hospital:

- Assist with the consolidation of the two hospitals into one facility, which will include a new 110-bed tower, which will open in the spring of 2007. This will bring the total available beds to approximately 420,
- Redesign Patient Access emphasizing customer service and clinical integration,
- Assist with the implementation of Cerner clinical information systems, and
- Coordinate the consolidation of financial services of the two hospitals.

Louis A. Weiss Memorial Hospital, Vanguard Health Systems
Chicago, Illinois

Chief Financial Officer February 2005 – June 2006

Senior financial executive for Louis A. Weiss Memorial Hospital (the Hospital) reporting to the Hospital's Chief Executive Officer (CEO) and indirectly to the Vanguard Health Systems (VHS) Regional Vice President, Finance for the Chicago Market. Direct reports include the Controller, the Directors of Budget, Cost and Reimbursement, Case Management/Social Services, Health Information Management, Information Systems, Materials Management, Patient Access and Patient Financial Services. Duties include: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis for the Hospital and its clinics, managed care contract

negotiations, coordination of external and internal audits and information systems implementations and management.

The Hospital was a 369-bed acute care teaching hospital operated as for-profit joint venture between the University of Chicago Hospitals and VHS. Eighty (80) percent of the equity as well as full governance responsibilities are held by VHS. The Hospital also serves as the principle clinical and teaching site for three (3) of the University of Chicago School of Medicine's (U of C) departments (Orthopedic Surgery, Plastic Surgery and Vascular Surgery). In addition to operating these three (3) U of C clinics, the hospital also operates twelve (12) other hospital-based clinics, both on and off campus, in a variety of specialties. These other clinics are staffed by twenty-five (25) employed physicians in various specialties, as well as by independent community physicians on a time-share basis. Clinical services provided by the Hospital include: Acute Rehabilitation, Behavioral Health, Cardiac Surgery and Catheterization, Infusion and Radiation Therapies and Obstetrics.

The following is a list of accomplishments while at Weiss Memorial Hospital:

- Recruited from external and internal sources: The Controller, the Directors of Budget, Cost and Reimbursement, Case Management/Social Services, Health Information Management and Patient Access,
- Reduced Net Days in Accounts Receivable from 88 to 57,
- Reduced the number of Discharged and Unbilled Days in Accounts Receivable from 15 to 5.5 (including 4 bill hold days,
- Reduced the Medical Record Delinquency rate from over 50 percent to 22 percent,
- Reduced Medicare Length of Stay from 5.3 to 4.4 days,
- Transitioned the Patient Accounts department to a Centralized Business Office, and
- Improved month end close processes as well as accounting and internal controls.

San Gabriel Valley Medical Center, Catholic Healthcare West

San Gabriel, California

Senior Vice President and Chief Financial Officer — December 2001 – February 2005

Senior financial executive for the hospital reporting to the hospital's Chief Executive (CEO) and indirectly to the Catholic Healthcare West (CHW) Southern California Division Chief Financial Officer (CFO). Direct reports included the Controller, the Directors of: Patient Financial Services, Patient Access, Case Management/Social Services, Decision Support, Health Information Management (Medical Records), Information Systems, Managed Care, and Materials Management. Duties included: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis for the Hospital, managed care contract negotiations, coordination of internal and external audits, information systems implementations and enhancements, and provide financial oversight to the San Gabriel Valley Medical Center Foundation.

San Gabriel Valley Medical Center was owned and operated by CHW as a not-for-profit community hospital. Governance of the Hospital is provided by both CHW and a Hospital Community Board of Directors. The facility was a full service 275-bed acute care teaching hospital affiliated with the University Southern California Keck School of Medicine. Among the services provided by the Hospital are: Obstetrics, Behavioral Health, Transitional Care (skilled nursing) and Cardiac Catheterization.

The following is a list of accomplishments while at San Gabriel Valley Medical Center:

- Built new Financial Management team,
- Reduced Days in Accounts Receivable from 72 to 50.6,
- Monthly Net Revenue as a percentage of Gross Revenue increased from 19 percent to 25 percent over the last six months of the fiscal year (fiscal year ended June 30, 2002),
- Reduced the number of Unbilled Days in Accounts Receivable from 14 to .7,
- Initiated, in conjunction with CHW's managed care office, the renegotiation of unfavorable managed care contracts,
- The hospital completed the fiscal year 2002 with positive cash flow from operations for the first time since its affiliation with CHW began in 1998 after having negative cash flow from operations of approximately $2,000,000 through the first six months of the fiscal year,
- Transitioned the Patient Accounts department to a Central Business Office,

- Assisted with the planning, development and implementation of a 21 fte Family Medicine intern and residency program,
- Improved internal controls related to: Cash handling, General Ledger, and Patient Accounting,
- Initiated a Revenue Capture Process Improvement project, which includes complete redesign of the charge capture process along with a comprehensive review and update of the charge master,
- Supply expense decreased from 13% to 11.5% of net revenue, and
- Implemented a redesign of the Case Management and Social Service functions to reduce length of stay and excess utilization.

Tulane University Hospital and Clinic, HCA Inc.

New Orleans, Louisiana

Vice President and Chief Financial Officer — September 1999 – July 2001
Facility Ethics and Compliance Officer

Senior financial executive reporting directly to the hospital's Chief Executive Officer and indirectly to the HCA Delta Division Chief Financial Officer. Direct reports included an Assistant Vice President for Finance, the Controller, the Directors of the Business Office, Case Management/Social Services, Decision Support, Health Information Management, Information Systems, Managed Care, Materials Management and. Revenue Cycle Projects. Duties included: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis for the Hospital's three campuses and clinics, managed care contract negotiations, coordination of internal and external audits, facility corporate compliance and information systems implementations and enhancements.

Tulane University Hospital and Clinic (TUHC) was owned and operated by University Healthcare System, L. C. (UHS), a for profit joint venture between Tulane University (the University) and HCA, Inc. TUHC served as the principle teaching hospital for the University's School of Medicine. HCA, Inc. owned eighty (80) percent of the equity in the joint venture with the University holding the remaining twenty (20) percent. However, governance was shared on a fifty-fifty (50-50) basis through a Governing Board of Directors consisting of twenty (20) members. The two joint venture partners appoint ten (10) members each. Additionally, UHS by-laws prescribe that the Board Chairman is to be selected from among the ten (10) members appointed by the University.

TUHC operated facilities on three (3) campuses with a total compliment of 353 adult beds. These facilities included a 214-bed tertiary teaching hospital and hospital based physician clinics on the Tulane Medical Center campus, the DePaul Hospital – a 110-bed psychiatric hospital and the Elmwood rehab hospital - a 29-bed acute rehab facility. Further, it was expected that during the fiscal year ending December 31, 2001 there will be approximately 12,000 admissions, 36,000 Emergency Department visits and 300,000 outpatient visits.

The following is a list of accomplishments while at TUHC:

- Recruited internally or externally every direct report with the exception of the Director of Information Systems,
- Enlisted the assistance of HCA corporate Internal Audit and Information Systems staff to review the integrity of the Patient Accounting and Registration Systems, assist with making necessary system recommendations and assist with developing training programs for Patient Accounting and Registration Staff,
- Reduced Days in Accounts Receivable from 87 to 56,
- Reduced Bad Debt Expense from 5.9% to 4.7% of Net Revenue,
- Reduced delinquent medical records to below 50% of the number allowed by JCAHO from 12% above the standard,
- Improved internal controls related to: Cash handling, General Ledger, Materials Management and Patient Accounting,
- Increased the number of Inventory Turns for the Materials Management Department to 25 from 12, and
- Increased rates paid by managed care plans 5% to 18%.
- As Facility Ethics and Compliance Officer implemented HCA's Ethics and Compliance program

University Hospital of Arkansas, University of Arkansas for Medical Sciences
Little Rock, Arkansas

Chief Financial Officer November 1990 – September 1999

Senior financial executive recruited to the University Hospital of Arkansas (UH) by W. David Heron, Vice Chancellor for Finance and Administration, University of Arkansas for Medical Sciences (UAMS), to whom there was an indirect reporting relationship in addition to reporting directly to the UH CEO. Direct reports included the Directors of Admitting; Budget and Cost Accounting, Clinical Decision Support; Financial Management, Health Information Management (Medical Records), Patient Business Services and Reimbursement and Social Services. Duties also include: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis, conducting debt capacity and feasibility studies for a $65 million bond issue, negotiation of managed care contracts, negotiate equipment acquisition and financing, participate in the development of a Primary Care Network and a Hospital based managed care network, and coordinate the development and implementation of Hospital information systems.

UH, as part of the UAMS, was a 400 bed tertiary hospital that served as the principle teaching hospital for the UAMS College of Medicine. In addition to UH and the College of Medicine the UAMS operated Colleges of Nursing, Pharmacy and Allied Health Related Professions. During the fiscal year ended June 30, 1999, the Hospital had approximately 15,000 admissions, 35,000 Emergency Department visits and 250,000 outpatient visits. The Hospital operates a level I trauma unit, a level III new born intensive care unit, the Arkansas Cancer Research Center, the Jones Eye Institute, the Donald Reynolds Center on Aging and the Ambulatory Care Center on its campus. Additionally, several off-campus clinics provide ob/gyn, renal dialysis and physical therapy services operated by the hospital.

The following is a list of accomplishments while at the UH:

- Assisted with the planning and implementation of Qual Choice of Arkansas, Inc., a managed care company established by the Hospital and the physician practice plan;
- Responsible for negotiating managed care contracts and direct contracts with employers;
- Reduced Days in Accounts Receivable from 165 to 55.8;
- Reduced the staffing compliment in the Finance division (which includes General Accounting, Cost Accounting, Budget, Reimbursement, Medical Records, Patient Accounts, Patient Registration and Social Services) by approximately 35 fte's;
- Assisted with the establishment of a hospital based home health agency;
- Developed, implemented or expanded the following information systems:
  - Re-implemented Patient Accounting system (HBOC Medipac),
  - Upgraded the Decision Support System (HBOC TrendStar) enabling the expansion of financial analysis and cost accounting capabilities,
  - Implemented previously unused modules of the General Ledger system (DBS E-Series) resulting in expanded financial reporting capabilities,
  - Patient Registration system (HBOC Patient Management) for the Hospital and Clinics,
  - Hospital budget system (SRC Budget Advisor) and financial analysis system (SRC Strategic Advisor),
  - Medical Records system (SoftMed) which includes chart tracking and location modules, and
  - Currently participating on the implementation steering committee for the order entry / results reporting system (ALLTEL TDS) and chair the Hospital Information Systems Implementation & Coordination Committee.
- Coordinated the preparation of Debt Capacity and Financial Feasibility studies leading to $65 million bond issue to finance expansion of the Hospital and Clinics, and
- Provided oversight to strategic planning initiatives as well as Continuous Quality Improvement and Re-engineering projects through participation on the Health System Executive Board.

Geisinger System Services – Danville, Pennsylvania

Administrative Director of Finance March 1990 – November 1990

Served as corporate controller for the Geisinger system of health care. Reported to the Geisinger System Services (GSS) Vice President of Finance. Direct reports were the Managers of Construction Accounting, General Accounting and Payroll, Systems Accounting (2), and Tax Accounting. Duties included: Consolidated financial reporting for the system's six not-for-profit and three for-profit legal entities, coordinate external audits and tax compliance for all entities; provide consultative support on unrelated business income activities, tax exemption, etc.; coordinate end user information system requirements, support, training, and documentation with the Information Management department; record keeping for the 401(k) savings plan, the 403(b) tax sheltered annuity and retiree health benefits; and serve as chairman of the Finance Group which was responsible for coordinating the development and implementation of accounting and statistical reporting policies and procedures.

GSS was the corporate home office for the Geisinger system of healthcare. The system included: The 577 bed Geisinger Medical Center, the 230 bed Geisinger Wyoming Valley Hospital, the Geisinger Clinic (600 employed physicians), the Geisinger Health Plan HMO (fourth (4^{th}) largest HMO in Pennsylvania), the Geisinger Marworth mental health hospitals, Geisinger Medical Management (a for-profit consulting and allied health business), the Geisinger School of Nursing, and the Geisinger Foundation (parent holding company and fund raising activities).

The following is a list of accomplishments while at GSS:

- Initiated five (5) year information systems master plan to upgrade all financial information systems to the vendors' most current version,
- Developed Job Specific Performance Dimensions for each position in GSS Finance, and
- Coordinated the system wide external financial audit.

Heartland Health System – Saint Joseph, Missouri

Corporate Controller March 1988 – February 1990

Recruited to Heartland Health System (HHS) by W. David Heron, Senior Vice President, Finance to serve as the Corporate Controller. Direct reports were the Directors of Accounting and Reimbursement, Budget and Cost Accounting, Financial Analysis, Medical Records and Patient Financial Services. Duties included: Annual budget preparation, financial and revenue cycle management, strategic financial planning and analysis negotiating physician and managed care contracts, negotiating equipment acquisition and financing, providing support for the administrative staff of the hospitals and assist in the coordination of a $51.6 million bond issue to refinance the System's debt.

HHS was a multi-facility not-for-profit health care system consisting of three (3) inpatient facilities and a for-profit management company. HHS was formed by the merger of Methodist Hospital and St. Joseph Hospital. Heartland Hospital East was a 205-bed acute care hospital with a level II trauma center. Heartland Hospital West was a full service community hospital with 221 acute care beds and a 50 bed psychiatric unit. Heartland Centre was a 200-bed long-term care facility providing acute rehabilitation, skilled nursing and intermediate long-term care. Heartland Health Management was a wholly owned for-profit management company which operated the system's retail pharmacy, home health agency, hospice, out patient renal dialysis facility, ambulance company and collection agency.

The following is a list of accomplishments while at HHS:

- Re-implemented the IBM Patient Accounting / Patient Management Systems,
- Consolidated the business offices of Heartland Hospitals East and West into one location resulting significant operational efficiencies and the elimination of fifteen (15) fte's,
- Reduced Days in Accounts Receivable from 131 to 68,
- Consolidated management of the Medical Records Departments at Heartland Hospitals East and West under one department director,
- Converted all medical records to a single unit record numbering system,
- Restructured the finance areas resulting in operational efficiencies and the elimination of three (3) fte's,
- Coordinated the preparation of Debt Capacity and Financial Feasibility studies leading to a $51.6 million bond issue to refinance HHS debt and to fund renovation of the Heartland Hospital West campus, and
- Served as the Interim Director of Materials Management for three (3) months.

AMI Southeastern Medical Center – North Miami Beach, Florida

Chief Financial Officer November 1986 – March 1988

Recruited to AMI Southeastern Medical Center (Southeastern) by Jose Fernandez, CEO (formerly CEO at Coral Reef Hospital), to serve as the CFO. Responsible for all financial management activities, which included: Accounts Payable, Business Office, Central Supply, Data Processing, Materiel Management, Medical Records, Patient Registration, Social Services and Utilization Review. General responsibilities included: Preparation of budgets, financial statement projections, and government regulatory reports.

Southeastern was a 224-bed full service hospital serving as the principle teaching facility for the Southeastern College of Osteopathic Medicine.

Coral Reef Hospital – Springhill Health Services, Inc. – Miami, Florida

Chief Financial Officer April 1986 – November 1986

Recruited to Coral Reef Hospital (CRH) by Vince Formica, CFO, to serve as Assistant Controller after performing a due diligence engagement for the minority physician partners. The physician partners were Arthur Andersen & Co. tax clients. Promoted to CFO reporting directly to the CEO and indirectly to W. David Heron, Vice President, Finance, Springhill Health Services, Inc. Responsible for all financial management activities, which included: Accounts Payable, Business Office, Central Supply, Data Processing, General Accounting, Materiel Management, Patient Registration, and Payroll. Also involved in negotiating joint venture agreements, long range planning, feasibility study preparation and the organization of an off shore insurance captive for professional liability.

Assistant Controller April 1985 – April 1986

Department head reporting to the Chief Financial Officer, and in his absence, acted as CFO. Responsible for: General Accounting, Accounts Payable, and Payroll; preparation of financial statements, budgets and regulatory reports; and managing short-term cash investments. Duties also included: Assisting the Business Office Manager in reviewing delinquent accounts and making recommendations for improving collections; assisting the Director of Materiel Management with the establishment and maintenance of purchasing and inventory internal controls.

CRH was a 260-bed community hospital with 150 acute care beds and 90 psychiatric beds located in Miami, Florida.

Arthur Andersen & Co., Certified Public Accountants – Miami, Florida

Staff Accountant December 1983 – April 1985

Performed all aspects of financial statement audits for publicly held, privately owned and governmental clients in the: Healthcare, hospital, insurance, banking, finance, real estate, county government and paramutual industries. Also participated in healthcare consulting engagements performing medical record reviews due diligence reviews and cash flow forecasts.

Joseph L. Fisher, Certified Public Accountant – Miami, Florida

Staff Accountant August – December 1983

Part-time position held while completing graduate school. Involved in all aspects of a Small Business practice. Responsibilities included: Providing audit, compilation and review services; preparation of client write-ups; preparation of C and S Corporation tax returns; and coordinate the procurement and installation of an in-house computer system.

Accounting Department, University of Miami (Florida) – Coral Gables, Florida

Graduate Assistant January – May 1983

Responsible for assisting an accounting professor in conducting research into applications of the statistical technique R Factor Analysis. This involved compiling data and writing reports documenting research findings. Also served as a substitute professor teaching undergraduate managerial accounting courses.

Baptist Hospital of Miami, Inc. – Miami, Florida

Financial Counselor April 1980 – June 1983

Involved in all aspects of patient accounts receivable. Duties included: Establishment and collecting preadmission deposits, assisting patients in making financial arrangements for the payment of their bills; expediting collections from patients and third party payers; and serving as a witness for the hospital in legal proceedings against patients who failed to fulfill their obligations to the Hospital.

EDUCATION

Graduate Accounting

Graduate School of Business, University of Miami (Florida)

Program included nine graduate level courses in accounting, three of which were electives. Elective accounting courses taken consisted of EDP Auditing, Accounting for Governmental and Not-for-Profit Organizations; and Federal Gift and Estate Taxation (with and emphasis in Estate Planning).

Master of Business Administration/Health Administration

Certificate of Health Administration

Certificate of Accounting

Graduate School of Business, University of Miami (Florida)

Graduate program leading to a Master of Business Administration degree with an emphasis in Health Administration.

Fulfilled undergraduate requirements for a major in accounting.

Bachelor of Arts Degree in Politics and Public Affairs

University of Miami (Florida)

Certificate of Insurance

Fulfilled requirements for a major in Finance with concentration in Insurance. Received the Risk and Insurance Managers Society Scholarship Award.

EXHIBIT D

CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT (this "Agreement") is made and entered into as of the 14th day of April 2015 by and between Paladin-Howard Management, LLC ("**Paladin**"), and FTI Consulting, Inc., a Maryland corporation ("**FTI**") (Paladin and FTI each a "**Party**" and sometimes collectively as the "**Parties**"), with reference to the following facts:

A. Paladin and FTI are desirous of conducting discussions and exchanging information in connection with that certain Agreement for Interim Management Services (the "**Services Agreement**").

B. In connection with the Services Agreement, the Parties may provide each other with certain non-public and confidential oral and written information, as well as certain information relating to Paladin's and FTI's respective business prospects, books and records, and operations (collectively referred to herein as the "Information") from their respective directors, officers, controlling persons, employees, representatives and/or agents ("Representatives"). Except as otherwise provided in Section 4 of this Agreement, the term "Information" as used in this Agreement shall include all such Information furnished to one party (the "Receiving Party") by the other party (the "Providing Party"), including but not limited to all analyses, compilations, data, studies, notes, interpretations, memoranda or other documents containing or based in whole or in part on any such furnished information or otherwise reflect or are derivative of such information.

Notwithstanding the foregoing, the term "Information" specifically excludes any information or material that: (a) is known by the Receiving Party or is in the Receiving Party's possession prior to its receipt from the Providing Party; (b) is or becomes publicly available through no fault or omission attributable to the Receiving Party; (c) is provided to the Receiving Party by a third party, unless the Receiving Party knows that such provision of information or material violates any confidentiality agreement between such third party and the Providing Party; (d) is independently developed by the Receiving Party without the use of the Information; or (e) is required to be disclosed by law, or any regulatory or governmental authority.

NOW, THEREFORE, in consideration of the Providing Party furnishing Recipient with the Information, Recipient agrees as follows:

The Receiving Party hereby agrees to keep all Information strictly confidential and, without the Providing Party's prior written consent will not, directly or indirectly, disclose or reveal any Information, or the fact that the Parties have entered into the Services Agreement, to any person other than the Receiving Party's employees, agents, attorneys, accountants, retained advisors in confidential relationships with the Receiving Party, and other representatives (and those of any of the Receiving Party's affiliates or subsidiaries) who are actively and directly participating in the Services Agreement and who would customarily have access to such Information in the normal course of performing their duties (such persons shall be informed of the confidential nature of the Information and the Receiving Party shall cause such persons to observe the terms of this Agreement).

The Receiving Party further agrees that the Information will be used solely for the purpose of evaluating and possibly consummating the Transaction. The Receiving Party will not use or permit the use of any Information in any manner or in respect of any transaction other than the Services Agreement.

Within fifteen (15) days of the Providing Party's written request at any time, the Receiving Party shall either return to the Providing Party or shall promptly destroy all copies of such materials, and shall promptly destroy all the Information.

The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which shall remain in full force and effect.

The terms of this Agreement shall continue in full force and effect until the date which is two (2) years after the date of this Agreement.

The parties hereby irrevocably and unconditionally consent to submit to the jurisdiction of the courts of the State of California and of the United States of America located in Los Angeles County, State of California for any actions, suits or proceedings arising out of or relating to this Agreement and the transactions contemplated hereby (and the parties agree not to commence any action, suit or proceeding relating thereto except in such courts), and further agree that service of any process, summons, notice or document by US registered mail:

in FTI'**s case:**
FTI Consulting, Inc.
105 Westwood Pl., Ste. 250
Brentwood, TN 37027
Attn: Senior Managing Director

in Paladin's case:
Paladin-Howard Management, LLC
2121 Rosecrans Ave, Suite 2350
El Segundo, CA 90245
Attention: Joel Freedman

This Agreement contains the entire understanding of the parties hereto with respect to the matters covered hereby and may be amended only by an agreement in writing.

This Agreement shall be binding upon, inure to the benefit of and be enforceable by the parties' respective successors and assigns.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date and year first written above.

FTI CONSULTING, INC.

By:_____

Name: _____

Title: _____

PALADIN-HOWARD MANAGEMENT, LLC

By: _____
Name: Joel Freedman
Title: _____

The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which shall remain in full force and effect.

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in FTI's case:
FTI Consulting, Inc.
105 Westwood Pl., Ste. 250
Brentwood, TN 37027
Attn: Senior Managing Director

in Paladin's case:
Paladin-Howard Management, LLC
2121 Rosecrans Ave, Suite 2350
El Segundo, CA 90245
Attention: Joel Freedman

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FTI CONSULTING, INC.

By: Jeff A Benton
Name: JEFF D. BENTON
Title: SENIOR MANAGING DIRECTOR

PALADIN-HOWARD MANAGEMENT, LLC

By: _____
Name: Joel Freedman
Title: _____

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in FTI's case:
FTI Consulting, Inc.
105 Westwood Pl., Ste. 250
Brentwood, TN 37027
Attn: Senior Managing Director

in Paladin's case:
Paladin-Howard Management, LLC
2121 Rosecrans Ave, Suite 2350
El Segundo, CA 90245
Attention: Joel Freedman

This Agreement contains the entire understanding of the parties hereto with respect to the matters covered hereby and may be amended only by an agreement in writing.

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IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date and year first written above.

FTI CONSULTING, INC.

By: _____

Name: _____

Title: _____

PALADIN-HOWARD MANAGEMENT, LLC

By: _____

Name: Joel Freedman

Title: Managing Member

EXHIBIT E

CERTIFICATE OF LIABILITY INSURANCE

9/11/2015 | DATE (MM/DD/YYYY) 9/10/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Lockton Insurance Brokers, LLC 725 S. Figueroa Street, 35th Fl. CA License #0F15767 Los Angeles CA 90017 (213) 689-0065	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED 1371555 Paladin Healthcare Capital, LLC 2121 Rosecrans, Ste. 2320 El Segundo 90245	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Sentinel Insurance Company, Ltd. 11000 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES PALCA32 CERTIFICATE NUMBER: 12555264 REVISION NUMBER: XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER	Y	N	72SBAAP0503	9/11/2014	9/11/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 1,000,000 $ 10,000 $ 2,000,000 $ 4,000,000 $ 4,000,000
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			NOT APPLICABLE			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ XXXXXXX $ XXXXXXX $ XXXXXXX $ XXXXXXX
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			NOT APPLICABLE			EACH OCCURRENCE AGGREGATE	$ XXXXXXX $ XXXXXXX
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		NOT APPLICABLE			PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ XXXXXXX $ XXXXXXX $ XXXXXXX

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
THIS CERTIFICATE SUPERSEDES ALL PREVIOUSLY ISSUED CERTIFICATES FOR THIS HOLDER, APPLICABLE TO THE CARRIERS LISTED AND THE POLICY TERM(S) REFERENCED.
The Plaza CP, LLC; Continental Development Corporation; and German American Capital Corporation are an Additional Insured to the extent provided by the policy language or endorsement issued or approved by the insurance carrier.

CERTIFICATE HOLDER

12555264

The Plaza CP, LLC
c/o Continental Development Corporation
Attn: Property Management
P.O. Box 916
El Segundo CA 90245

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE