Total revenues from all sources, including:

Medical practices such as the xxxxxxxxxxxxxxxx often base the majority of their productivity measures on encounters, fees or combination of both. This however, does not accurately indicate the amount of resources consumed in provision of service nor is the fee charged based on resources expended or cost in providing the service. Charges are market based and while cost in providing a service factored, a fee is not directly related to resources used. A better way to track productivity and cost benchmarking is found in the use of the national standard of relative value system (RVU), a resource-based value scale developed by the government. RVUs are the best statistically valid and reliable measurement to justify propagating change. The RVU system is explained in detail in the December 1, 2006 Federal Register, pages 69624 to 70251.

The median physician work RVU (wRVU) representing all professional services performed by the actual healthcare provider for family practice providers without obstetrics totals 4,735 wRVU’s according to the MGMA Physician Compensation and Production Survey: 2009 Report based on 2008 Data. Review of the same report updated as the 2010 Report based on 2009 data reflects a value of 4,845 wRVU’s. In establishing the maximum productivity for the xxxxxxxxxxxxxxxx, the value of 4,800 wRVU per full-time equalivant practitioner will be used. The practice has 1 FTE practitioner. In projection years for 2011 and 2012, the practice revenues are not projected at capacity.

The graph illustrates the opportunity in care mapping resulting from additional services provided by the practice such as smoking cessation, medical nutrition therapy, and limited Medicare preventive care exams of those patients joining Medicare being at risk or having a diabetes condition. Laboratory services rendered within the practice do not impact overall or practitioner wRVU figures.

Revenue Projections

Revenue projections for each year are established after application of certain assumptions.

Assumption 1: Two Categories of Patients

There are two categories of patients within the xxxxxxxxxxxxxxx. Those considered (a) private pay or indigent in nature and those (b) having insurance through a third party payor organization or governmental agency (i.e. Medicare, CHAMPUS, Veterans Affairs, Tricare, Medicaid).

Assumption 2: Compensation

Those patients being private pay or indigent in nature results in collections of $40 payment for the initial (first) visit and $30 for second visits. The second visit price applies regardless as to if they see the nurse practitioner and diabetes educator or just the diabetes educator alone.

Those patients having insurance through a third party payor organization results in collections equal to allowable rates defined by each payor source. Medicaid compensation for nurse practitioners services rendered by XXXXXX compensates at a rate equal to 45.4% of the nurse practitioner Medicare allowable rate. Compensation consideration for commercial health plans and BCBS of Florida is factored at the Medicare allowable rate for Nurse Practitioners. Indemnity plans are factored at a rate equal to 10% higher than the Medicare allowable rate.
Assumption 3: Payor Mix

The compensation is adjusted based on percentage of patients seen by payor group. Overall, between the two categories of patients in the practice, private pay and indigent will account for 31% while third party payor organizations will make up 69% of the population based on charges of services rendered.

For the payor mix specifically for the third party payor group, the following assumptions are applied.

Gross charges were used in preparation of payor mix. XXXXXX uses total gross charges attributed to a physician for all professional services. Gross charges are the full dollar value, at the practice’s established undiscounted rates, of services provided to all patients, before reduction by charitable adjustments, Medicare limiting charge, contractual adjustments, bad debts, etc.

Assumption 4: Net Collection Rate

The net collection rate illustrates the ability of the practice to collect the funds that are defined as collectable (the allowable amount as defined by a payor contract). For purpose in establishing projections, the value of 95.5% was used in 2013 and during the prior two years, a value of 93.3%. MGMA reports the value for private practice to be 95.68% with HFMA reporting a target of 95.5%. Net Collection rate reflects the collections realized from collectable money. Bad debt write off should be less than 5%. HFMA sets the target at less than 3% of gross revenue. XXXXXX standard is to exceed 90% net collection rate. The net collection rate is applied against both categories of patients.
Revenue Projections

With the above assumptions in place, the following is the projected growth in revenue with 2013 representing the practice operating at capacity with 1 FTE nurse practitioner factored. There is a 55% increase in 2012 and then to reach capacity, an additional 34% increase necessary.

Revenue Projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$278,292.22</td>
</tr>
<tr>
<td>2012</td>
<td>$250,000.00</td>
</tr>
<tr>
<td>2013</td>
<td>$325,794.72</td>
</tr>
</tbody>
</table>

Revenue by source in 2013 includes.

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenue</td>
<td>$278,292.22</td>
</tr>
<tr>
<td>Indigent / Private Pay</td>
<td>$42,497.50</td>
</tr>
<tr>
<td>Third Payor Organization</td>
<td>$235,794.72</td>
</tr>
</tbody>
</table>

Assumptions behind revenue figures:

The term “visit” or “encounter” is defined as a documented face-to-face contact between a patient and healthcare provider who exercises independent judgment in the provision of service. If a patient sees multiple providers on the same day for the same set of problems/diagnosis, it is considered one encounter. Therefore, if a patient seeks care from the nurse practitioner and then meets with the diabetes educator finishing the visit with the nurse practitioner, the visit is one (1) and not one for each provider encountered.

Each advanced practice nursing visit rendered has an established level of care and corresponding wRVU. The national utilization data related to distribution of encounters across the spectrum of an office visit has been adjusted to factor the acuity in the type of patients seen by the practice. All patients seen are either at risk for a diabetic condition or have a current diagnosis of diabetes. As such, it is expected that an increase in level of acuity and patient visit would exist.
The following are projected visit volumes for the practice. The practice is aggressively approaching managed care and third party payor organizations seeking participation to allow patients to realize a richer benefit option when seeking care. Managed care contracting will provide the avenue to financially incentive insured patients to seek care from the practice. The practice is upgrading its practice management software at which time will position the practice to better manage patients who seek care and desire to utilize their out-of-network benefits in cases where the practice may not hold a contract.

**Infrastructure for Revenue Operations**

The technology used to support the management and decision making within the practice is significantly being enhanced to an industry recognized and respected platform. There are multiple benefits afforded the practice as a result. The details of the patient flow and steps within the Revenue Operations process to enable the greatest efficiency are outlined in the Protocol Manual, a living document taking shape as installation of the practices new software occurs. The following illustrates the overall patient flow within the practice and enhancements in operations impacting the ability of the practice to collect funds from third party payor sources.
Few highlights of the redesigned process are as follow:

**Scheduling:** Unlike the corporate arena where scheduling is a task to accomplish a meeting, scheduling in a medical practice is a marketing opportunity. Scheduling is not a task but rather a sales and marketing call for the practice. This change isn’t a change in task performed but in philosophy and approach in handling which when complimented with a strong understanding of the financial awareness and ability to interpret data results in successful experience for a patient.

**Recall Management:** XXXXXXX will reach out to patients needing future care or follow-up. Should a patient seek care and through evaluation determination made regarding need for follow-up, for example in three (3) months, a record of that will occur within the practice management system. At the beginning of the given month, that data will be retrieved and outreach conducted. This increases compliance with treatment plan outlined as well as assurance of return visit and ability of XXXXXXX to achieve revenue projections established.

**ANSI 270/271 Eligibility:** The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. The ANSI X12N 270/271 This includes the sharing of eligibility data through a 270 file request and receive a 271 eligibility response files in a real-time environment. response. This will allow XXXXXXX to know at time of scheduling after obtaining base line insurance information the eligibility of a patient and financial obligations of their insurance policy.

**Benefit Interpretation:** The ANSI 271 response file contains critical data in determining the financial responsibility and assisting in interpretation of benefits. Core understanding of medical benefit plans and application in being either an ancillary provider or professional service provider important in calculating financial responsibility. XXXXXXX is seeking professional service providership as compared to being an ancillary care provider with payor organizations resulting in benefit application as an outpatient medical practice. Training began and will continue though installation and set-up of the new practice management system allowing for proper setup to maximize collections through upfront review of benefits with a patient. Of course, it is the ultimate responsibility of the patient to understand the benefits they purchased and should seek guidance with questions they may have with their carrier directly.

**Insurance Interpretation:** There are four pieces to the understanding the payor market; network; medical management; bearer of risk and third party administrator. The relationship between these four components define the manner in which to define the allowable amount, where claims are to be sent, who holds risks and delineates the relationship between a network and insurance to properly select and work with third party payors. The grid delineating this relationship is located in the Protocol Manual on page 16.
Providership: The practice has initiated efforts to secure participation of all affiliated providers with governmental payors (i.e. Medicare, Medicaid) as well as commercial payors requiring a unique provider number for billing (i.e. BCBS). Not all payors had billing numbers limiting the opportunity for collections. Upon completion of this, all providers affiliated with the practice, regardless of FTE status, will have billing numbers.

Managed Care Contracting: A billing provider number obtained during Providership allows for submission of claims. This does not necessarily allow a patient to realize in-network application of a richer benefit structure. A contract with the managed care payor does. All patients having an out-of-network benefit structure can seek care from the practice today. It is not required to have a contract with managed care organizations in which to build a practice however; having a contract does provide access with less financial obligation to the patient.

Encounter Capture: Audit has been initiated which was previously absent to ensure that all patients scheduled have an affiliated charge reflective of the appointment type for a visit. This required the implementation of a more detailed roster of appointment types now used in the practice allowing for audit by charge posting staff of missing encounter data.

Coding through EMR: With implementation of the electronic medical record (EMR), documentation of the visit will occur and be retained in the EMR. The evaluation and management coding tool of the EMR will use documentation created to recommend based on industry rules and national coding guidelines the recommended level of service. This provides validation to the thoughts of the practitioner on the level of service and provides for adjustment to documentation during the clinical visit possibly absent impacting the level of service and in turn, revenue.

Paperless Operations: The EMR eliminates the paper chart and provides the ability to scan and retain documents from referring providers or the patient directly in the EMR. As such, once documents are scanned, they can be returned to the patient and do not need retained in hard copy. The PMS allows for scanning of the patients identification card, drivers license, promissory notes, attestations and other documents too allowing for preparation, scanning and giving back to the patient the original paperwork. This eliminates filing, maintenance and manual storage. It also increases efficiency and reduces resource allocation in patient management, in document retrieval and navigation in seeking compensation.

Electronic Medical Record: Installation of an electronic medical record will occur in 2011. A centralized, easily accessible and secure patient information network is a key to putting patient information at the center of XXXXXXX's clinical environment. The result is ability to share patient information that is legible and organized, reduce costs by shortening billing cycles and other core administrative and clinical operations, direct data entry by clinicians creates higher quality documentation, provides structure for documentation for consistent level of quality and service, and aids clinicians in immediate patient treatment and to capture key information.

Syntax and Integrity Testing: Traditional clearinghouse services perform just enough entry-level edits to meet the minimum requirements for passing claims onto payers being usually the SNIP/WEDI levels 1 and 2. This entry-level edit confirms the structure of the file, determines if required information is present and reported in the correct sequence, confirms that numerical fields contain numeric values and alpha fields contain valid characters and date fields contain valid dates. The syntax and integrity requirement testing edit confirms that valid code values are used to report information. Information such as acceptance of assignment, accident indicators, primary and secondary insurance indicators, patient relationship to insured and other similar elements. This provides base level testing that data necessary for the claim to process at the payor exists.

Claim Editor Engine – Claim Scrub: It is nearly a requirement and industry standard feature for the advanced level claim edits to occur further ensuring that a claim prepared for submission and payment is accurate, proper and will be paid the first time. The Claim editor engines such as the one that exists within Practice Partner allows for a “clean claim” to be sent. Additional levels of edit include financial edits, referential integrity and situational testing, CPT/ICD9 validity code set testing, specialty lines of service testing, and payor specific edits.

ANSI 837 Claim Submission: Following the documentation of a clinical visits in the EMR and processing of the claim through the editor and testing processes, all claims for services are submitted through a industry recognized format of the ANSI 837 claim file. There still exists today insurers who are unable to receive claims electronically. However, from a practice perspective, XXXXXXX will transmit 100% of claims electronically to the clearinghouse affording it the full range of benefits in edits and testing from which the clearinghouse will send electronically or drop the claim to paper and mail. At no time will XXXXXXX print a primary insurance claim and mail.

Payment Exception Reporting: According to the American Medical Association’s 2010 annual meeting in Chicago, one in five medical claims are processed inaccurately costing the healthcare system $15 billion dollars. Under the new XXXXXXX workflow process, great effort and attention is being allocated to ensure the claim sent is complete and accurate in nature but even so, it is not an expectation that the payor will properly process the clean claim. As a result, it is important to ensure that only do claims process correctly but that they allow the contractually agreed payment amount.
This is applicable to both governmental payors and commercial payors. As such, the allowable amounts for rendered services are loaded into the new PMS system for monitoring. This does not exist today for XXXXXXX. This complimented with proper insurance interpretation prior to the service being rendered will allow for XXXXXXX to maximize collections.

**Secondary Claim Submission:** Secondary claims in all cases where possible will be transmitted electronically. Secondary claim submission requires data elements in the electronic file from the processed data received from the primary insurance carrier. Those secondary claims unable to transmit electronically are printed, explanation of payment form the primary insurance attached and mailed manually.

**Funds Management:** There is one funds management process governed by the revenue operations process and contains segregation of duty for posting payments, receiving payments, and making deposits. The person collecting money in the practice does not have the ability to post payments or adjustments to the account in turn, reducing risk of theft. Merchant account services exist and being expanded to ensure the merchant services are able to process all healthcare savings card programs along with flexible savings accounts. XXXXXXX will be able to accept this resulting in ability to accept nearly all payment options it may encounter.

**ANSI 835 Claim Payment:** With increased patient volumes desired, the acceptance of manual checks from payer organizations must cease to exist. As a result, during the providership and managed care contracting process, in all cases electronic funds transfer and electronic remittance acceptance being obtained. Supporting paperless processing, data from insurance carriers should arrive electronically and be processed electronically which is supported by the new Practice Management System. Installation of the new software includes the tasks of set up for ERA processing from all payors able to process payments and data electronically. This reduces staff resources, paperwork, filing, storage and simplifies document retrieval in working unpaid or accounts paid in error.

**Single TIN per Remittance:** With the intense attention to technology and automation in the revenue operations workflow of the practice, it is critical that there exist only one tax identification number and one banking account in which to link all processing together. This reduces administrative costs and provides a solid foundation for audit and compliance. XXXXXXX uses the single tax identification number from which any medical service billing affiliated with that single TIN will be processed through the same infrastructure. As well, the providership and managed care relationships too are tied to this single tax identification number and banking information for streamlined workflow.

**Performance Indicators:** There are a series of performance indicators that are used to monitor the performance of practices revenue operations. Monitor not just one measurement but all performance indicators together. The performance indicators monitored by XXXXXXX are referenced in the Protocol Manual starting on page 86.

**CAS Codes:** Claim adjustment reason codes (CAS) communicate an adjustment, meaning that they communicate why a claim or service line was paid differently than it was billed. CAS codes are both alpha and alpha numeric in value being a two or three digit length. CAS codes are a code list external to the X12 family of standards maintained by the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC). XXXXXXX will move from custom created adjustment codes to follow national standards supporting a more expanded electronic communication platform.

**Correspondence Trending:** Correspondence mail is defined as "no check" mail received. All "no check” mail is captured on a correspondence log to enable trending and identification of reason for non payment. All correspondence will be posted and recorded timely to allow for identification of trending of problems. A caution is to avoid creating band-aid fixes or work around processes that ultimately need a larger work flow process addressed. The industry average cost to rework a claim is $25.00.

**Appeal Management:** XXXXXXX is establishing a denial-management system that provides analysis reporting while creating and managing appeals. The more claims you can create appeals for, the more claims will be approved. There does not exist today an efficient appeals management system in place from which to work and manage appeals. A focus on this system will occur post installation of Practice Partner.

**ANSI 276/277 Claims Status:** The Health Insurance Portability and Accountability Act (HIPAA) requires all health insurance payers in the United States to comply with the electronic data interchange (EDI) standards for healthcare as established by Secretary of Health and Human Services (HHS). The ANSI X12N 276/277 provides the standard for compliance for health care claim status transactions. Once a claim is submitted electronically, it is possible with many carriers to request the status of the claim using industry recognized format for request (276 file) and response (277 file). This allows XXXXXXX to obtain the status on where the claim exists in process with a payor organization prior to receipt of an explanation of payment or explanation of benefits from the carrier. This provides explanation at a line item charge level of the steps or action that needs taken to resolve delays and seek payment.
Recovery Services: XXXXXX has not initiated the support of a recovery services team in the collections on unpaid medical claims. XXXXXX will work with a recovery services team where unpaid medical claims meeting the criteria for placement will occur. There are specific criteria in review planned for finalization with completion of Practice Partner installation to govern the process. This additional tool will assist in collection efforts and increase revenue potential.

Payment Options: XXXXXX accepts cash, check and credit card as payment today. The practice has begun to implement programs allowing for payment plans, automated clearinghouse drafting, patient credit services, promissory note and third party non-recourse patient finance. Online credit card processing and check conversion too will exist for XXXXXX providing an array of payment options for patients and programs in which to make payment against services rendered.

Electronic Statements: "Why are we sending statements?” is the first question asked as numerous opportunities presented that allowed for the collection of the patients financial responsibility (scheduling, virtual registration, time of service). XXXXXX will process statements electronically using a third party vendor to professional mail statements. XXXXXX patient statements will be processed weekly with criteria that no patient will receive a statement if one generated within the past month. This protocol will reduce the aging of a patient balances and capture new balances identified quickly.

Progressive Collections: Aggressive collection efforts must exist to achieve revenue projections. The expectation that payment is required at time of service has already begun within the practice by staff successfully. There is a cultural shift occurring successfully within the practice that payment is required for services rendered. There are discounting opportunities to assist private pay or indigent patients but even those patients are being taught that payment is expected for care rendered.

There are numerous aspects being implemented along side the installation of the new practice management system and electronic medical record to administratively support the quality of care rendered and maximizes operations. As a result, technology provides solutions replacing the manual and labor resource intense processes that exist today allowing for the increase in patient volume without the addition of administrative staffing.

Care Mapping

There exist two divisions of the practice being a pre-diabetes program for patients at risk of getting diabetes and a second population being those with diabetes and enrolled in the diabetes management program of XXXXXX. The clinical care map outlines the frequency in which a patient will be seen and standards of care provided in addressing their medical condition, diabetes.

The pre-diabetes patients will have two visits during a one-year period for screenings and monitoring by the healthcare practitioners. This will include counseling on carbohydrate counting. The following illustrates the total annual encounters projected for pre-diabetes patients.

The diabetes management program is designed with a multi-disciplinary team approach in the care and management of a patient. A patient will have an initial evaluation and visit a nurse practitioner. During that visit, a treatment plan will be designed specific for that patient using the standardized parameters in a patient having 2 diabetes education sessions, possibly a medical nutrition therapy services (1 hour) and necessary lab work completed. In 2012, the two diabetes education sessions are separate from the two nurse practitioner visits during the calendar year. In 2013, one of the two individual diabetes education sessions will be included as part of the second visit with the nurse practitioner extending the
length of the visit and capture of additional prolonged service opportunity from 10% to 30% of patients seen. The medical nutrition therapy sessions are not projected to be in conjunction with an advanced practice visit. Depending on the individual patient need, additional visits or diabetic education sessions might be necessary. Those additional services are not figured into the revenue projects or the standardized care map.

Assumptions include in 2013 identification of 65 new pre-diabetes patients and 100 new diabetes management patients. The largest growth in new patients is attributed to 2012 having the largest growth in new patients.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Diabetes Management</th>
<th>MNT</th>
<th>Diabetes Education</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>300</td>
<td>30</td>
<td>600</td>
<td>930</td>
</tr>
<tr>
<td>2012</td>
<td>700</td>
<td>140</td>
<td>1400</td>
<td>2240</td>
</tr>
<tr>
<td>2013</td>
<td>1600</td>
<td>170</td>
<td>800</td>
<td>2570</td>
</tr>
</tbody>
</table>

Quality Reporting

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110-275) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275). In 2011, the program name was changed to Physician Quality Reporting System (Physician Quality Reporting). 2011 Physician Quality Reporting System Measures List includes 194 quality measures (this includes 190 individual quality measures and the 4 measures in the Back Pain measures group, which are not reportable as individual Physician Quality Reporting System measures) selected for the 2011 Physician Quality Reporting System. Of these measures, XXXXXX established that for 2011, it will monitor 5 of the measures relative to the program. The PQR measures XXXXXX will monitor in 2011 are outlined starting on page 23 of the Protocol Manual.

Marketing and outreach plan - Insurance companies / payer panels

Contracting Plan: The practices contracting strategy takes into consideration that one aspect of the practice is a specialty based service wrapped around a primary care service. In both cases, it is important to initially contract with the major carriers and plans in the market. This will ensure that patients accessing the practice will receive in-network benefits and not be subject to higher cost sharing and out-of-network fees. Contracting with insurance carriers is divided into a three-phase approach. Phase one include governmental plans such as traditional Medicare and traditional Medicaid contracts for participation. Phase two will include those plans and carriers identified as possible referral sources for the practice which include Medicaid and/or Medicare replacement plans. Phase three, will be of lower priority such as those plans or network PPO plans having less immediate need but would allow for access to broader patient base.

Phase I:
• Traditional Medicare: FAU is an established group with Medicare with enrolled providers of the practice. Phase I initiative includes the addition of other providers within the group not yet enrolled.

• Traditional Medicaid: FAU is an established group with Medicare with enrolled providers of the practice. Phase I initiative includes the addition of other providers within the group not yet enrolled.

Phase II:
The following are the plans actively being pursued by the practice. The membership figures are reflective of statewide enrollment for plans operating in Palm Beach County.

• Blue Cross and Blue Shield of Florida
  o Commercial PPO – 1.1 Million membership statewide

• Humana Medical Plan, Inc. & Humana Health Insurance Company of Florida
  o Commercial PPO – 103K
  o Commercial HMO – 170K
  o Medicaid HMO (Non-Reform) – 44K
  o Medicare HMO – 273K

• United Healthcare of Florida, Inc. & United Healthcare Insurance Company
  o Commercial PPO (1.1 Million)
  o Commercial HMO – 82K
  o Medicaid HMO (Non-Reform) – 101K

• Molina Healthcare of Florida, Inc.
  o Medicaid HMO (Non-Reform) – 35K
  o Medicare HMO – 328 members

• Freedom of Health Inc.
  o Medicaid HMO (Non-Reform) – 12K
  o Medicare HMO – 43K

• Wellcare of Florida, Inc.
  o Medicare HMO – 63K
  o Healthy Kids HMO (Staywell) – 51K
  o Medicaid HMO (Non-Reform) – 191K

• Health Care District of Palm Beach County
  o Personal Health Plan
  o Vita Health

Phase III:
• Aetna Health, Inc.
• Coventry Health Care of Florida, Inc. & Coventry Health Plan of Florida, Inc.
• Multiplan, Inc.
• Universal Healthcare Inc.