Prepared for:
Infectious Disease Society of America
Arlington, Virginia

Market Study of Infectious Disease Physician Executive Compensation
To be stated in Potential Service Agreements between Certain Health Systems / Hospitals and Certain Physicians Affiliated with the Infectious Disease Society of America

FINAL REPORT
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Exhibits A – D
EXECUTIVE SUMMARY

Value Management Group, LLC d/b/a VMG Health (“VMG”) has been engaged by the Infectious Disease Society of America (“IDSA”) to perform a market study related to the compensation to be stated in potential service agreements (“Agreements”) between certain health system(s) or hospital(s) (“Hospital(s)”) and certain physicians associated with IDSA (“Physician(s)”). It is our understanding that the fee to be stated in the potential Agreements is a physician executive hourly rate related to administrative or clinical management services related to the infectious disease service line (“Service Line”) at the Hospitals. VMG has been engaged by IDSA to perform a market study related to the physician executive hourly rate payable by the Hospitals to the Physicians to be stated in the Agreements. Specifically, we have been asked to provide hourly rates assuming the Physicians provide their expertise related to the strategic initiatives at the Service Lines for Physicians whose experience warrants median, 75th percentile, and 90th percentile of compensation. We have not been asked to determine which percentile to which any certain physician belongs.

Based upon the available data, facts, and circumstances, we have determined that the following physician executive hourly rates are consistent with the market for the provision of the administrative or clinical management services per the potential Agreements:

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<tr>
<th>Conclusion</th>
<th>Tier 3</th>
<th>Tier 2</th>
<th>Tier 1</th>
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<tr>
<td>Hourly Conclusion (rounded) - Independent Contractor</td>
<td>$180</td>
<td>$240</td>
<td>$280</td>
</tr>
<tr>
<td>Hourly Conclusion (rounded) - Employed (without Benefits &amp; Malpractice Insurance)</td>
<td>$155</td>
<td>$215</td>
<td>$255</td>
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It is important to note that the hourly rates shown above are reflective of administrative/clinical management or physician executive services only. Additional services, such as on-call coverage, may warrant a premium to the rates above. We have not been engaged to provide an opinion or market study related to infectious disease on-call coverage services. This would require an additional analysis.

Additionally, this data is reflective of national survey data. For many specialties, there are a limited number of respondents for specific geographic regions and, therefore, we rely upon national data with a larger number of respondents. Please see the “Cost Approach Analysis – Physician Executive Hourly Rate” for more details on the surveys utilized in this market study and Exhibit B for more details on the number of respondents for the specialty of infectious disease in each survey.

Lastly, we understand that some of the administrative services provided by the physician executives may be provided from his or her own office space. In this case, an overhead mark-up may be warranted to account for space, utilities, systems, and minor technology costs incurred by the Physicians to service the Agreements. It is important to note that we have not reviewed
any cost data for any specific Physicians’ overhead. Based on market data, typical overhead as a percent of salary costs is approximately 11.0%. If actual cost data was provided to support a higher range, we have observed as high as 15.0% for an overhead mark-up (applied to personnel costs or, in this case, the physician executive hourly rate).

Our market study is valid for two years from the date of this report. This valuation analysis is intended solely for the use of IDSA, the Hospitals, and the Physicians for management planning and regulatory compliance purposes. Our analysis is to be used for no other purpose or distributed, in whole or in part, to third parties, other than the Internal Revenue Service, Office of Inspector General or other regulatory authorities, without the express written consent of VMG.

The standard of value being addressed by this market study is that of fair market value (“FMV”). We define FMV as the price at which property would exchange between a willing buyer and a willing seller, when each party has reasonable knowledge of the relevant facts, and neither party is under compulsion to buy or sell. Based on the guidelines established by the Stark II regulations, we have expanded our definition of FMV to encompass general market value (“GMV”), which is the compensation that would be included in a service agreement, as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party (42 C.F.R. 411.351). Usually, FMV or GMV is based on the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.

We have not conducted all of the necessary steps required to provide a FMV opinion. Ultimately, a FMV compensation appraisal would include consideration of the data considered in this analysis and other economic and non-economic factors. This being said, the indications of value provided by this market study are systematic and unbiased overall guidelines. The guidelines may be relied on in the event that there is access to only limited relevant information. In addition, when services provided per a particular type of agreement are consistent and comparable to those in the market, a market study is typically reflective of FMV.

The indications of value provided by this study are consistent with a Valuation Calculation as defined by the American Society of Appraisers (hereinafter referred to as “ASA”). The ASA’s Business Valuation Standards refer to a Valuation Calculation as one of the three acceptable scopes of appraisal. According to the ASA, the following are characteristics of a Valuation Calculation:

a) The objective is to provide an approximate indication of value based upon the performance of limited procedures agreed upon by the appraiser and the client.

b) Calculations have the following qualities:
1) Their results may be expressed as either a single dollar amount or a range.
2) They may be based upon consideration of only limited relevant information.
3) The appraiser performs limited information and analysis procedures.
4) The calculations may be based upon conceptual approaches agreed upon with the client.
SITUATIONAL ANALYSIS

VMG has been engaged by IDSA to perform a market study related to the physician executive hourly rate payable by the Hospitals to the Physicians to be stated in the Agreements.

ORGANIZATION ANALYSIS

IDSA was founded in 1963 and is located in Arlington, Virginia. IDSA is an organization representing physicians, scientists, and other healthcare professionals who specialize in infectious disease with over 9,000 members. IDSA members include clinicians, scientists, researchers, public health officials, epidemiologists, and other infectious disease specialists throughout the United States and in almost 100 other countries. IDSA publishes two medical journals, holds annual meetings, issues practice guidelines, and promotes scientifically supported public policy. IDSA focuses on issues such as antimicrobial resistance, emerging infections, influenza, Lyme disease, bioterrorism, and other infectious disease related issues.

MARKET ANALYSIS – PHYSICIANS IN ADMINISTRATIVE ROLES

Physicians are moving into a variety of executive roles in hospitals and hospital-affiliated organizations such as health maintenance organizations, independent practice associations, management service organizations, and physician service organizations. Membership in the American College of Physician Executives (“ACPE”) has increased approximately 5.4% compounded annually from 2008 to 2010. However, physician executive compensation growth as a whole is slowing. According to the 2011 Cejka Search and ACPE’s Physician Executive Compensation Survey, based on 2010 data, total compensation for physician executives has increased approximately 2.9% compounded annually over the last two years. This is well below the 5.6% compounded annual growth rate reported in the 2009 survey and is the lowest growth rate since 2001. The greatest deceleration in growth belonged to the title of CEO, which dropped from a compounded annual growth rate of 6.3% in 2009 to a compounded annual growth rate of 2.1% in 2011. It is difficult to discern whether this trend is a result of macroeconomic market conditions or if a greater supply of physician executives has increased competition for these administrative positions.

In CEOs, a national study of healthcare, physician executives ranked their key strengths as follows:

1. Aligning physician incentives and systems;
2. Developing, implementing, and monitoring "best practices" for the clinical enterprise;
3. Effectively advising the board, other senior executives, and the medical staff;
4. Creating and nurturing strong bonds between administration and physicians to enhance quality and monitor utilization outcomes; and
5. Focusing clearly on the interests of the organization and patients.
These strengths are required in the majority of the agreements we review for physicians in administrative roles. A physician executive can be a source of independent clinical expertise and impartial judgment with respect to quality-related information. For example, data from the Centers for Medicare & Medicaid Services (“CMS”) is best interpreted by a physician leader, who can answer questions such as the following:

1. Are the data (concerning, for example, mortality, length of stay, utilization rates) good indicators of quality? Why or why not?
2. If data are significantly above the norm or higher than a previous year's, have the reasons for that been sought? What are they? Are the data valid? Why or why not?

Because they can interpret raw data, physician executives can be especially useful to a hospital. Quality and efficiency metrics often require careful interpretation by medical professionals. A physician executive can turn the data into meaningful information. In addition, a physician executive must be familiar with various local, regional, and national regulatory and accreditation requirements pertaining to the organization's clinical, research, and educational programs. Finally, a physician executive can provide leadership to the structure and function of the clinical enterprise.
AGREEMENT SUMMARY

We were not provided with a copy of a draft Agreement or Agreements, which would be between certain Hospitals and certain Physicians. It is our understanding that the fee to be stated in the potential Agreements is a physician executive hourly rate related to administrative or clinical management services related to strategic decisions for the infectious disease Service Line at the Hospitals. We also understand that the physicians may be independent contractors or employed and, therefore, may or may not be responsible for their own benefits and malpractice insurance (respectively). Therefore, we have shown our conclusions as an independent contractor rate and an employed rate.

The scope of this engagement is for VMG to perform a market study related to the physician executive hourly rate payable by the Hospitals to the Physicians.
QUALIFYING ASSUMPTIONS & VALUATION NOTES

The analysis presented in this report is based on certain underlying assumptions. The facts described in this report were provided by IDSA management or obtained from independent third parties including published sources. We have accepted this information without further verification. Key assumptions include:

- **Based on IDSA’s representations, the Physicians may be independent contractors or employed and, therefore, may or may not responsible for their own employee benefits and malpractice insurance (respectively). Therefore, we have shown our conclusions as an independent contractor rate and an employed rate. The independent contractor rate assumes the Agreement requires the Physician to be responsible for his or her own benefits and malpractice insurance.**

- **Based on IDSA’s representations, the hourly administrative services to be stated in the prospective Agreement(s) require physicians and, specifically, require physicians specialized in infectious disease. We also understand the Physicians would be qualified to provide strategic oversight to the Service Line.**

- **VMG personnel are not clinical experts. It is ultimately the responsibility of the user to determine the tier to which a physician belongs, as well as if the agreement requires a particular tier to provide the outlined services. We have provided general guidelines for considering tier selection in Exhibit D.**

- **Based on discussions with IDSA management, VMG has not been asked to opine on a particular physician's rate but rather were asked to provide tiered levels of compensation based on the particular physician's experience, skillset, and notoriety.**

- **We assume there would be no overlap of services provided by the Hospitals, the Physicians, or any third party on behalf of the Hospitals.**

- **The physician executive services / hourly administrative services to be provided per the Agreements are required for efficient operation and / or to benefit the community.**

- **We have not considered the financial implications to the Hospital in conducting this analysis.**

- **Certain matters are outside the purview of our expertise. As a result, our value recommendations assume the parties to the subject compensation arrangement**
comply fully with all federal, state, and local laws and ordinances, including how the compensation is structured.

- Our market study assumes the contracting entity would first determine: the duties being requested under the arrangement are necessary and not superfluous, the services required under the agreement are required based on operational needs and/or community need, the arrangement is the best fiscal option absent any consideration of referrals, the assumptions contained herein are accurate and appropriate to the best of their knowledge and the negotiations were at arm’s length and that the agreement makes sense commercially.
HEALTHCARE REGULATIONS

In determining the compensation in this market study, we consider the regulatory environment surrounding healthcare. Since Medicare funding could trigger a review of transactions between referring entities, there are several relevant bodies of law which guide the determination of FMV. The federal anti-kickback statute, which prohibits the payment of remuneration in exchange for patient referrals, and the Stark self-referral law, which limits certain physician referrals are two regulations guiding healthcare’s regulatory environment. Within these bodies of law, the government stipulates that stated compensation in a professional service agreement between a hospital and physician must be set at FMV. For purposes of our analysis, we have examined these bodies of law to help us define our basis and methodologies in determining the market study conclusions.

FEDERAL ANTI-KICKBACK STATUTE

The federal anti-kickback statute prohibits the payment of remuneration in exchange for, or in order to induce, the referral of patients or other business which is reimbursable under Medicare. The anti-kickback statute is a criminal statute. A violation of the statute is punishable as a felony by a fine of up to $25,000 per violation or by imprisonment for up to five years, or by both fine and imprisonment. In addition, violators may be excluded from participation in the Medicare program. In 1997, the statute was amended to subject violators of the anti-kickback statute to civil monetary penalties in the amount of $50,000 per violation plus "damages of not more than three times the total amount of remuneration offered, without regard to whether a portion of the remuneration was offered for a lawful purpose."

The statute has been applied in the context of a wide variety of business transactions, agreements and arrangements between a physician or a family member of a physician and an entity where Medicare funds are involved. There should be no benefit to the physicians that could be construed as an inducement for their referrals, such as a hospital compensating a physician above FMV.

STARK SELF-REFERRAL LAW

The federal legislation limiting certain physician referrals is commonly known as the Stark legislation and is distinguishable from the federal anti-kickback statute. The anti-kickback statute is a criminal statute, with some intent or some level of knowledge of wrong doing. In contrast, the Stark self-referral law is not a criminal statute and referrals prohibited by Stark are absolutely prohibited unless they are specifically exempted under the Act.

Stark I, which became effective on January 1, 1992, generally prohibits a physician from referring specimens for clinical laboratory testing reimbursable by Medicare or Medicaid to any entity with which the physician has a financial relationship under the statute. It is important to
note that "financial relationships" include both ownership interests and compensation arrangements.

The expanded self-referral statute is frequently referred to as "Stark II." The scope of this expansion was based on the enactment of Omnibus Budget Reconciliation Act ("OBRA") which extended the self-referral prohibition to cover other "designated health services" reimbursable by Medicare. These designated health services include clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including MRIs, CT scans, and ultrasound; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrition, equipment and supplies; prosthetics and/or orthotics; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The government continues to develop and expand Stark legislation in an effort prevent Medicare over-usage abuse through self-referrals.

A violation of the Stark law can result in many different penalties. For instance, the health services provided may not be paid for by Medicare, or any payment received will need to be refunded. Additionally, any person who "knows or should know" that a referral violates Stark will be liable for up to $15,000 civil money penalty per claim. Failure to meet the reporting requirements of Stark is subject to a civil monetary penalty of up to $10,000 per day for which reporting is required.

In addition to Stark II’s focus on FMV, Stark II requires that contractual arrangements between physician-owned entities should “involve a transaction that is commercially reasonable and furthers the legitimate business purposes of the parties.”
VALUATION METHODOLOGIES

In determining the compensation in this market study, we have considered generally accepted valuation methodologies. The generally accepted valuation methodologies considered in this engagement include the following:

The **Cost Approach** takes into consideration the cost of replicating a comparable asset, security, or service with the same level of utility.

The **Market Approach** estimates value by comparing the value of similar assets, securities or services traded in a free and open market to the subject asset, security or service.

The **Income Approach** estimates value by analyzing the historical financial information in order to estimate the future cash flows generated by assets, securities or services.

FAIR MARKET VALUE DEFINITIONS AND GUIDELINES

The implications of defining FMV correctly are crucial to most healthcare arrangements between hospitals and physicians. Regulatory constraints imposed by the IRS on tax-exempt buyers and certain sellers by fraud and abuse, and Stark laws require FMV as a standard. Published definitions of FMV are similar amongst the business valuation industry and healthcare’s regulatory environment. However, healthcare regulations provide additional guidance as it relates to methodologies and data.

**The Business Valuation Definition**

A Glossary of Terms was jointly developed by representatives of the American Institute of CPAs (“AICPA”), the American Society of Appraisers (“ASA”), the Canadian Institute of Business Appraisers (“CIBA”), the Institute of Business Appraisers (“IBA”), and the National Association of Certified Valuation Analysts (“NACVA”). According to that Glossary of Terms, the definition of the term FMV is as follows:

_The price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s-length in an open and unrestricted market, when neither is under compulsion to buy nor to sell, and when both have reasonable knowledge of the relevant facts._
Regulatory Definitions and Guidelines

It is important to note that the determination of FMV under healthcare regulations may not always be consistent with generally accepted appraisal standards. In fact, certain departures from standard appraisal practice may be required:

Moreover, the definition of “fair market value” in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. (STARK II, PHASE II, FR Vol. 69, No. 59)

Specifically, reliance on certain types of market data in determining FMV is prohibited. For instance, Stark states the FMV may not consider the value or volume of referrals and that one should not rely on data produced by referral relationships:

The methodology must exclude valuations where the parties to the transactions are at arm’s-length but in a position to refer to one another. (STARK II, PHASE II, FR Vol. 69, No. 59)

Depending on the circumstances, the “volume or value” restriction will preclude reliance on comparables that involve entities and healthcare providers in a position to refer or generate business. (STARK II, PHASE II, FR Vol. 66, No. 3)

Notable definitions related to FMV as stated in Stark include:

This provision defines fair market value as the value in arm’s-length transactions, consistent with the General Market Value (“GMV”), with other specific terms for rentals or leases. (STARK II, PHASE I, FR Vol. 66, No. 3)

GMV is compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties. (STARK II, PHASE I, FR Vol. 66, No. 3)

The compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician. (STARK II, PHASE II, FR Vol. 69, No. 59)

Commercial reasonableness is another pertinent definition in our determination of FMV. According to Stark II:

An arrangement will be considered “commercially reasonable” in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member
or group practice) of similar scope and specialty, even if there were no potential DHS (designated health services) referrals. (STARK II, PHASE II, FR Vol. 69, No. 59)

In addition to the definitions driving our FMV conclusion, the federal government has also presented guidelines in various publications which serve to drive our methodology for determining FMV. Most notably, the Stark regulations provide the following guidance:

We will continue to scrutinize the Fair Market Value of arrangements as Fair Market Value is an essential element of many exceptions. Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value. Ultimately, the appropriate method for determining Fair Market Value for purposes of the physician self-referral law will depend on the nature of the transaction, its location, and other factors. (STARK II, PHASE III, FR Vol. 72, No. 171)

Stark also makes specific statements as it relates to determining FMV for physicians providing administrative services:

A Fair Market Value hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is Fair Market Value for the clinical work performed and the rate paid for administrative work is Fair Market Value for the administrative work performed. We note that the Fair Market Value of administrative services may differ from the Fair Market Value of clinical services. A Fair Market Value hourly rate may be used to determine an annual salary, provided that the multiplier used to calculate the annual salary accurately reflects the number of hours actually worked by the physician. (STARK II, PHASE III, FR Vol. 72, No. 171)

### Valuation Methodologies Conclusion

The above guidelines are considered in the determination of FMV. Specifically, key elements of our analysis will include:

1. Adequate market data, considering objective and independently published salary survey data;
2. Limited reliance on data produced by referral relationships; and
3. Other case specific factors, including terms of the arrangement.

In an effort to avoid potential violations of the federal anti-kickback statute, and the Stark self-referral law, it is critical for parties to document why an agreement is at FMV. Moreover, it is important to consider all terms of an agreement, not just the monetary value, in establishing and evaluating FMV.
MARKET STUDY OF THE PHYSICIAN EXECUTIVE HOURLY RATE

Please note that while we have considered the Cost, Market, and Income Approaches to value the physician executive hourly rate, the Income Approach is not utilized in our analysis due to the difficulties in measuring the relative impact of the administrative or clinical management services performed by the Physicians on the profitability of the Hospitals. In addition, healthcare laws and regulations require that the Physicians’ compensation be made without regard to referrals to the Hospitals. Either of these considerations limits the use of the Income Approach in our analysis. As we discuss in more detail in the following sections, our analysis of the physician executive hourly rate to be included in the Agreements considers the Cost and Market Approaches. The Cost Approach utilizes market data for clinical compensation. This methodology considers what an organization might pay a practicing physician in order to allocate a portion of his or her time towards administrative services. The Market Approach utilizes market survey data for physicians dedicated to administrative services.

HOURLY BASIS

When determining the market study range related to physician compensation for administrative duties, we report our conclusion of value based on an hourly rate. Current healthcare regulations as well as the part-time nature of the services drive the need to utilize this methodology. The following further supports the basis for this policy. Section 415.60 of The Code of Federal Regulations discusses allocation of physician compensation costs:

- Each provider that incurs physician compensation costs must allocate those costs in proportion to the percentage of total time that is spent in furnishing each category of service.

- Each provider that claims payment for services of physicians must meet all of the following requirements: 1) Maintain time records or other information it used to allocate physician compensation in a form that permits the information to be validated; 2) Report the information on which the physician compensation allocation is based; and 3) Retain each physician compensation allocation and the information on which it is based.

In addition, VMG participated in two teleconferences on September 18, 2007. During these teleconferences, there was a discussion reinforcing the position to report FMV for physician compensation related to administrative duties based on an hourly rate. The speakers represented on the calls were professionals in both the healthcare regulatory environment and the business valuation industry:
o HCPro (a national healthcare compliance company) – Stark Law Updated: The latest news and real world compliance strategies <http://www.hcmarketplace.com/prod-5606.html>; and
o NACVA: A Practical Guide to Physician Compensation Arrangements.

Both audio conferences addressed whether it is possible to be compliant by reporting an annual FMV amount based on part-time physician hours in administrative roles. Both speakers stated that the most compliant process is to require physicians to be paid hourly based on a monthly log. Therefore, we have reported our market study range based on an hourly rate for the physician executive duties to be listed in the potential Agreements.

RELEVANCE OF CLINICAL COMPENSATION FOR ADMINISTRATIVE SERVICES

The Cost Approach utilizes compensation data available from published sources to establish a range of market compensation paid to physicians in professional practice. While the services provided under the subject arrangement will differ in nature from the services a physician provides in medical practice, a medical entity may have the option of employing a physician or physicians to serve in a similar role.

How much reliance to be placed on this approach may be determined by addressing two questions:

1. Does the role require a physician?
2. Does the role require the physician’s specialty?

If the answer to both of the above questions is yes, the Cost Approach produces a reliable conclusion of value for the subject agreement. In addition, representatives speaking on two audio conferences on September 18, 2007 organized by HCPro and NACVA addressed the issue of relying on clinical market compensation for administrative roles. Representatives from these calls specifically stated the above questions were essential in determining if clinical compensation rates can be relied upon for compensating administrative duties. In addition, according to the Integrated Healthcare Strategies Medical Director Survey (formerly Clark Consulting Medical Director Survey), there is a strong correlation between what specialists receive in compensation from clinical practice and the hourly rate they receive for administrative positions.

For further support of the Cost Approach, the federal government has provided guidelines for valuing physicians’ compensation as it relates to all duties, including administrative duties. Stark II, Phase II final regulations were published in the Federal Register on March 26, 2004 (69 Fed. Reg. 16053). Phase II regulations, issued by the Centers for Medicare and Medicaid Services (“CMS”) established a "safe harbor" for hourly physician compensation rates, which suggested guidance in calculating an hourly rate through the utilization of several surveys. These surveys
report physician compensation in professional practice, and CMS allowed these surveys to serve as a proxy for administrative pay.

Stark II, Phase III which was published September 5, 2007 expressly eliminated the Safe Harbor. Reasons cited for this elimination included the cost and availability of the named surveys. However, we still believe it relevant to utilize several independent clinical compensation surveys in deriving our conclusion of value for certain administrative duties. We have also utilized this Safe Harbor’s suggested annual hours of 2,000 in deriving an hourly rate for our analysis.

**Empirical Evidence Linking Clinical and Administrative Compensation**

We have observed the 75th percentile of clinical compensation data correlates with the median of physician executive compensation data. For some specialties we believe this relationship reflects the physician’s experience and qualifications when serving an executive role which utilizes the physician’s relevant education and experience. The 75th percentile also supports the fact that these roles require additional skills aside from the clinical practice of medicine. Specifically, physician executive positions most often require familiarity with protocols and best practices, as well as leadership skills. Therefore, it is typical for the physicians to have historically high productivity, many years of experience in the subject field, and often times these physicians have served on boards or have been involved with the administrative leadership of a hospital. This quality of leadership is typically compensated in any setting, whether it is the medical field or any other business line.

Although we have observed a link between median physician executive compensation and the 75th percentile of clinical compensation for most specialties, this link is less relevant for higher paid specialties. Specifically, we have observed physician executive compensation is in line with median clinical compensation for higher paid specialties. These observations are based on a review of survey data and our experience.

In order to derive our market study range, we compared the inflation-adjusted median physician executive compensation data to the clinical compensation for the subject specialty. The clinical compensation data was based on the weighted average by number of respondents found in three surveys: the *MGMA Physician Compensation and Production Survey: 2012 Report Based on 2011 Data*, the *Sullivan Cotter 2012 Physician Compensation and Productivity Survey Report*, and the *AMGA 2012 Medical Group Compensation and Financial Survey*.

In addition to the above described analysis, we conducted a separate analysis to further understand the relationship between physician compensation for clinical versus administrative roles. We requested, and were provided with, raw data from the *2011 Physician Executive Compensation Survey* for program directors and consultants. We understand these roles
require a physician to apply knowledge of his or her specialty in fulfilling their duties. Within the raw data, the physicians were asked to allocate how much of his or her compensation was attributable to clinical versus administrative services. Based on these answers, we were able to determine which role (clinical or administrative) warranted higher compensation. The results revealed that approximately 20% of the respondents reported identical compensation for clinical and administrative duties, approximately 40% reported higher compensation for clinical duties, and approximately 40% reported higher compensation for administrative duties.

Based on the above facts and analyses, the most pertinent steps in determining the applicability of clinical compensation for administrative roles is to understand:

1. The services being provided;
2. If the services require a physician;
3. If the services require a particular specialty; and
4. If the services require leadership skills or extensive experience within that specialty.

The following sections outline the market study analysis for the physician executive hourly rate to be paid to the Physicians for fulfilling the hourly administrative services related to the potential Agreements based on the Cost Approach and the Market Approach.

**COST APPROACH ANALYSIS – PHYSICIAN EXECUTIVE HOURLY RATE**

The relevance of the Cost Approach, which relies on clinical data, is based on understanding the services being provided by the physician executive. If the forthcoming agreement requires a physician and specifically a physician in a particular specialty, clinical compensation is a reasonable indication of value. It is our understanding that the subject positions are best served by physicians specialized in infectious disease. Therefore, we have utilized infectious disease survey data to analyze the physician executive hourly rate. The following details the surveys utilized in the Cost Approach analysis:

**MGMA Physician Compensation and Production Survey: 2012 Report Based on 2011 Data**

This published study includes compensation for 62,245 physicians and non-physician providers in 2,913 groups. The data is reported for more than 170 specialties. Respondents include both medical practices and other types of organizations involved in physician practice management. The 2012 survey is based on 2011 data.

**Sullivan, Cotter and Associates: 2012 Physician Compensation & Productivity Survey**

This published study includes data based on the responses of over 400 health care organizations and reflects total cash compensation levels paid to 76,000 physicians, PhDs, mid-level providers, residents and medical group executives representing 219 specialties. The 2012 survey is based on 2011 data.

Information contained in this published study is based on responses of 225 medical groups representing approximately 55,800 providers. This is the twenty-third edition of this survey. The 2012 survey is based on 2011 data.

**Adjustments to Survey Data**

Based on discussions with IDSA, we understand the Physicians may be independent contractors or employed and, therefore, may or may not responsible for their own employee benefits and malpractice insurance (respectively).

In deriving an appropriate market study range for physician executive compensation, certain adjustments have been made to the survey data. The following describes the drivers for the adjustments, the effects on the physician executive compensation, and the adjustment methodology. Calculations for the adjustments and application of the adjustments can be found in the exhibits.

**Inflation**

To derive the applicable inflationary growth of compensation, we utilized inflationary growth as tracked by the Consumer Price Index ("CPI"). We utilized the 12-month unadjusted medical care services CPI (ended March 2013). We then applied two years of inflationary growth to Sullivan Cotter, MGMA, and AMGA compensation levels to reflect compensation payable in 2013. Please see Exhibit B for application of the inflation adjustment.

**Benefits**

In the event that the physician is employed to serve in the subject position, the employer would incur additional costs including the employer’s share of payroll taxes, health insurance, retirement benefits, continuing education, and malpractice insurance. In an independent contractor arrangement, the physician must pay for these costs through the compensation under the contracted rate. Please see Exhibit B for more details on the benefits and malpractice data.

- **Physician Benefits**: In order to estimate these costs, we utilized the *Sullivan Cotter & Associates: 2012 Physician Compensation & Productivity Survey* data. The benefit costs for this survey include the cost of health, life and disability insurances; employer contributions to pension/retirement plans; FICA, payroll and unemployment taxes; professional license fees; and continuing medical education. The costs do not include the cost of malpractice insurance or paid time off.
• **Physician Malpractice Insurance:** In order to estimate a typical malpractice insurance allowance provided to physicians, we utilized the AMGA 2012 Medical Group Compensation and Financial Survey data.

**Hours Worked**

The hourly rate should be derived by dividing the weighted average median annual compensation by the appropriate number of hours worked by the physician executives. In determining the appropriate number of hours, we look to Stark II, Phase II final regulations which were published in the Federal Register on March 26, 2004 (69 Fed. Reg. 16053). Phase II regulations, issued by the Centers for Medicare and Medicaid Services (“CMS”) established a "safe harbor" for hourly physician compensation rates, which suggested guidance in calculating an hourly rate, which includes dividing salary survey data by 2,000 hours to establish an hourly rate. Stark II, Phase III which was published September 5, 2007 expressly eliminated the Safe Harbor. However, we still believe CMS’ guideline to utilize 2,000 hours is relevant in deriving our market study range for an hourly rate for physicians in administrative roles. Please see Exhibit B for the application of the annual hours.

**Cost Approach Conclusion – Physician Executive Hourly Rate**

After adjusting for the aforementioned factors, the Cost Approach indicates a conclusion of $141 per hour for the specialty of infectious disease based on the weighted average median of the aforementioned three surveys (Note: This rate includes benefits and malpractice insurance.) Please see Exhibit B for a summary of the Cost Approach conclusion.

**MARKET APPROACH ANALYSIS – PHYSICIAN EXECUTIVE HOURLY RATE**

The methodology employed utilizes physician executive data available from published sources to establish a range of market rates paid for similar services. It is important to note that the studies referenced likely capture only a small portion of the total universe of administrative compensation paid to physicians. We have placed sole reliance on the Market Approach due to the fact that the physician executive title best reflects the job description for the Physicians providing the hourly administrative services to the Hospitals. The following describes the survey utilized in our analysis:

**2011 Cejka Search and ACPE Physician Executive Compensation Survey**

Cejka Search is a nationally recognized executive and physician search organization providing services exclusively to the healthcare industry for more than 25 years. Partnering with organizations in pursuit of the nation’s best providers of healthcare for more than 25 years, Cejka Search completes hundreds of assignments annually across all levels of the healthcare continuum.
The American College of Physician Executives (“ACPE”), located in Tampa, Florida, is the leading national professional association representing physicians in management and boasting a membership of nearly 10,000, including some of the nation’s top healthcare leaders. Members of the Cejka Search and the ACPE Physician Executive Compensation Survey Committee are charged with recommending survey content and format that are relative to physician executive compensation and administrative responsibilities.

The Cejka Search / ACPE Physician Executive Survey was e-mailed and mailed in mid-May 2011 to 9,348 ACPE members. By late June, a total of 2,170 surveys were received by the survey deadline. However, approximately 185 were discarded from the survey tabulation due to insufficient information that would have resulted in erroneous or misleading results. The total questionnaires used in the survey tabulation were 1,985, representing a 20% response. The survey includes direct compensation by title, organization type, years of experience, scope of responsibilities, compensation method (i.e., salary plus bonus), executive bonus percent, medical specialty and post-graduate business degree. We utilized compensation by medical specialty for our analysis.

According to the Cejka Survey, administrative services typically performed by physicians include the following:

- Administrative Management (Organization Policy and Compliance, Addressing Reimbursement Issues, Strategic Planning, Marketing, Physician Compensation);
- Quality Management (Patient Safety, Cost Management, Quality Measurement, Utilization Review, Medical Protocol Development, Medical Error Reduction);
- Operational Management (Daily Operations, Improvement Initiatives, Driving Operational Performance);
- Program Development (Mergers and Acquisitions, New Service Line Development, Joint Ventures);
- Recruitment (Network Development, Physician Recruitment);
- Liaison (Liaison between Physicians and Management, Organization and Board of Directors, Organization and Community);
- Personnel Management (Physician Compensation and Reimbursement, Human Resource Management); and
- Educational (Supervision of Clinical and/ or Basic Science Research, Teaching, Supervision of Residents/ Fellows).

**Compensation by Medical Specialty**

The Cejka survey provides compensation data for physician executives in various medical specialties. Therefore, we utilized the physician executive survey data for the specialty of infectious disease. The initial survey calculation can be found in Exhibit C.
Adjustments to Administrative Compensation Data

When determining the market study range related to physician compensation for administrative duties, certain adjustments should be made. Please refer to the previous sections of this report that address the inflation, benefits and malpractice insurance, and hourly rate adjustments. These adjustments can be found on Exhibit C.

Market Approach Conclusion – Physician Executive Hourly Rate

After adjusting for the aforementioned factors, the Market Approach indicates the following for the specialty of infectious disease:

<table>
<thead>
<tr>
<th>MARKET APPROACH CONCLUSIONS</th>
<th>Median</th>
<th>75th %</th>
<th>90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Approach Conclusions</td>
<td>$181</td>
<td>$242</td>
<td>$282</td>
</tr>
</tbody>
</table>

Based on discussions with IDSA management, we have been asked to provide a range of hourly rates to be utilized by the Physicians and the Hospitals based on a particular Physician’s credentials and experience. (Note: This rate includes benefits and malpractice insurance.) Please see Exhibit C for a summary of the physician executive Market Approach conclusion.
SUMMARY OF MARKET STUDY CONCLUSIONS

We have considered both the Cost and Market Approaches starting with compensation data available from published sources to establish a range of market compensation paid to physicians in professional practice. In addition, we utilized physician executive compensation data to establish a range of market compensation paid to physician executives in the medical specialty of infectious disease and to analyze the physician executive hourly rate. We have placed sole reliance on the Market Approach due to the fact that the physician executive title best reflects the job description for the Physicians providing the administrative services related to the prospective Agreements. Based upon the available data, facts, and circumstances, we have determined that the following physician executive hourly rates are consistent with the market:

<table>
<thead>
<tr>
<th>Conclusion</th>
<th>Tier 3 Median</th>
<th>Tier 2 75th</th>
<th>Tier 1 90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hourly Conclusion (rounded) - Independent Contractor</td>
<td>$180</td>
<td>$240</td>
<td>$280</td>
</tr>
<tr>
<td>Hourly Conclusion (rounded) - Employed (without Benefits &amp; Malpractice Insurance)</td>
<td>$155</td>
<td>$215</td>
<td>$255</td>
</tr>
</tbody>
</table>

Based on VMG research, industry observations, and our experience, VMG has developed general guidelines, as shown in Exhibit D, as a means of determining which percentile of survey data to rely upon. It is important to note the expertise required per the Agreement will also be relevant in selecting the appropriate percentile for a particular arrangement. In addition, VMG personnel are not clinical experts; it is ultimately the responsibility of the user to determine the tier to which a physician belongs, as well as if the agreement requires a particular tier to provide the outlined services.

Our market study is valid for two years, as long as the Agreements commence within six months from the date of this report. This valuation analysis is intended solely for the use of IDSA, the Hospitals, and the Physicians for management planning and regulatory compliance purposes. Our analysis is to be used for no other purpose or distributed, in whole or in part, to third parties, other than the Internal Revenue Service, Office of Inspector General or other regulatory authorities, without the express written consent of VMG.

Respectfully submitted,

Jen Johnson, CFA
Partner
VMG Health, LLC
Contributing Appraiser: Alex Higgins
STATEMENT OF LIMITING CONDITIONS

The value recommendations contained in this report are qualified as follows:

- The facts described in this report were provided by client management or obtained from independent third parties including client’s accountants, published sources, and commercial databases. We have accepted this information without further verification. Our value recommendations assume this information is materially true and correct.

- Certain matters are outside the purview of our expertise. As a result, our value recommendations assume: (1) Parties to the forthcoming agreement comply fully with all federal, state, and local laws and ordinances; (2) Funding for pensions and healthcare liabilities, if any, is adequate; and (3) There are no undisclosed factors that might render the services that are the subject of this report materially more or less valuable. Any statements in this report about the above issues are based on management representations. The user is responsible for independent investigation of these matters, and their own determination of their impact on the recommended value(s).

- Nothing contained in this report should be construed as investment, legal, or tax advice. This valuation is intended only for the use of the addressee and only for the purpose described. All other uses of this report are unauthorized and prohibited. The report may not be distributed, either in whole or part, to any party not identified, and mere possession of the report does not convey a right of reliance.

- VMG has not, as part of this assignment, examined either the historical, interim, or prospective financial statements according to generally accepted auditing standards, and so expresses no opinion thereon in this valuation report.

- Any estimates of future performance described in this report (or the exhibits hereto), pertain to a specific valuation method. This method matches performance scenarios with their associated risk rates as a means of quantifying the value parameters. Use of either the future performance scenarios or the discount rate separately or outside the valuation context is unauthorized and prohibited. Actual operating results may vary materially from those described.

- The obligation of VMG is solely a corporate obligation, and no officer, principal, director, employee, agent, shareholder, or controlling person shall be subjected to any personal liability whatsoever to any person or entity, nor will any such claim is asserted by or on behalf of any other party to this agreement or any person relying on the opinion.

- The fee for this assignment is provided only for the preparation of this report for the specific valuation date. All other services including updates of value for any other date; preparation and testimony in court or before governmental agencies; or meetings about
the valuation report after its delivery will be provided at additional cost for fees and expenses.

- In conducting this market study, VMG has not inquired into the applicability of, and has assumed the compliance by all parties with, all federal, state, and local statutes, laws, ordinances, rules, and regulations applicable to the healthcare industry generally, the parties to the transaction specifically, or the legal structure of either the parties involved or the transaction itself, including without limitation the Ethics in Patient Referrals Act (the "Stark Law"), the Medicare-Medicaid Anti-Fraud and Abuse Amendments (the "Anti-Kickback Statute"), the Medicare and Medicaid Patient and Program Protection Act (the "Safe Harbors"), the False Claims Act, the Civil Money Penalties Law, the Health Insurance Portability and Accountability Act ("HIPAA"), any other federal laws related thereto, any amendments thereto, any state laws of similar scope and focus, any regulations promulgated thereunder, any common-law interpretations or obligations related thereto, any interpretations thereof by any courts at the federal, state, or local level, and any regulations promulgated by any federal or state agency, including without limitation regulations promulgated by the United States Department of Health and Human Services, the Health Care Financing Agency, the Centers for Medicare and Medicaid Services, the HHS Inspector General, and any predecessor or successor agency.

- Our opinion assumes the contracting entity has determined: the duties being requested under the arrangement are necessary and not superfluous, the services required under the agreement are required based on operational needs and/or community need, the arrangement is the best fiscal option absent any consideration of referrals, the assumptions contained herein are accurate and appropriate to the best of their knowledge and the negotiations were at arm’s length and that the agreement makes sense commercially.
SOURCES

- Discussions with IDSA management
- MGMA Physician Compensation and Production Survey: 2012 Report Based on 2011 Data
- Sullivan Cotter 2012 Physician Compensation and Productivity Survey
- AMGA 2012 Medical Group Compensation and Financial Survey
- CEJKA 2011 Physician Executive Compensation Survey
- IDSA website
APPRAISER’S CERTIFICATION

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

☐ The statements of fact contained in this report are true and correct.

☐ The reported analysis, opinion, and conclusions are limited only by the reported assumptions and limiting conditions and are my personal, impartial, and unbiased professional analysis, opinions, and conclusions.

☐ I, and the firm I represent, have no present or prospective interest in the property or the contract that is the subject of this report and no personal interest with respect to the parties involved.

☐ I, and the firm I represent, have no bias with respect to the property or contract that is the subject of this report or to the parties involved with this assignment.

☐ Our engagement in this assignment was not contingent upon developing or reporting predetermined results.

☐ Our compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of the report.

☐ No one provided significant personal property appraisal or valuation consulting assistance to the person signing this certification. Our firm has not made a personal inspection of the property and/or facilities that are the subject of this report.

☐ All information has been provided to the satisfaction of this firm.

Respectfully submitted,

Jen Johnson, CFA
Partner
VMG Health, LLC

Contributing Appraiser: Alex Higgins
### Market Study Summary

<table>
<thead>
<tr>
<th>Valuation Approach</th>
<th>Exhibit</th>
<th>Tier 3</th>
<th>Tier 2</th>
<th>Tier 1</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Executive Compensation Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Approach - Median Clinical Compensation</td>
<td>B</td>
<td>$141</td>
<td>$141</td>
<td>$141</td>
<td>0.0%</td>
</tr>
<tr>
<td>Market Approach - Physician Executive Compensation</td>
<td>C</td>
<td>$181</td>
<td>$242</td>
<td>$282</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hourly Conclusion (rounded) - Independent Contractor</td>
<td></td>
<td>$180</td>
<td>$240</td>
<td>$280</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hourly Conclusion (rounded) - Employed (without Benefits &amp; Malpractice Insurance)</td>
<td></td>
<td>$155</td>
<td>$215</td>
<td>$255</td>
<td></td>
</tr>
</tbody>
</table>

*These exhibits do not represent a full opinion without a narrative report which will explain our underlying data, methodologies and assumptions.*

---

**Key Terms:**

IDSA = Infectious Disease Society of America  
Physician(s) = Certain physician(s) affiliated with IDSA  
Hospital(s) = Certain health system(s) or hospital(s)  
Agreements = Potential service agreements between Hospital and certain Physician(s) affiliated with IDSA

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**Summary of Exhibits**

A. Summary, Key Terms, Summary of Exhibits, Qualifying Assumptions and Valuation Notes  
B. Cost Approach Analysis - Physician Executive Hourly Rate  
C. Market Approach Analysis - Physician Executive Hourly Rate  
D. Physician Executive Tier Analysis - General Guidelines
### COST APPROACH ANALYSIS

#### SURVEY DATA - INFECTIOUS DISEASE

<table>
<thead>
<tr>
<th></th>
<th>MGMA (data effective as of 2011)</th>
<th>Sullivan Cotter (data effective as of 2011)</th>
<th>AMGA (data effective as of 2011)</th>
<th>Market Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25th %</td>
<td>Mean</td>
<td>Median</td>
<td>75th %</td>
</tr>
<tr>
<td><strong>Infectious Disease</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Physicians:</td>
<td>194</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Facilities:</td>
<td>85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of Total Surveyed:</td>
<td>19.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflation Adjustment (1)</td>
<td>5.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MGMA (data effective as of 2011)</strong></td>
<td>$189,951</td>
<td>$250,575</td>
<td>$263,774</td>
<td>$290,679</td>
</tr>
<tr>
<td><strong>Sullivan Cotter (data effective as of 2011)</strong></td>
<td>$170,400</td>
<td>$218,634</td>
<td>$207,630</td>
<td>$239,750</td>
</tr>
<tr>
<td><strong>AMGA (data effective as of 2011)</strong></td>
<td>$190,430</td>
<td>$236,537</td>
<td>$229,511</td>
<td>$275,962</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>996</td>
<td>100.0%</td>
<td>$191,324</td>
<td>$243,796</td>
</tr>
</tbody>
</table>

1. Inflation adjustment is based on the professional services component of the 12-month unadjusted medical care services consumer price index ended March 2013. (http://bls.gov/cpi/cpid1303.pdf).

### SUPPLEMENTAL DATA

#### ESTIMATED BENEFITS

<table>
<thead>
<tr>
<th>Benefits - Sullivan Cotter Median - Infectious Disease (2)</th>
<th>Inflation Adjustment (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>$38,032</td>
</tr>
<tr>
<td>Total Estimated Benefits</td>
<td>$42,348</td>
</tr>
</tbody>
</table>

#### ESTIMATED INSURANCE - AMGA Median Infectious Disease

<table>
<thead>
<tr>
<th>Insurance Adjustments (4)</th>
<th>Total Estimated Benefits &amp; Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>FICA, payroll and unemployment taxes; and professional license fees.</td>
<td></td>
</tr>
<tr>
<td>Total Estimated Benefits &amp; Insurance</td>
<td>$50,380</td>
</tr>
</tbody>
</table>

2. Sullivan Cotter benefits include the cost of health, life and disability insurances; employer contributions to pension/retirement plans; continuing medical education expenses; FICA, payroll and unemployment taxes; and professional license fees.

3. Benefits, continuing education, and professional liability insurance have been inflated by CPI, or 2.1%. Sullivan Cotter and AMGA data has been adjusted for two years of inflation.

### COST APPROACH CONCLUSION

| Total Compensation Indication with Benefits & Malpractice Insurance | $281,463 |
| Hourly Rate (divided by 2,000 hours) (4) | $141 |

4. Stark II, Phase II final regulations were published in the Federal Register on March 26, 2004 (69 Fed. Reg. 16053). Phase II regulations, issued by the Centers for Medicare and Medicaid Services ("CMS") established a "safe harbor" for hourly physician compensation rates, which suggested guidance in calculating an hourly rate, which includes dividing salary survey data by 2,000 hours to establish an hourly rate. Stark II, Phase III which was published September 5, 2007 expressly eliminated the Safe Harbor. However, we still believe it prudent to utilize 2,000 hours in deriving our conclusion of value for an hourly rate for physicians in administrative roles.
EXHIBIT C
INFECTIOUS DISEASE SOCIETY OF AMERICA
INFECTIOUS DISEASE PHYSICIAN EXECUTIVE ANALYSIS
MARKET APPROACH ANALYSIS
FINAL REPORT

MARKET APPROACH ANALYSIS

CEIKA SEARCH - PHYSICIAN EXECUTIVE COMPENSATION SURVEY (data effective as of 2010)

<table>
<thead>
<tr>
<th></th>
<th>25th %</th>
<th>Mean</th>
<th>Median</th>
<th>75th %</th>
<th>90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infectious Disease - All</strong></td>
<td>25 Respondents</td>
<td>$225,000</td>
<td>$305,850</td>
<td>$272,728</td>
<td>$404,000</td>
</tr>
<tr>
<td>Total Compensation with Inflation (1)</td>
<td>8.0% Three Years of Inflation</td>
<td>$243,010</td>
<td>$330,322</td>
<td>$294,559</td>
<td>$436,338</td>
</tr>
<tr>
<td>Hourly conversion, divided by 2,000 hours (2)</td>
<td></td>
<td>$122</td>
<td>$165</td>
<td>$147</td>
<td>$218</td>
</tr>
<tr>
<td><strong>All Physician Executives - All</strong></td>
<td>1985 Respondents</td>
<td>$240,000</td>
<td>$338,537</td>
<td>$305,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Total Compensation with Inflation (1)</td>
<td>8.0% Three Years of Inflation</td>
<td>$259,211</td>
<td>$365,635</td>
<td>$329,414</td>
<td>$432,018</td>
</tr>
<tr>
<td>Hourly conversion, divided by 2,000 hours (2)</td>
<td></td>
<td>$130</td>
<td>$183</td>
<td>$165</td>
<td>$216</td>
</tr>
</tbody>
</table>

CONCLUSION

Average Physician Executive Survey Data

<table>
<thead>
<tr>
<th></th>
<th>25th %</th>
<th>Mean</th>
<th>Median</th>
<th>75th %</th>
<th>90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$156</td>
<td>$217</td>
<td>$257</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SUPPLEMENTAL DATA

<table>
<thead>
<tr>
<th>Inflation Adjusted Benefits &amp; Malpractice Data (See Exhibit B)</th>
<th>Annual Indication</th>
<th>Hourly Rate Adjustment (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Benefits</td>
<td>$40,348</td>
<td>$20</td>
</tr>
<tr>
<td>Median Malpractice Insurance</td>
<td>$10,032</td>
<td>$5</td>
</tr>
</tbody>
</table>

(1) Inflation adjustment is based on the professional services component of the 12-month unadjusted medical care services consumer price index ended March 2013.

(2) Stark II, Phase II final regulations were published in the Federal Register on March 26, 2004 (69 Fed. Reg. 16053). Phase II regulations, issued by the Centers for Medicare and Medicaid Services (“CMS”) established a “safe harbor” for hourly physician compensation rates, which suggested guidance in calculating an hourly rate, which includes dividing salary survey data by 2,000 hours to establish an hourly rate. Stark II, Phase III which was published September 5, 2007 expressly eliminated the Safe Harbor. However, we still believe it prudent to utilize 2,000 hours in deriving our conclusion of value for an hourly rate for physicians in administrative roles.

(3) Per Cejka, physician executives provide a variety of administrative duties including, but not limited to, the following: administrative management, quality management, liaison, medical staff activities, education, operational management, program development, recruitment, medical practice management, financial management, and human resources management / performance evaluation.

MARKET APPROACH CONCLUSION

<table>
<thead>
<tr>
<th>Median, 75th Percentile, and 90th Percentile Physician Executive Survey Data</th>
<th>25th %</th>
<th>Mean</th>
<th>Median</th>
<th>75th %</th>
<th>90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Benefits</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Malpractice Insurance</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Compensation Indications with Benefits &amp; Malpractice Insurance</td>
<td>$181</td>
<td>$242</td>
<td>$282</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**PHYSICIAN EXECUTIVE TIER ANALYSIS - GENERAL GUIDELINES**

### TIER 1 PHYSICIAN EXECUTIVE PROFILE - 90TH PERCENTILE HOURLY RATE

<table>
<thead>
<tr>
<th>Standards</th>
<th>Indication (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Physician Executive or Administrative Leadership Experience</td>
<td>11+</td>
</tr>
<tr>
<td>Hours worked per Week in Leadership Positions (average over all years)</td>
<td>21+</td>
</tr>
<tr>
<td>Years of Clinical Experience (not including residency or fellowship)</td>
<td>11+</td>
</tr>
<tr>
<td>Number of Publications and Speaking Engagements</td>
<td>26+</td>
</tr>
<tr>
<td>Degrees Held by Physician (2)</td>
<td>MD plus Additional Relevant Degree</td>
</tr>
</tbody>
</table>

### TIER 2 PHYSICIAN EXECUTIVE PROFILE - 75TH PERCENTILE HOURLY RATE

<table>
<thead>
<tr>
<th>Standards</th>
<th>Indication (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Physician Executive or Administrative Leadership Experience</td>
<td>6 - 10</td>
</tr>
<tr>
<td>Hours worked per Week in Leadership Positions (average over all years)</td>
<td>11 - 20</td>
</tr>
<tr>
<td>Years of Clinical Experience (not including residency or fellowship)</td>
<td>6 - 10</td>
</tr>
<tr>
<td>Number of Publications and Speaking Engagements</td>
<td>6 - 25</td>
</tr>
<tr>
<td>Degrees Held by Physician (2)</td>
<td>MD</td>
</tr>
</tbody>
</table>

### TIER 3 PHYSICIAN EXECUTIVE PROFILE - MEDIAN HOURLY RATE

<table>
<thead>
<tr>
<th>Standards</th>
<th>Indication (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Physician Executive or Administrative Leadership Experience</td>
<td>0 - 2</td>
</tr>
<tr>
<td>Hours worked per Week in Leadership Positions (average over all years)</td>
<td>0 - 10</td>
</tr>
<tr>
<td>Years of Clinical Experience (not including residency or fellowship)</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Number of Publications and Speaking Engagements</td>
<td>0 - 5</td>
</tr>
<tr>
<td>Degrees Held by Physician (2)</td>
<td>MD</td>
</tr>
</tbody>
</table>

**Notes:**

(1) Indications are based on VMG research, industry observations, and our experience.

(2) Additional relevant degrees include MBA (Master of Business Administration), MHA (Master of Health Administration), MMM (Master of Medical Management), and MPH (Master of Public Health).