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Hearing Date: September 13, 2013 at 10:00 a.m.
Objection Deadline: September 6, 2013 at 10:00 a.m

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re:	Chapter 11 Case
SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.,	Case No. 13- 22840 (RDD)
Debtors.	(Jointly Administered)

DEBTORS' MOTION FOR AN ORDER PURSUANT TO SECTION 365 OF THE BANKRUPTCY CODE AUTHORIZING DEBTORS TO REJECT AN EXECUTORY CONTRACT, *NUNC PRO TUNC*, TO THE DATE OF TERMINATION OR THE FILING DATE OF THIS MOTION, WHICHEVER IS EARLIER

Sound Shore Medical Center of Westchester ("**SSMC**"), and its debtor affiliates (each a "**Debtor**" and together, the "**Debtors**") in the above chapter 11 cases (the "**Chapter 11 Cases**"), hereby file this Motion (the "**Motion**") for the entry of an Order pursuant to Section 365 of Bankruptcy Code, rejecting the Debtors' executory contract with Executive Health Resources, Inc. ("**EHR**"), and all related amendments and supplements thereto, attached hereto as Exhibit A. In support of the Motion, the Debtors respectfully represent as follows:

SUMMARY OF RELIEF REQUESTED

1. As set forth in more detail below, the Debtors have determined that the Debtors' executory contract with EHR (the "**EHR Executory Contract**") is no longer necessary for the Debtors' continued operations and does not provide any meaningful value or benefit to the Debtors and

their estates. Accordingly, to avoid the accrual of any unnecessary administrative expenses under the EHR Executory Contract, by this Motion, the Debtors seek entry of an order, substantially in the form annexed hereto as Exhibit B (the "**Proposed Order**"), pursuant to Section 365(a) of Title 11, United States Code, 11 U.S.C. §§ 101 *et seq.* (the "**Bankruptcy Code**"), authorizing the Debtors to reject the EHR Executory Contract, *nunc pro tunc*, as of the earlier of (i) the date on which the respective agreement was terminated, or (ii) the filing of this Motion.

JURISDICTION

2. This Court has jurisdiction over this Motion under 28 U.S.C. § 1334. This is a core proceeding within the meaning of 28 U.S.C. § 157(b)(2). Venue of this proceeding is proper pursuant to 28 U.S.C. §§ 1408 and 1409.

3. The statutory predicate for the relief requested herein is Section 365(a) of the Bankruptcy Code.

BACKGROUND

4. A significant portion of the Debtors' core business is focused around Sound Shore Medical Center of Westchester ("**SSMC**"). SSMC is a not-for-profit 242-bed, community-based teaching hospital offering primary, acute, emergency and long-term health care to the working class residents of southern Westchester. SSMC's affiliate, Mount Vernon Hospital ("**MVH**"), is a voluntary, not-for-profit, 176-bed hospital located in Mount Vernon, New York. MVH also operates the Dorothea Hopfer School of Nursing, chartered by New York State since 1901. Howe Avenue Nursing Home d/b/a Helen and Michael Schaffer Extended Care Center ("**SECC**"), the third operating Debtor, is a 150-bed, comprehensive facility offering short-term rehabilitation/sub-acute care, as well as skilled long-term care.

5. SSMC, MVH and SECC (with their affiliated Debtors) together comprise the Sound Shore Health System, Inc. ("**SSHS**" or the "**System**") which was formed in 1997 when the three affiliated healthcare institutions joined together to create one of the largest regional healthcare systems between New York City and Albany. Today, the System provides a range of specialized services, including orthopedic surgery, behavioral health, pediatrics, OB/GYN, continuing care facilities, a nursing home and community care clinics providing primary care services for the indigent and uninsured. Their affiliation with the New York College of Medicine also enables the Debtors to provide a teaching environment in multiple disciplines to their community and patients.

6. As the largest "safety net" providers for southern Westchester County, the Medical Centers serve a disproportionate share of patients in the Medicaid and uninsured populations. Annually, they are responsible for approximately 13,000 acute discharges, 55,000 emergency department visits and 60,000 indigent care clinic visits.

7. Given the historical deterioration of the Debtors' financial condition and the pressing need to find a strategic partner, which has been recounted in detail to the Court, the Debtors entered into an asset purchase agreement (the "**Purchase Agreement**") with Montefiore SS Operations, Inc., Montefiore MV Operations, Inc., Montefiore HA Operations, Inc, and Montefiore SS Holdings, LLC, Montefiore MV Holdings, LLC, and Montefiore HA Holdings, LLC, (collectively referred to as "**Buyer**") providing for the sale of all of their Owned Real Property, Furniture, Fixtures, Inventory, Assigned Contracts and related operating assets, which collectively comprise the Acquired Assets (all as therein defined). Buyer which will thereafter continue operations at the Debtors' former facilities under their own auspices.

EHR EXECUTORY CONTRACT

8. The Debtors have been conducting a comprehensive review of their executory contracts to determine which contracts will be assumed and/or rejected. Given the Debtors' intent to sell their assets to Buyer, many of the Debtors' existing agreements and contracts will no longer be necessary to their continued operations pending such sale. The Debtors will thus seek to reject those contracts that provide no meaningful value or benefit to the Debtors' estates. As part of their ongoing review of the executory contracts, the Debtors have reviewed the EHR Executory Contract which is the subject of this Motion, and have determined, in the exercise of their sound business judgment, that continuing the EHR Executory Contract would be burdensome to the Debtors' operations and would provide no corresponding benefit or utility to the Debtors' estates.

9. The Debtors' agreement with EHR covers certain medical necessity compliance services provided by EHR to the Debtors. The Debtors are eligible members of the Greater New York Hospital Association ("**GNYHA**") under GNYHA's standard member services agreement, which necessitates compliance with certain regulatory requirements. In connection with the GNYHA membership agreement, EHR was responsible for reviewing the Debtors' Medicare admissions with respect to claims status on cases which did not initially meet specified screening criteria. The Debtor currently employs other ordinary course professionals who have agreed to perform the services previously provided by EHR on terms that are more reasonable and beneficial to the Debtors' estates than those requested by EHR. The services covered by the EHR Executory Contract are thus no longer necessary for the Debtors' ongoing operations or the administration of the Debtors' estates. Thus, maintaining the EHR Executory Contract would impose unnecessary costs and burdens upon the estates. The Debtors do not believe the EHR

Executory Contract provides any meaningful benefit or value to the Debtors' estates. Accordingly, the Debtors are seeking to reject the EHR Executory Contract.

RELIEF REQUESTED

10. As set forth above, by this Motion, the Debtors seek authorization to reject the EHR Executory Contract, attached hereto as Exhibit A, as of the earlier of (i) the date on which the respective agreement was terminated, or (ii) the filing of this Motion.

BASIS FOR RELIEF REQUESTED

11. Section 365(a) of the Bankruptcy Code provides, in pertinent part, that a debtor in possession, "subject to the court's approval, may assume or reject any executory contract or unexpired lease of the debtor." 11 U.S.C. § 365(a). See, NLRB v. Bildisco & Bildisco, 465 U.S. 513, 521 (1984); see also, In re Lavigne, 114 F.3d 379, 386 (2d Cir. 1997). The United States Court of Appeals for the Second Circuit has stated that "[t]he purpose behind allowing the assumption or rejection of executory contracts is to permit the debtor or debtor-in-possession to use valuable property of the estate and to 'renounce title to and abandon burdensome property.'" Orion Pictures Corp. v. Showtime Networks, Inc. (In re Orion Pictures Corp.), 4 F.3d 1095, 1098 (2nd Cir. 1993) (quoting 2 Collier on Bankruptcy 365.01[1] (15th ed. 1993)).

12. In considering a motion to assume or reject a contract or lease, the court should "... plac[e] itself in the position of the debtor or debtor-in-possession and determine[e] whether assuming [or rejecting] the contract would be a good business decision or a bad one." Id. at 1099. "More exacting scrutiny would slow the administration of the debtor's estate and increase its cost, interfere with the Bankruptcy Code's provision for private control of administration of the estate, and threaten the court's ability to control a case impartially." Richmond Leasing Co. v. Capital Bank, N.A., 762 F.2d 1303, 1311 (5th Cir. 1985).

13. Courts defer to a debtor's business judgment in rejecting an executory contract or unexpired lease, and upon finding that a debtor has exercised its sound business judgment, approve such rejection under section 365(a) of the Bankruptcy Code. See NLRB v. Bildisco & Bildisco, 465 U.S. 513, 523 (1984) (recognizing the "business judgment" standard used to authorize rejection of executory contracts); Nostas Assocs v. Costich (In re Klein Sleep Products, Inc.), 78 F.3d 18, 25 (2'd Cir. 1996) (recognizing the "business judgment" standard used to authorize rejection of executory contracts); In re Minges, 602 F.2d 38, 42-43 (2nd Cir. 1979) (holding that the "business judgment" test is appropriate for determining when an executory contract can be rejected); In re Kong, 162 B.R. 86, 94-95 (Bankr EDNY 1993) (explaining that the business judgment standard requires only a demonstration that rejection will benefit the estate); In re Child World, Inc., 142 B.R. 87, 89 (Bankr. S.D.N.Y. 1992).

14. The "business judgment" standard is not a strict standard; it requires only a showing that either assumption or rejection of the executory contract or unexpired lease will benefit the debtor's estate. See In re Helm, 335 B.R. 528, 538 (Bankr. S.D.N.Y. 1996) ("To meet the business judgment test, the debtor in possession must 'establish that rejection will benefit the estate'") (citation omitted); In re Balco Equities, Inc., 323 B.R. 85, 99 (Bankr. S.D.N.Y. 2005) ("In determining whether the debtor has employed reasonable business discretion, the court for the most part must only determine that the rejection will likely benefit the estate.") (quoting G Survivor, 171 B.R. at 757)). Further, under the business judgment standard, "[a] debtor's decision to reject an executory contract must be summarily affirmed unless it is the product of 'bad faith, or whim or caprice'" In re TransWorld Airlines, Inc., 261 B.R. 103, 121 (Bankr. D. Del. 2001).

15. As noted above, the Debtors have reviewed the EHR Executory Contract and have determined that it is no longer necessary or beneficial to the Debtors' ongoing business, and create unnecessary and burdensome expenses for the Debtors' estates. In addition, the Debtors have determined that no meaningful value would be realized by the Debtors if the EHR Executory Contract was assumed and assigned to third parties. Accordingly, it is in the best interests of the Debtors' estates to reject the EHR Executory Contract and avoid incurring additional unsecured or potential administrative claims relating to the EHR Executory Contract. Rejection of the EHR Executory Contract and the attendant reduction in the estates' administrative costs thus reflects the Debtors' exercise of sound business judgment.

NUNC PRO TUNC REJECTION

16. It is well-established that a bankruptcy court has the authority to deem the rejection of an unexpired lease or executory contract retroactive to a date prior to the date of entry of an order approving the rejection. See In re At Home Corp., 392 F.3d 1064, 1070 (9th Cir. 2004); Thinking Machines Corp. v. Mellon Financial Servs. Corp. (In re Thinking Machines Corp.), 67 F.3d 1021, 1028 (1st Cir. 1995); In re Stonebridge Technologies, Inc., 430 F.3d 260, 273 (5th Cir. 2005); In re Jamesway Corp., 179 B.R. 33, 37-38 (Bankr. S.D.N.Y. 1995). Courts have authorized rejections of executory contracts and unexpired leases, including retroactive rejections, based on the equities of the circumstances. See Thinking Machines, 67 F.3d 1021 at 1028 (finding that, "[i]n the section 365 context, this means that bankruptcy courts may enter retroactive orders of approval, and should do so when the balance of the equities preponderates in favor of such remediation"). Courts have permitted retroactive rejection in other cases in this Circuit and elsewhere. See e.g., Sec. Investor Prot. Corp. v. Bernard L. Madoff Inv. Sec. LLC, Adv. Pro. No. 08-01789 (BRL) (Bankr. S.D.N.Y. February 4, 2009).

17. The Debtors believe that expedited rejection of the EHR Executory Contract is necessary due to the dire financial condition of the Debtors and the need to reduce unnecessary administrative claims against their estates. Expedited relief is appropriate under the circumstances herein since the EHR Executory Contract is no longer necessary for the Debtors' continued operations and any delays in rejection may lead to unnecessary costs and expenses for the Debtors' estates.

NOTICE

18. Notice of this Motion has been provided to all parties in interests in accordance with the Administrative Order Establishing Case Management and Scheduling Procedures (the "**Case Management Order**"), entered on June 4, 2013, notice of this Motion has been given to the parties identified on the General Service List and the Master Service List (as such terms are identified in the Case Management Order). The Debtors submit that no other or further notice need be provided.

NO PREVIOUS REQUEST

19. No prior motion for the relief requested herein has been made to this or any other Court.

WHEREFORE the Debtors respectfully request the entry of an order, substantially in the form annexed hereto as Exhibit B, authorizing the Debtors to reject the EHR Executory Contract and granting such other and further relief as the Court may deem just and proper.

Dated: August 26, 2013
Great Neck, New York

GARFUNKEL WILD , P.C.
Counsel for Debtors and Debtors in Possession

By: _____
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Afsheen A. Shah
111 Great Neck Road
Great Neck, New York 11021
Telephone: (516) 393-2200
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EXHIBIT A

EHR®
EXECUTIVE HEALTH RESOURCES

STANDARD GNYHA MEMBER SERVICES AGREEMENT

THIS STANDARD GNYHA MEMBER SERVICES AGREEMENT (the "Agreement") is made and entered into by and between Executive Health Resources, Inc., a Pennsylvania corporation with its principal place of business at 15 Campus Boulevard, Suite 200, Newtown Square, PA 19073 ("EHR"), and Sound Shore Health System, Inc., a New York not-for-profit corporation with its principal place of business at 16 Guion Place, New Rochelle, NY 10801 ("Customer"). EHR and Customer may be individually referred to as a "Party" or collectively as the "Parties."

BACKGROUND

EHR provides medical necessity compliance consulting services to hospitals. The Customer is an eligible member of the Greater New York Hospital Association, its subsidiaries or affiliates, or its group purchasing partner entities ("GNYHA") and provides healthcare services to patients through one or more affiliated hospitals (each, individually a "Hospital," and collectively the "Hospitals"). The Customer, on its own behalf and on behalf of certain of its Hospitals, is interested in retaining EHR and EHR is interested in being retained by the Customer to provide the EHR Services (as defined below) to the Customer and the Hospital(s), subject to the terms and conditions in this Agreement and any Hospital Addendum (as defined below).

TERMS

NOW, THEREFORE, for and in consideration of the mutual covenants and conditions contained herein, and intending to be legally bound hereby, the Parties agree as follows:

1. **Definitions.** Capitalized terms used in this Agreement shall have the following meanings:

1.1. "Affiliate" means any entity that controls, is controlled by, or is under common control with a Party. For purposes of this Agreement, "control" means possessing, directly or indirectly, the power to direct or cause the direction of the management, policies or operations of an entity, whether through ownership of voting securities, by contract or otherwise.

1.2. "Confidential Information" means all confidential and proprietary information disclosed by the Disclosing Party to the Receiving Party in the course of performing this Agreement, including, but not limited to, any of the terms of this Agreement and any other agreements or contracts between the Parties, any trade secret, patient information (including medical and financial records), process, technique, algorithm, computer program (source and object code), design, drawing, formula, test data, know-how, other works of authorship, unpublished financial information, strategy, business plans or similar information relating to any research project, work in process, future development, engineering, manufacturing, marketing, servicing, financing or personnel matter relating to the Disclosing Party, its present or future products, sales, suppliers, clients, customers, employees, investors or business, whether in oral, written, graphic or electronic form. Although certain Confidential Information will be labeled "Confidential" or "Proprietary" (or similar wording), or identified orally as such, Confidential Information shall include information that the Receiving Party should otherwise reasonably construe as confidential or proprietary under the circumstances.

1.3. "Consumer Price Index" or "CPI" means the consumer price index for Medical Care Services published by the Bureau of Labor Statistics of the U.S. Department of Labor.

1.4. "CPI Adjustment" means all fees, including case rates, which are adjusted based on the CPI for Medical Care Services. The resultant adjusted fees are rounded to the nearest full dollar.

1.5. "Effective Date" means the date of the later signature of the Parties to this Agreement, as identified below.

1.6. "EHR Physicians" means the Institute for Physician Advisor Certification (IPAC™)-certified physicians who provide EHR Services on behalf of EHR.

1.7. "EHR Services" means those services specified in **Exhibit A.**

1.8. "Exhibits" are as follows and are herein incorporated by reference into this Agreement:

Exhibit A – Service Definitions
Exhibit B – Service Pricing, Case Rate(s) and Notes
Exhibit C – EHR Terms and Conditions
Exhibit D – Business Associate Agreement

1.9. "Go Live Date" means the earlier of: (i) the date on which a Hospital refers its first case to EHR that has been denied by a payer; or (ii) the ninetieth (90th) day after the Hospital Addendum Effective Date. The Go Live Date may be different for each Hospital.

1.10. "Hospital Addendum" means an addendum to the Agreement that adds one (1) Hospital of the Customer to the Agreement, binds that Hospital(s) to the terms of this Agreement, defines the EHR Services to be provided to such Hospital(s), and sets forth the other terms and conditions of the Addendum including but not limited to the term and termination of the Addendum.

1.11. "Term" means the period of time this Agreement is in effect. The Term of this Agreement shall commence and be effective as of the Hospital Addendum Effective Date for the first Hospital Addendum to this Agreement and shall remain in effect for so long as at least one (1) Hospital Addendum remains in effect.

2. **EHR Services.** During the Term, EHR shall provide to each of the Hospital(s) those EHR Services specifically indicated by check (√) marks on Table 1 of the Hospital Addendum for such Hospital(s) in accordance with the terms and conditions identified in this Agreement and any Addenda.

3. **Duties and Obligations of the Customer.**

3.1. **Provision of Assistance.** Customer acknowledges and agrees that EHR may request that Customer develop or provide documentation, materials, and assistance to EHR in connection with the provision of the EHR Services, and Customer agrees to do so in a timely manner.

3.2. **Customer Notification.** Customer agrees to notify EHR within fifteen (15) days after receipt of notification of an investigation by government agency or contractor, where the subject of the investigation includes cases reviewed or appealed by EHR on behalf of the Customer.

3.3. **Business Associate Agreement.** Customer and EHR agree to execute a Business Associate Agreement in the form attached hereto as **Exhibit D,** or a form substantially similar thereto. Any Business Associate Agreement previously executed by the Parties shall be incorporated herein by reference, unless otherwise superseded upon mutual written agreement of the Parties.

4. **Fees.** Customer shall pay to EHR all fees for the contracted EHR Services identified in each Hospital Addendum, as specified in **Exhibit B.** The first CPI Adjustment will take place at the end of the Initial Term for the first Hospital Addendum and then at the end of each respective Renewal Term.

5. **General Provisions.**

5.1. **Representations.** Each Party represents and warrants to the other that (i) it has the full corporate right and power to enter into and fully perform the obligations it has undertaken in this Agreement; (ii) it is not under any obligations, contractual or otherwise, to any other entity that might conflict, interfere, or be

inconsistent with any of the provisions of this Agreement; and (iii) it shall comply in all material respects with all applicable laws, rules and regulations necessary for it to perform its obligations under this Agreement.

5.2. **Entire Agreement**. Except as otherwise specifically provided for herein, this Agreement, including the Exhibits and Addenda attached hereto and the documents executed in connection therewith, set forth the entire understanding and agreement of the Parties relating to the subject matter hereof. This Agreement supersedes all prior agreements relating to the subject matter hereof.

5.3. **Modification**. This Agreement may be amended, modified, superseded, canceled, renewed or extended only by a written instrument executed by both Parties.

5.4. **Assignment**. Except as provided below, neither Party may assign (by operation of law or otherwise) this Agreement (or any of its rights and obligations under this Agreement) without the prior written consent of the other Party. Notwithstanding the foregoing, either Party may assign this Agreement (together with all of its rights and obligations relating to this Agreement and the subject matter of this Agreement) without the consent of the other Party (a) to any of its Affiliates or (b) to a third party in connection with a merger, reorganization, or sale or other transfer of all or substantially all of the assets of the business or operating unit related to the subject of this Agreement. Subject to the foregoing, this Agreement shall be binding upon and shall inure to the benefit of the Parties and their respective successors and permitted assigns.

5.5. **Governing Law**. The laws of the State of New York, excluding that body of law known as conflicts law, will govern all disputes arising out of or relating to this Agreement. With respect to any dispute or litigation arising out of or relating to this Agreement as to which arbitration is not required pursuant to this Agreement: (a) the Parties agree that it shall be filed in and be heard exclusively by the state or federal courts with jurisdiction to hear such disputes in Westchester County, New York; and (b) the Parties hereby submit to the personal jurisdiction of such courts.

5.6. **Waiver of Breach**. The waiver by either Party hereto of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof, and no waiver shall be effective unless made in writing and signed by an authorized representative of the waiving Party.

5.7. **Access to Records**. In accordance with Medicare requirements under section 952 of the Omnibus Reconciliation Act of 1980 (P.O. 96-499) and such regulations related thereto as may be promulgated by the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), EHR shall, while this Agreement is in effect and until the expiration of four (4) years after furnishing any EHR Services hereunder, make available, upon written request to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records of EHR that are necessary to certify the nature and extent of the costs incurred by Customer with respect to the EHR Services furnished by EHR hereunder. EHR shall notify Customer immediately of any request for records encompassed by this Section.

5.8. **Relationship of the Parties**. EHR acknowledges and agrees that (a) its relationship to Customer is strictly and solely that of an independent contractor, and that neither EHR nor any of its Affiliates, employees, contractors, agents or other representatives is or will be construed as an employee of Customer or otherwise entitled to any employment benefits provided by Customer, including any unemployment or disability benefits; and (b) it is solely responsible for determining the method and means by which it will accomplish the EHR Services and otherwise fulfill its obligations hereunder. Nothing contained herein shall be construed to create an agency, partnership or joint venture between the Parties.

5.9. **Force Majeure**. Except with respect to the payment of fees and expenses hereunder, neither Party shall be responsible for any failure to perform any obligations under this Agreement due to unforeseen circumstances or to causes beyond the Party's reasonable control, including, but not limited to, acts of God, change of law, war, terrorism, riot, embargoes, acts of civil or military authorities, fire, floods, accidents, strikes, third party non-performance, failure to obtain export licenses or shortages of transportation, facilities, fuel

energy, labor or materials and any other cause whatsoever, which is unavoidable or beyond such Party's reasonable control.

5.10. **No Third Party Beneficiaries**. This Agreement is for the sole and exclusive benefit of EHR and Customer and their respective successors and permitted assigns in accordance with section 5.4 above. It shall not be deemed to be for the direct or indirect benefit of any patient or customer of the Customer, and no patient or customer of the Customer shall be deemed to be a third party beneficiary of this Agreement or to have any other contractual relationship with EHR by reason of this Agreement.

5.11. **Severability**. If any provision, clause or condition of this Agreement is held by any court of competent jurisdiction or by an arbitrator to be void, invalid, inoperative or otherwise unenforceable, such defect shall not affect any other provision, clause or condition, and the remainder of this Agreement shall be effective as though such defective provision, clause or condition had not been a part of this Agreement.

5.12. **Notices**. All notices and other communications required or permitted to be given hereunder shall be given in writing and shall be delivered personally, mailed by U.S. registered or certified mail, postage prepaid, return receipt requested, or sent by nationally recognized overnight courier service, addressed to either Party at its then principal place of business. Notice shall be deemed to have been duly given on the date of delivery (if delivered personally or by nationally recognized overnight courier service) to the Party whom notice is to be given or as of the date indicated on the return receipt if delivered by U.S. registered or certified mail (or, if such notice is refused, on the date when delivery of such notice is first refused). All notices will be sent to the following addresses:

If to EHR:
Executive Health Resources, Inc.
Attn: President & CEO
15 Campus Blvd, Suite 200
Newtown Square, PA 19073

If to Customer:
Sound Shore Health System, Inc.
Attn:
16 Guion Place
New Rochelle, NY 10801

5.13. **Headings and Counterparts**. The headings of sections and paragraphs herein are included for convenience of reference only and shall not control the meaning or interpretation of any of the provisions of this Agreement. This Agreement may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which, when taken together, shall be deemed to constitute but one and the same agreement.

5.14. **Surviving Sections**. Whenever the context requires, any commitment or obligation provided for in this Agreement shall survive termination or expiration hereof.

5.15. **Hospital Addendums**. Customer and EHR agree that Hospitals owned by or otherwise affiliated with Customer may join in this Agreement by Hospital Addendum.

5.16. **Execution of Agreement**. To be effective, this Agreement must be executed by Customer and received by EHR no later than April 30, 2013.

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IN WITNESS WHEREOF, each Party has executed this Agreement as of the date set forth below such Party's name.

EXECUTIVE HEALTH RESOURCES, INC.

By: Kirk Schultz
Kirk Schultz (May 7, 2013)

Name: Kirk Schultz

Title: Chief Administrative Officer

Date: April 29,2013

SOUND SHORE HEALTH SYSTEM, INC.

By: JPManangakis

Name: John P Manangakis

Title: Sr Vice President

Date: April 29, 2013

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EXHIBIT A

SERVICE DEFINITIONS

The following Service Definitions apply to the EHR Services:

I. Services Relevant to Commercial Payers.

a. **Managed Medicare Admission Review (with or without Delegated UR) - Concurrent.** EHR will review Managed Medicare admissions to make recommendations with respect to claims status (inpatient, observation/outpatient, etc.) on cases that do not meet initial case management admission screening criteria (such as InterQual® or Milliman®). EHR Physicians work with case management and the attending physicians, when appropriate, to perform medical necessity review concurrently at time of admission or retrospectively (up to forty-eight (48) hours post discharge) based on medical judgment and clinical evidence (consistent with local and/or national standards of care). EHR will issue a recommendation regarding the appropriate level of medical care and provide individualized case documentation. It is Customer/Hospital's responsibility to identify those Managed Medicare payer contracts for which pro-active admission review is appropriate. This review does not apply to admissions that have already been denied or downgraded. Appeal Support identified in section X(b) applies to these case reviews.

b. **Commercial Admission Review (with or without delegated UR) – Concurrent.** EHR will review Managed Medicaid and/or commercial admissions to make recommendations with respect to claims status (inpatient, observation/outpatient, etc.) on cases that do not meet initial case management admission screening criteria (such as InterQual® or Milliman®). EHR Physicians work with case management and the attending physicians, when appropriate, to perform medical necessity review concurrently at time of admission or retrospectively (up to forty-eight (48) hours post discharge) based on medical judgment and clinical evidence (consistent with local and/or national standards of care). EHR will issue a recommendation regarding the appropriate level of medical care and provide individualized case documentation. It is Customer/Hospital's responsibility to identify the applicable Managed Medicaid and commercial payer contracts for which pro-active admission review is appropriate. This review does not apply to admissions that have already been denied or downgraded. Appeal Support identified in sections X(a) and X(c), applies to these case reviews.

c. **Length of Stay Management - Concurrent.** EHR will perform a focused telephonic review process in which key diagnoses or physician cases are reviewed while the patient is admitted to the hospital. EHR will make recommendations with respect to a discharge plan and will work with case management and the medical staff to facilitate timely discharge planning and process. In addition, if a focused review is not requested, EHR will, when requested by the Customer/Hospital, on an as needed basis, communicate with the medical staff, provide management support, and facilitate discharge planning. EHR's review will focus on timely and efficient utilization of hospital resources, and on ensuring a smooth transition from inpatient to alternative level of care settings.

The EHR Services described in sections I(a) and (b) also apply to Post-Discharge case reviews.

II. Services Relevant to Medicare.

a. **Medicare Admission Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending physicians to review Medicare admissions and apply medical necessity definitions, medical judgment, and CMS regulations to make recommendations on claim status for those cases that do not meet initial case management admission screening criteria (such as InterQual® or Milliman®). EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will review all such cases (while the patient is in the hospital), and make a recommendation regarding admission status, and provide individualized case documentation. This process will be carried out in accordance with the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 CFR 482.30). Appeal Support identified in section X(b) applies to these case reviews.

b. **Medicare Continued Stay Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending and consulting physicians, to review ongoing Medicare inpatient hospital stays and apply medical necessity definitions, medical judgment, and CMS regulations to recommend and document medical necessity appropriateness for continued inpatient hospital stay on cases that do not meet case management medical necessity screening criteria (such as InterQual® or Milliman®). EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will issue a utilization review recommendations regarding continued stay, and provide individualized case documentation. The purpose of this review is for the Hospital to be in compliance with the facility's Utilization Management Plan as mandated in Medicare Conditions of Participation (42 CFR 482.30)

c. **Medicare Readmission Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending and consulting physicians, to review the medical necessity of an admission in which a patient has been recently discharged. EHR will review the case to recommend if the second admission is related to the first admission, whether the care provided on the second admission could have or should have been provided during the first admission. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will issue a utilization review recommendation regarding readmission, and provide individualized case documentation. Appeal Support identified in section X(b) applies to these case reviews.

d. **Medicare Other Procedural Setting Review and Compliance - Concurrent.** EHR Physicians work with case management, the admission department, the business office and the attending and consulting physicians, to review surgical cases to recommend the

appropriate level of care. These surgical cases can be reviewed pre-operatively to recommend whether the procedure has been registered in the correct status (for example, whether a procedure is listed as "inpatient only" by Medicare) or post operatively to recommend the appropriate level of medical care. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will provide written documentation of the EHR Physicians recommendation and the clinical and regulatory rationale supporting the decision.

e. **MRI Inpatient Utilization Review - Concurrent.** EHR Physicians will perform a concurrent focused review of the site appropriateness of an ordered inpatient MRI based on criteria developed with the Hospital. Screening occurs prior to scheduling of the test. If the MRI does not meet the established screening criteria and appears to be inappropriate for the inpatient setting, case management notifies EHR. After review with the Hospital's case management department, and gathering additional clinical and treatment information from the attending and consulting physicians (when applicable), the EHR Physician recommends the site appropriateness of the inpatient MRI, determining whether the study is appropriate and medically necessary to be done in the inpatient setting or whether it is more appropriate for it to be performed post discharge in an outpatient setting. Once the utilization recommendation has been made, an outcome recommendation letter is sent to the Hospital, and the case manager is contacted with the outcome.

f. **Bed Management / Transfer Center Management - Concurrent.** EHR Physicians work with case management to screen all transfers into the Customer/Hospital by applying medical necessity criteria or physician judgment as appropriate. EHR Physicians then work with the transferring and attending physician to ensure appropriateness of transfers.

The EHR Services described in sections II(a) through (f) also apply to Post-Discharge case reviews.

III. Services Relevant to Medicaid.

a. **Medicaid Admission Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending physicians to review Medicaid admissions and apply medical necessity definitions, medical judgment, and state and federal Medicaid regulations to recommend and document Medicaid admission claim status on cases that do not meet initial case management admission screening using admission criteria (such as InterQual® or Milliman®). EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will review all such cases (while patient is still in the hospital), issue a final utilization review recommendation regarding admission status, and provide individualized case documentation. Appeal Support identified in section X(c) applies to these case reviews.

b. **Medicaid Continued Stay Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending and consulting physicians, to review ongoing Medicaid inpatient hospital stays and apply medical necessity definitions, medical judgment, and Medicaid regulations to recommend and document medical necessity appropriateness for continued inpatient hospital stay on cases that do not meet case management medical necessity screening criteria (such as InterQual® or Milliman®). EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will issue a utilization review recommendation regarding continued stay, and provide individualized case documentation. The purpose for this review is for Hospital to be in compliance with the facility's Utilization Management Plan.

c. **Medicaid Readmission Review and Compliance - Concurrent.** EHR Physicians work with case management and the attending and consulting physicians, to review the medical necessity of an admission in which a patient had been recently discharged. EHR will review the case to recommend if the second admission is related to the first admission, whether the care provided on the second admission could have or should have been provided during the first admission. Using this information and state Medicaid rules and regulations, EHR will review the medical relatedness of the readmission. EHR will issue a utilization review recommendation regarding readmission, and provide individualized case documentation. (Note: for certain States, readmission timelines are strictly defined according to Medicaid billing rules and not medical necessity requirements, and thus would not provide an opportunity for EHR to review and/or intervene). Appeal Support identified in section X(c) applies to these case reviews.

d. **Medicaid Other Procedural Setting Review and Compliance - Concurrent.** EHR Physicians work with case management, the admission department, the business office and the attending and consulting physicians, to review Medicaid surgical cases to recommend the appropriate level of care. These surgical cases can be reviewed pre-operatively to recommend whether the procedure has been registered in the correct status or post operatively to recommend the appropriate level of care. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will provide written documentation of the EHR Physicians recommendation and the clinical and regulatory rationale supporting the decision.

Except where precluded by state or federal law or regulation, the EHR Services defined in sections III(a) through (d) also apply to Post-Discharge case reviews.

IV. Specialty Case Reviews (All payers, unless otherwise noted).

a. **Cardiology Procedure Review - Concurrent Post Procedure Review.** EHR will review Interventional Cardiac Procedures including Implantable Defibrillators (ICDs), Pacemakers, Angioplasties, Stents, Brachytherapy, Atherectomy, and Ablations to recommend the appropriate level of medical care based on medical necessity. This applies to elective procedures and those performed in conjunction with a medical admission. Determining the medical necessity of Interventional Cardiac Procedures involves complex clinical and regulatory evaluation by specially trained EHR Physicians. During implementation, EHR will work with the Hospital to establish an initial

screening process to be performed by Hospital staff to recommend which cases should be reviewed by EHR Physicians. After an Interventional Cardiac Procedure is performed, EHR will review the case to recommend the appropriate level of medical care based on medical necessity. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR Physicians will work closely with the attending physician, cardiologist, anesthesiologist, and other consulting physicians, when appropriate, to understand the medical necessity and ensure appropriate documentation for the level of medical care provided. EHR will provide written documentation of the EHR Physicians recommendation and the clinical and regulatory rationale supporting the decision. Appeal Support identified in section X(a-c) applies to these case reviews.

b. **Vascular Procedure Review - Concurrent Post Procedure Review.** EHR will review Vascular Procedures, including Carotid procedures, Cerebrovascular procedures, Renovascular procedures, and Upper and Lower extremity vascular procedures, to recommend the appropriate inpatient/outpatient level of care based on medical necessity. This applies to elective procedures and those performed in conjunction with a medical admission. Determining the medical necessity of Vascular Procedures involves complex clinical and regulatory evaluation by specially trained EHR Physicians. During implementation, EHR will work with the Hospital to establish an initial screening process to be performed by Hospital staff to recommend which cases should be reviewed by EHR Physicians. After a Vascular Procedure is performed, EHR will review the case to recommend the appropriate level of medical care based on medical necessity. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR Physicians will work closely with the attending physician, anesthesiologist, and other consulting physicians to understand the medical necessity. EHR will provide written documentation of the EHR Physicians recommendation and the clinical and regulatory rationale supporting the decision. Appeal Support identified in section X(a-c) applies to these case reviews.

c. **Kyphoplasty / Vertebroplasty Procedure Setting Review.** EHR will review Kyphoplasty and Vertebroplasty procedures to make recommendations on the appropriate level of care based on medical necessity. This applies to elective procedures and those performed in conjunction with a medical admission. These procedures are not on the CMS "inpatient only" list and are no longer on the "inpatient only" procedure list of the leading inpatient screening criteria. Thus, determining the medical necessity of Kyphoplasty and Vertebroplasty procedures requires a case-by-case review, including complex clinical and regulatory evaluation by specially trained EHR Physicians. During implementation, EHR will work with the Hospital to establish an initial screening process to be performed by Hospital staff to recommend which cases should be reviewed by EHR. After Kyphoplasty or Vertebroplasty procedure is performed, EHR will review the case and make recommendations as to the appropriate level of medical care based on medical necessity (while the patient is still in the hospital). EHR Physicians will work closely with the attending physician, orthopedic surgeon, interventional radiologist, anesthesiologist, and other consulting physicians, when appropriate, to understand the medical necessity. EHR will apply the rules and regulations, as promulgated by appropriate government agencies and non-government organizations along with its proprietary clinical risk assessment methodologies, based on published evidence-based standards and EHR's collective physician experience, to the facts of each case. EHR will provide written documentation of the EHR Physicians' recommendation and the clinical and regulatory rationale supporting the decision. Appeal Support identified in section X(a-c) applies to these case reviews.

d. **Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent.** EHR will review Medicare Inpatient Rehabilitation post-admission cases for patients who have completed a multidisciplinary evaluation and for whom an individualized plan of care has been created, generally on day 4 of the stay. EHR will review the medical records, consult with case management and attending physicians, to the extent available, and make recommendations regarding (a) whether the inpatient admission was reasonable and appropriate, and therefore medically necessary; (b) whether the continued provision of intensive inpatient rehabilitation services is reasonable and appropriate according to the initial plan of care, and therefore medically necessary; and (c) whether the patient information provided to EHR supports (i) the inpatient rehabilitation admission, and (ii) the continued provision of inpatient rehabilitation services as of the initial plan of care. Excluded from this review is the timeliness of documentation, documentation of services rendered, and administrative recordkeeping. Customer shall provide EHR with the following information from the medical record: the pre-admission screening, the post-admission physician evaluation, and the overall plan of care. EHR's review process will be carried out in accordance with the Medicare Benefit Policy Manual, Chapter 1, section 110 and the requirements for utilization review as set forth by the Medicare Conditions of Participation (42 CFR 482.30). Appeal Support identified in section X(b) applies to these case reviews.

e. **LTAC (Long Term Acute Care) Reimbursement Denials Review and Appeal - Retrospective.** Retrospective Reimbursement Denials Review and Appeal is conducted after the Customer/Hospital has received a formal letter notifying the Hospital that a claim has been downgraded or denied for a former inpatient and the case in question has been determined by the Customer/Hospital and EHR to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by the Customer/Hospital to EHR. EHR's specially trained physician advisors will conduct a retrospective reimbursement denials review, which will, when deemed appropriate, result in a formal appeal letter prepared by EHR on behalf of the Customer/Hospital to the appropriate payer. Copies of all retrospective reimbursement denials review appeal letters will be provided to the Customer/Hospital.

The EHR Services described in sections IV(a) through (c), also apply to Post-Discharge case reviews.

V. Denials Review and Appeals (Medical Necessity and Coding). Any Hospital under this Agreement, selecting one (1) or more denials in subsections (a) or (b), must choose, on its applicable Hospital Addendum, one (1) of the five (5) options provided in subsection (c) below regarding Outcomes.

a. **Government Denials.**

1. **Redetermination & Reconsideration Levels (For Medicaid: Peer-to-Peer Review or Formal Written Appeals Level) – Medical Necessity Denial.** Upon designation as the Customer's appointed representative, EHR will work with the

Customer's case management staff and attending and consulting physicians, to review and appeal cases in which Medicare and Medicaid agents (such as Quality Improvement Organizations ("QIOs"), Fiscal Intermediaries ("FIs"), Medicare Administrative Contractors ("MACs"), Medicaid Integrity Contractors ("MICs") and Recovery Audit Contractors ("RACs")) have issued denials of payment. EHR will pursue the appeal on behalf of the Customer, provided however, that EHR shall have no obligation to appeal any case where EHR made a recommended medical necessity determination with respect to such case that was not adopted by the Customer. The scope of the services hereunder are limited to those appeals up to but excluding appeals at the ALJ level, and does not include litigation support or expert witness services.EHR requires an AOR (Appointment of Representation) Form to be completed by the Customer/Hospital to enable EHR to file appeals on Customer/Hospital's behalf.

2. **Redetermination & Reconsideration Levels (For Medicaid: Peer-to-Peer Review or Formal Written Appeals Level) – Coding Denial.** Upon designation as the Customer's appointed representative, EHR will work with the Customer's case management staff and attending and consulting physicians, to review and appeal cases in which Medicare and Medicaid agents (such as Quality Improvement Organizations ("QIOs"), Fiscal Intermediaries ("FIs"), Medicare Administrative Contractors ("MACs"), Medicaid Integrity Contractors ("MICs") and Recovery Audit Contractors ("RACs")) have issued denials of payment for coding reasons. EHR will pursue the appeal on behalf of the Customer, provided however, that EHR shall have no obligation to appeal any case where EHR made a recommended medical necessity determination with respect to such case that was not adopted by the Customer. The scope of the services hereunder are limited to those appeals up to but excluding appeals at the ALJ level, and does not include litigation support or expert witness services.EHR requires an AOR (Appointment of Representation) Form to be completed by the Customer/Hospital to enable EHR to file appeals on Customer/Hospital's behalf.

3. **ALJ Level (For Medicaid: Hearing Level - different names apply to different States).** EHR will review all cases, denied at the Reconsideration Level with the Customer/Hospital to recommend if any particular case should be appealed to the Administrative Law Judge ("ALJ"). This service includes the creation and submission of a written memorandum (supporting written argument) to the ALJ and the presence of an EHR Physician on the ALJ phone call, if applicable, for the purposes of presenting the case per the written memorandum. Customer/Hospital is not required to appear at the ALJ hearing. Additionally, Customer/Hospital is not required to engage counsel for the cases referred to EHR that requires an appeal at this level, except as required by state law for Medicaid. For Medicaid cases requiring counsel, an EHR Physician will be available to provide testimony by phone if requested. Each case appealed at this level is considered a new/additional case. This service only includes appeal(s) at the ALJ Level. Hearing expenses may apply.

4. **Departmental Appeals Board Level (For Medicaid: Different names apply to different States).** EHR will review all cases, denied at the ALJ Level with the Customer/Hospital to recommend if any particular case should be taken to the Departmental Appeals Board ("DAB") Level. This service includes the creation and submission of a written memorandum (supporting written argument) to the DAB and the presence of an EHR Physician and/or EHR Physician Attorney at the DAB hearing, if applicable, for the purposes of presenting the case per the written memorandum (supporting written argument). Each case appealed at this level is considered a new/additional case. This service only includes appeal(s) at the DAB Level. Hearing expenses may apply.

b. **Commercial Appeals.**

1. **Concurrent Reimbursement Medical Necessity Denials Review and Appeals.** Concurrent Reimbursement Denials Review and Appeals is conducted when payer claim status for inpatient services or admission has been downgraded or denied and the patient is an inpatient at the time or has been recently discharged (concurrent reimbursement denial or downgrade). A denial or downgrade is defined as denied if payer-approved reimbursement is anything less than 100% of what would be the expected reimbursement if the admission was reimbursed entirely at an acute inpatient level of care or higher (i.e. ICU level of care). EHR will review concurrent reimbursement denials and downgrades with the Customer/Hospital's case management department and/or medical leadership, and EHR will recommend which concurrent reimbursement denials/downgrades are appropriate for appeal. EHR will perform telephonic appeals with appropriate representatives of the relevant payer, and communicate the results to the appropriate Customer/Hospital personnel.

2. **Retrospective Reimbursement Medical Necessity Denials Review and Appeals.** Retrospective Reimbursement Denials Review and Appeals is conducted after the Customer/Hospital has received an explanation of benefits or received a formal letter notifying the Hospital that a claim has been downgraded or denied based on medical necessity for a former inpatient and the case in question has been determined by the Customer/Hospital and EHR to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by the Customer/Hospital to EHR. EHR's specially trained physician advisors will conduct a retrospective reimbursement medical necessity denials review, which will, when deemed appropriate, result in a formal appeal letter prepared by EHR on behalf of the Customer/Hospital to the appropriate payer; provided however, that EHR shall have no obligation to appeal any case where EHR made a recommended medical necessity determination with respect to such case that was not adopted by the Customer. Copies of all retrospective reimbursement denials review appeal letters will be provided to the Customer/Hospital.

3. **Retrospective Reimbursement Coding Denials Review and Appeals.** Retrospective Reimbursement Denials Review and Appeals is conducted after the Customer/Hospital has received an explanation of benefits or received a formal letter notifying the Hospital that a claim has been downgraded or denied based on a coding issue for a former inpatient and the case in question has been determined by the Customer/Hospital and EHR to be appropriate for retrospective reimbursement review and appeal. The relevant chart(s) containing the patient record of an inpatient admission that has been retrospectively denied or downgraded by the payer will be sent by the Customer/Hospital to EHR. EHR's certified coders

will conduct a retrospective reimbursement coding denials review (with input from specially trained physician advisors as needed), which will, when deemed appropriate, result in a formal appeal letter prepared by EHR on behalf of the Customer/Hospital to the appropriate payer; provided however, that EHR shall have no obligation to appeal any case where EHR made a recommended medical necessity determination with respect to such case that was not adopted by the Customer. Copies of all retrospective reimbursement denials review appeal letters will be provided to the Customer/Hospital.

4. **Commercial and Managed Medicare External Hearings.** EHR will review all cases, denied at the initial payer levels of appeal with the Customer/Hospital, to recommend if any particular case should be appealed to the External Hearing Entity ("EHE") (i.e., ALJ, Independent Review Organization ("IRO"), etc.). This service may include the creation and submission of a written memorandum (supporting written argument) to the EHE and/or the presence of an EHR Physician on the EHE phone call for the purposes of presenting the case per the written memorandum. Customer/Hospital is not required to appear at the EHE hearing. Additionally, Customer/Hospital is not required to engage counsel for the cases referred to EHR that requires an appeal at this level, except as required by law. Each case appealed at this level is considered a new/additional case. This service only includes appeal(s) at the EHE Level. Hearing expenses and filing fees may apply and shall be the responsibility of Customer.

5. **Departmental Appeals Board Level.** EHR will review all cases, denied at the ALJ/EHE Level with the Customer/ Hospital to recommend if any particular case should be taken to the Departmental Appeals Board ("DAB") Level. This service includes the creation and submission of a written memorandum (supporting written argument) to the DAB and the presence of an EHR Physician and/or EHR Physician Attorney at the DAB hearing, if applicable, for the purposes of presenting the case per the written memorandum (supporting written argument). Each case appealed at this level is considered a new/additional case. This service only includes appeal(s) at the DAB Level. Hearing expenses may apply.

c. **Outcomes.** Customer shall provide EHR with appeal outcome information for valuation purposes (frequency upon mutual agreement) utilizing one of the options below, as selected by the Hospital on its applicable Hospital Addendum. If Customer fails to select an option below, Option 5 shall apply.

<table>
<tr><td>Option 1</td><td>Provide EHR personnel with remote access to Customer's patient financial system to look up collection values of denied/appealed cases. [Frequency: as needed]</td></tr>
<tr><td>Option 2</td><td>Provide EHR with a Customer employee contact to look up collection values of denied/appealed cases (list to be supplied by EHR) on a periodic basis. [Frequency: weekly or monthly]</td></tr>
<tr><td>Option 3</td><td>Intentionally deleted.</td></tr>
<tr><td>Option 4</td><td>EHR and Customer mutually agree in writing to dollar values for quantifying denial appeal results (e.g. $X for an acute stay, $Y for an Observation stay, etc.).</td></tr>
<tr><td>Option 5</td><td>Customer agrees to adopt EHR's standard dollar values, as amended, for quantifying denial appeal results (see table below).
<table>
<tr><th>LEVEL OF CARE</th><th>RATE</th></tr>
<tr><td>DRG Case Rate</td><td>$6,500</td></tr>
<tr><td>ICU</td><td>$2,800</td></tr>
<tr><td>TELEMETRY</td><td>$2,350</td></tr>
<tr><td>MEDICAL/SURGICAL</td><td>$1,900.00</td></tr>
<tr><td>SUBACUTE</td><td>$1,000.00</td></tr>
<tr><td>SKILLED</td><td>$750.00</td></tr>
<tr><td>OBSERVATION</td><td>$450.00</td></tr>
</table></td></tr>
</table>

d. **Litigation Support or Expert Witness at Judicial Review in US District Court.** EHR can support the Customer/Hospital in litigation matters; however, this service is contracted and priced separately.

e. **Document Retrieval Services.** EHR will work with the Customer/Hospital to retrieve necessary and available documentation required for EHR to appeal Customer/Hospital's cases. EHR will directly retrieve said appeal documentation, including not less than the entire patient medical record as one electronic file to be used for the appeal, from Customer/Hospital's information system through remote-access log-in capabilities. This includes remote log-in to one (1) information system for each Hospital. Customer/Hospital agrees to provide EHR with access to the system, to notify EHR that document(s) need to be retrieved, and to support EHR operational requirements to ensure the success of the appeal process. EHR shall provide to Customer/Hospital with a weekly log of all open cases received by EHR either via eConnect Portal or report. Customer/Hospital also agrees to verify this log to ensure that EHR has received all cases sent/submitted by Customer/Hospital and to immediately alert EHR of any missing appeals. These services are being provided by EHR solely for the convenience of Customer/Hospital. Accordingly, EHR disclaims any and all liability associated with EHR's failure to obtain any appeal documentation directly from Customer/Hospital's information system and Customer/Hospital acknowledges and accepts such disclaimer upon selection of this service.

VI. RAC Data Tracking Service.

a. **RAC Data Tracking Service - Data Entry.** EHR will work with the Customer/Hospital to data enter the status and update of status of each RAC appeal in the Customer/Hospital's information system through remote log-in capabilities. This includes remote log-in to one information system for each Hospital.

b. **RAC Data Tracking Service - EHR Standard Reports.** EHR will provide to the Customer/Hospital EHR standard reports that include the data and information needed for tracking the status of RAC appeals. The standard reports are provided on a monthly basis.

c. **RAC Data Tracking Service - File Updates Through "EHR Integrated" technology vendors.** EHR has established relationships with various providers of RAC Tracking Software and has certified these vendors as "EHR Integrated" if they were able to meet minimum data exchange requirements. This service enables EHR and the Customer/Hospital to exchange data about RAC appeals seamlessly. If the Customer/Hospital chooses to work with an EHR Integrated technology vendor, the need for data entry (section VI(a)) should be eliminated. The list of EHR RAC Integrated technology vendors is available upon request.

VII. Analysis and Review Services.

a. **Conditions of Participation: Quarterly Review of Services.** On a quarterly basis, EHR and Hospital will mutually agree upon the types of Medicare cases that will be reviewed by EHR. The volume of cases to be reviewed will be selected by Customer. The charts will be submitted to EHR's Advisory Services department in accordance with EHR's standard chart submission requirements, which shall be provided to Customer during implementation. Upon conclusion of the quarterly review, Customer/Hospital will be provided a written report for each case reviewed, outlining the compliance findings and issues associated with the case. Depending on the type of review that is being undertaken, the findings could reflect an admission status recommendation, a ranking (1-4) on defensibility of the case, or documentation guidance. EHR will conduct quarterly telephonic meetings with the Customer's designated UM/UR committee members to discuss the results. EHR recommends an 8-10 case review ("Quarterly Tier 1") for hospitals under 150 beds; a 12-15 case review ("Quarterly Tier 2") for hospitals between 150 and 300 beds; and a 17-20 case review ("Quarterly Tier 3") for hospitals over 300 beds. Additional cases may be reviewed at current pricing tier. These cases shall not count towards Customer/Hospitals' case minimums under this Agreement.

b. **Compliance Integrity Benchmarking and Analytics.** Customer/Hospital will periodically send billing and case management data to EHR for on-going compliance monitoring. EHR will provide Customer/Hospital with compliance performance reviews and/or benchmarking analysis. Our compliance monitoring will assist participating hospitals in the following three core areas: (i) first level screening – are all Medicare admissions screened and documented; (ii) second level status – are all failed first level screens being reviewed by a physician; and (iii) billing status – does the bill accurately reflect the decisions made at the first and second level review. As part of this service, EHR will perform statistical analysis of billing, remittance advice, and screening criteria results data that has been aggregated across participating EHR customers in order to facilitate a comparison of experience among hospitals ("Benchmarks"). EHR agrees to not charge Customer for its standard analysis performed as a part of EHR's Compliance Integrity Program. EHR will not disclose Customer/Hospital's data, individual performance measures, or Customer/Hospital's identity (name, location, etc) when Customer/Hospital's information is aggregated as part of a Benchmark statistic. Customer may request that EHR perform analysis that is unique to the Customer or outside EHR's standard scope of services. If the Customer requests such an analysis, EHR retains the right to decline the request or charge an agreed upon fee for the work, as proposed by EHR and accepted by Customer in writing.

VIII. Implementation Services.

a. **Initial Implementation.** EHR will work with designated Customer/Hospital staff to ensure adequate and appropriate implementation of the EHR Services. This will include the collection and transfer of appropriate information between the Customer/Hospital and EHR, initial case management and physician education, meeting with appropriate members of the Customer/Hospital and medical staffs, and introducing the program to designated executives at the Customer/Hospital. Standard implementation typically includes an EHR Implementation Director on-site at the Customer/Hospital for one (1) to two (2) days as well as remote coordination, data management, and set-up. This also includes one (1) dedicated calendar day of medical staff and executive staff education by a Senior EHR Physician Advisor. An implementation fee shall be applied for each Customer/Hospital implemented.

b. **Implementation - Additional Services After Initial Implementation.** This applies when (1) Customer/Hospital purchases additional services after the Customer/Hospital has already been implemented or (2) Customer/Hospital has purchased a service but at the Customer/Hospital's request, the service was not implemented at the Initial Implementation. An implementation fee shall be applied for each Customer/Hospital receiving additional services after initial implementation.

c. **Re-Implementation.** This service is the same as the Implementation service described in section VIII(a) above; except this is provided as a refresher to the Customer/Hospital personnel at the request of the Customer/Hospital. An implementation fee shall be applied for each Customer/Hospital re-implemented.

d. **Vendor Registration and Registration Maintenance.** If Customer requires EHR to register through Customer's vendor registration system/vendor, then EHR will charge Customer a registration fee and an annual maintenance fee. Customer, however, agrees that EHR shall not be required to provide EHR's financial or other confidential information or EHR employees' personal information through this registration process.

IX. Other Services. The following additional services are available after the Go Live Date:

a. **Customized Education.**

1. **Customized Case Manager Education.** EHR will, when requested, prepare and provide didactic case management education in the form of lectures, handouts and informal group sessions. The venues and subjects discussed will be at the discretion of the Customer/Hospital and will be determined jointly by EHR and the Customer/Hospital.

2. **Customized Physician Education.** EHR will, when requested, prepare and provide didactic physician education in the form of lectures, handouts, and informal group sessions. The venues and subjects discussed will be at the discretion of the Customer/Hospital and will be determined jointly by EHR and the Customer/Hospital.

3. **Customized Executive Education.** EHR will, when requested, prepare and provide formal didactic education or present summary information to members of the Customer/Hospital's Board of Directors or Executive Team. The content and venue of these presentations will be at the discretion of the Customer/Hospital and the date will be determined jointly by EHR and the Customer/Hospital.

b. **Consultative Services.** Upon request of the Customer/Hospital, EHR will take part in committees, meetings or task forces dealing with particular issues facing the Customer/Hospital. The purpose of EHR's involvement will be to leverage the operational expertise of EHR and the experience of EHR with the Customer/Hospital to contribute to the discussion. EHR will also, when requested, take part in additional projects such as contract negotiation and review, form review, and quality assurance. EHR's initiation of and participation in such projects will be at the discretion of the Customer/Hospital and will be determined jointly by EHR and the Customer/Hospital.

c. **Services Not Included in this Agreement.** The following types of case reviews will require a separate services agreement and are not covered under this Agreement:

1. Case reviews that are to be performed under the attorney-client privilege,
2. Case reviews to support an active investigation by Program Safeguard Contractors ("PSCs"), Zone Program Integrity Contractors ("ZPICs"), the Department of Justice ("DOJ"), Federal Bureau of Investigation ("FBI"), Office of Inspector General ("OIG"), U.S. Attorney's office, including expert witness work,
3. Retrospective Kyphoplasty reviews,
4. Post Discharge Reviews that are outside of the normal rebilling timeframe, and
5. Post Discharge Reviews in which the Customer/Hospital would like a custom summarization of results and review/discussion sessions.

X. Appeals Support.

a. **Appeals Support Related to Commercial Services.** During the Term and for so long as Customer and/or Hospital is contracted for concurrent commercial services, EHR will appeal to the commercial payer, on a concurrent and/or retrospective basis, traditional fee-for-service cases reviewed by EHR pursuant to this Agreement at the Identified Case Levels (as defined below) without additional charge, provided that: (a) EHR performs a standard chart review of such cases, (b) the case is not then currently being reviewed or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) a bill has been submitted prior to the issuance of the denial where the bill status matches EHR's recommended medical necessity determination for such case, (d) a denial contradicting EHR's recommended medical necessity determination is issued on or after the date EHR sends its recommended medical necessity determination letter to Customer/Hospital, and (e) Customer/Hospital provides a copy of EHR's recommended medical necessity determination report with the patient chart to the entity issuing the denial. For purposes of this Agreement, the "Identified Case Levels" means any internal level of appeal offered by the payer. For the avoidance of doubt, EHR is only obligated to pursue the appeals of the Identified Cases under this Section during the Term. This support applies only to select EHR Services defined in sections I and IV of this Exhibit.

b. **Appeals Support Related to Medicare Services.** During the Term and for so long as Customer and/or Hospital is contracted for concurrent Medicare services, EHR will appeal QIO/RAC/FI/MAC medical necessity denials of traditional fee-for-service Medicare cases reviewed by EHR pursuant to this Agreement at the Identified Case Levels (as defined below) without additional charge, provided that: (a) EHR performs a standard chart review of such cases, (b) the case is not then currently being reviewed or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) a bill has been submitted prior to the issuance of the denial where the bill status matches EHR's recommended medical necessity determination for such case, (d) a denial contradicting EHR's recommended medical necessity determination is issued on or after the date EHR sends its recommended medical necessity determination letter to Customer/Hospital, and (e) Customer/Hospital provides a copy of EHR's recommended medical necessity determination report with the patient chart to the entity issuing the denial. For purposes of this Agreement, the "Identified Case Levels" means the following levels: (i) Discussion/Rebuttal (if required), (ii) Redetermination, and (iii) Reconsideration. For the avoidance of doubt, EHR is only obligated to pursue the appeals of the Identified Cases under this Section during the Term. This support applies only to select EHR Services defined in section II and IV of this Exhibit.

c. **Appeals Support Related to Medicaid Services.** During the Term and for so long as Customer and/or Hospital is contracted for concurrent Medicaid services, EHR will appeal medical necessity denials of traditional fee-for-service Medicaid cases reviewed by EHR pursuant to this Agreement at the Identified Case Levels (as defined below) without additional charge, provided that: (a) EHR performs a standard chart review of such cases, (b) the case is not then currently being reviewed or under investigation by CMS, OIG, DOJ or other government entity, or any of their related contractors, (c) a bill has been submitted prior to the issuance of the denial where the bill status matches EHR's recommended medical necessity determination for such case, (d) a denial contradicting EHR's recommended medical necessity determination is issued on or after the date EHR sends its recommended medical necessity determination letter to Customer/Hospital, and (e) Customer/Hospital provides a copy of EHR's recommended medical necessity determination report with the patient chart to the entity issuing the denial. For purposes of this Agreement, the "Identified Case Levels" means any level of appeal prior to the Hearing Level, as identified in section V(c) of this Exhibit. For the avoidance of doubt, EHR is only obligated to pursue the appeals of the Identified Cases under this Section during the Term. This support applies only to select EHR Services defined in section III and IV of this Exhibit.

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EXHIBIT B
SERVICE PRICING, CASE RATE(S) AND NOTES
Table 1 - EHR Services Available to the Customer

Services Included	*Pricing Method*
Commercial Payers:	Case Rate listed in Table 2.
Managed Medicare Admission Review (with or without Delegated UR) - Concurrent	
Commercial Admission Review (with or without delegated UR) – Concurrent	
Length of Stay Management (Concurrent/Post Discharge)	
Medicare (Concurrent/Post Discharge):	
Admission Review and Compliance	
Continued Stay Review and Compliance	
Readmission Review and Compliance	
Other Procedural Setting Review and Compliance	
MRI Inpatient Utilization Review	
Bed Management / Transfer Center Management	
Medicaid (Concurrent/Post Discharge):	
Admission Review and Compliance	
Continued Stay Review and Compliance	
Readmission Review and Compliance	
Other Procedural Setting Review and Compliance	
Specialty Procedural Review (All Payers, Concurrent/Post Discharge):	$325/case
Cardiology Procedure Review – Post Procedure	
Vascular Procedure Review – Post Procedure	
Kyphoplasty / Vertebroplasty Procedure Setting Review	
Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent[9]	
LTAC (Long Term Acute Care) Reimbursement Denials Review and Appeal – Retrospective (All Payers)	$650/case
Denials Review and Appeals (Medical Necessity and/or Coding Denials)	
Government Denials	
Redetermination & Reconsideration Levels – Prior EHR review	No Cost to Customer
Redetermination & Reconsideration Levels – No prior EHR review	Included in the Case Rate[11]
Commercial Denials (Concurrent/Post Discharge/Retrospective[1])	
Prior EHR concurrent review[2]	No Cost to Customer
No prior EHR concurrent review	Included in the Case Rate[11]
Appeal Hearings:	
ALJ (Medicare)/Hearing Level (Medicaid)/External Hearing Entity (Commercial) – Prior EHR Appeal	$450/case[8]
ALJ (Medicare)/Hearing Level (Medicaid)/External Hearing Entity (Commercial) – No Prior EHR Appeal	$700/case[8]
DAB Level	$450/hr[8]
Document Retrieval Services	$25/case[10]
RAC Data Tracking Service:	
Data Entry	$25/case
EHR Standard Reports	No Cost to Customer
File Updates Through EHR Integration Partners	No Cost to Customer
Analysis and Review Services:	
Conditions of Participation: Quarterly Review of Services[3]	$2,500/quarter (Quarterly Tier 1)
(Quarterly Tier 1 = up to 10 cases; Quarterly Tier 2 = up to 15 cases; Quarterly Tier 3 = up to 20 cases)	$3,700/quarter (Quarterly Tier 2)
	$4,900/quarter (Quarterly Tier 3)
Compliance Integrity Benchmarking and Analytics	No Cost to Customer
Implementation and Other Services:	
Initial Implementation	$5,000 per Hospital[12]
Implementation – Additional Products After Initial Implementation or Reimplementation	$2,500 per Hospital
Re-implementation (at mutual agreement - after Go Live Date)	$5,000 per Hospital
Vendor Registration (if required by Customer)	At Cost
Customized Education and Other Services	$3,000/session[4], as requested
Custom reports[6]	At Cost

Table 2

Second Level Review Pricing

Case Rate = $240 per case

Table 3

A. Notes.

1. **Retrospective Denials.** Retrospective denials include both medical necessity and coding denials.
2. **Prior EHR concurrent review.** A "prior EHR concurrent review" may only be EHR's prior review of either a Managed Medicare Admission Review – Concurrent or a Commercial Admission Review – Concurrent.
3. **Conditions of Participation: Quarterly Review of Services.** Each Hospital will be billed quarterly for all cases submitted by that Hospital, but not less than the Quarterly Tier rate selected by said Hospital in the applicable Hospital Addendum. Any cases sent by Hospital in excess of the Hospital selected Quarterly Tier shall be billed at the applicable case rate noted in Table 2, as is then in effect at the conclusion of a given quarter. Hospital shall have the right to terminate the Conditions of Participation: Quarterly Review service at anytime upon providing EHR with not less than ninety (90) days prior written notice. Termination of this service shall not in any way cause the Agreement or any Addenda to terminate.
4. **Session.** Each session shall be for a period not longer than one (1) business day.
5. **Case.** A "case" is defined as one (1) patient for one (1) hospital visit or stay for purposes of determining the number of cases. A subsequent hospital visit or stay by the same patient shall be deemed a separate case.
6. **Weekly and Monthly Reporting.** EHR will provide weekly and monthly reports to the Customer, samples of which will be shared with the Customer/Hospital during implementation. The weekly reports are designed to facilitate coordination between EHR and the Customer/Hospital's case management department regarding the cases submitted for each EHR Service and the status of those cases. The monthly reports are designed to supplement the invoicing by showing detail of all cases submitted for each EHR Service and the status of each case.
7. **Retrospective Denials and Denials Review and Appeals (Redetermination, Reconsideration, ALJ, External Hearing and DAB Levels).** An additional amount of $5 per case per level will be charged to the Hospital to cover courier and postage expense.
8. **Hearing Expenses.** In the event EHR personnel is requested/required to appear in person to represent the Customer in a hearing, and in addition to the per case fees (or per hour fee for DAB Hearings) listed in Table 1, EHR shall charge the Customer travel fees and expenses. For travel fees, Customer shall be charged the lesser of $450 per hour or the daily rate of $1,800. Customer shall not be charged for more than eight (8) hours of travel for a given hearing. For travel expenses, Customer shall be charged actual expenses in accordance with section 7 of **Exhibit C**. Post hearing litigation support (i.e., briefs), shall be subject to additional fees. Any filing fees shall be passed through to Customer at actual cost.
9. **Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent** services are available Monday through Friday, 8:00 a.m. to 5:00 p.m. EST.
10. **Document Retrieval Services.** EHR will waive the $25 per case fee for any month where Customer/Hospital sends over 20 cases in that month. Notwithstanding the above, this case fee shall not apply to any case covered under Appeal Support services.

11. **Appeals Only Customers.** For Customer Hospitals selecting only appeal services (i.e., no concurrent services, no specialty services are selected by any Hospital under this Agreement), the applicable case rate is $325/case. Once Customer Hospitals contract for concurrent/specialty services, the rate for appeal services shall default to the then current Case Rate listed in Table 2.

12. **Initial Implementation.** The Initial Implementation fee for appeal only customers is $2,500 per Hospital.

B. Minimums and Conversions.

1. **Initial Minimum.** A Hospital will be obligated for a minimum contractually required number of cases each month, as identified in the applicable Hospital Addendum. The monthly volume for each Hospital, for services listed in Table 1 above that are included in the Price Tiers of Table 2 and Specialty Procedural Review volume, will be combined each month to determine if said Hospital has satisfied the monthly minimum number of cases. This monthly minimum number of cases will be referred to as the "Initial Minimum."

2. **Conversion.** For each Hospital, the average number of cases submitted will be calculated after the completion of the first three (3) full months post Go Live Date. This will be referred to as the "Initial Average". If 75% of the Initial Average is greater than the Initial Minimum, then a new minimum number of cases each month for the respective Hospital will be set equal to 75% of the Initial Average (the "Conversion"). This new monthly minimum number of cases from this point on will be referred to as the Hospital Minimum (75% of the Initial Average). A Hospital will be charged for each case that is over the Hospital Minimum at the applicable case rate listed in Table 2. For the purpose of invoicing:

   a. Pre-Conversion, each Hospital will be billed for all cases submitted by that Hospital, but not less than the Initial Minimum for that Hospital.

   b. Post-Conversion, each Hospital will be billed for all cases submitted by that Hospital, but not less than the Hospital Minimum for that Hospital.

   c. For any Hospital starting on a date other than the first of the month, the Initial Minimum number of cases will be pro-rated based upon the number of days from the Go Live Date through the end of the month.

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EXHIBIT C

EHR TERMS AND CONDITIONS

1. Confidential Information.

1.1. **Confidentiality.** Each Party acknowledges that, during the Term of this Agreement, it will receive Confidential Information from the other Party. The Party disclosing Confidential Information is referred to as the "Disclosing Party," and the party receiving Confidential Information is referred to as the "Receiving Party." The Receiving Party shall not disclose, provide or otherwise make available to any third party, except for a subcontractor of EHR in accordance with the terms of Section 2.2.3, any Confidential Information of the Disclosing Party and shall use such Confidential Information on an internal organization need-to-know basis only to the extent necessary to effect the provisions and purposes of, and as expressly contemplated under the terms of this Agreement and for no other purpose. Notwithstanding the foregoing, EHR shall have the right to use aggregated, non-personally identifiable data obtained in the course of providing EHR Services, and such information shall not constitute Confidential Information.

1.2. **Equitable Remedies.** The Parties acknowledge and agree that the restrictions contained in this section 1 are reasonable and necessary to protect the legitimate interests of the Disclosing Party and that any violation of such restrictions would result in irreparable injury to the Disclosing Party. If restrictions should be adjudged unreasonable at any proceeding, then such restrictions shall be reduced by the elimination or reduction of such portion thereof so that such restrictions may be enforced in a manner adjudged to be reasonable. The Receiving Party acknowledges and agrees that the Disclosing Party shall be entitled to preliminary and permanent injunctive relief for a violation of any such restrictions without having to prove actual damages. The Disclosing Party shall also be entitled to an equitable accounting of all earnings, profits and other benefits arising from such violation, which rights shall be cumulative and in addition to any other rights or remedies to which such Party may be entitled in law or equity.

2. Representations and Warranties.

2.1. **EHR Representations and Warranties.** EHR makes the following representations and warranties with respect to the EHR Services:

2.1.1. **EHR Physicians.** The EHR Physicians providing EHR Services under this Agreement are not "sanctioned individuals" as defined in the Social Security Act, 42 U.S.C. section 1320a-7, regarding individuals penalized for Medicare/Medicaid fraud or abuse, and have no action pending or threatened against them.

2.1.2. **Performance and Qualification.** EHR will perform the EHR Services in a professional manner, using qualified individuals with suitable training, education, experience, competence and skill to perform the EHR Services in accordance with industry standards.

2.1.3. **Corporate Compliance.** EHR represents and warrants to Customer that it maintains its own Corporate Compliance Program and it agrees that it will comply with such program.

2.2 **Customer Representations and Warranties.** Customer makes the following representations and warranties:

2.2.1 Customer has the full right and authority to disclose to EHR all materials, documentation, patient records, information and other input provided or made accessible to EHR under this Agreement, including, without limitation, Protected Health Information, pursuant to the Business Associate Addendum attached hereto.

2.2.2 **Authorization of Representation.** Customer hereby retains EHR to perform the EHR Services, the scope of which may include, but shall not be limited to: (a) the preparation of reimbursement reviews and reimbursement appeals on behalf of Customer including the preparation of correspondence with respect to such reviews and appeals on behalf of Customer personnel specified by Customer, and (b) the receipt of third party payer correspondence relating to the reviews and appeals. In connection herewith, the Customer agrees to execute any documentation necessary for EHR to perform such services, including, but not limited to, a letter of authorization, which EHR shall provide to third party payers, if requested.

2.2.3 The Customer herein authorizes EHR to use, in its sole discretion, subcontractors in connection with providing the EHR Services to the extent that such subcontractors agree to the same terms and conditions that apply through this Agreement with respect to Confidential Information and through the Business Associate Agreement with respect to Protected Health Information.

2.2.4 Customer represents that EHR shall be the exclusive provider of physician advisor medical necessity Medicare and Medicaid concurrent admission reviews for the Customer and its hospital(s).

2.3 **Payment of Fees and Expenses.** EHR shall submit invoices for fees and expenses on a monthly basis. All invoices shall be due and payable no later than thirty (30) days after the date of the invoice. Upon execution of this Agreement, Customer and/or Hospital shall establish a purchase order to facilitate the payment of invoices; however, none of the provisions of a purchase order will add to, modify or supersede the provisions of this Agreement. EHR reserves the right to charge interest at a rate of on-half percent (0.5%) compounded monthly from the date of the invoice on all invoices that are not paid when due. EHR reserves the right, at its sole discretion, to temporarily or permanently discontinue the provision of any or all EHR Services if invoices are more than ninety (90) days past due. Nonetheless, EHR shall continue to invoice Customer according to the terms and conditions of this Agreement and any executed Hospital Addendum.

2.4 **Non-Solicitation.** During the Term and for a period of one (1) year following the expiration or termination of this Agreement, neither Party shall, directly or indirectly, (a) knowingly solicit the employment in any capacity of any person then employed or retained by the other Party (including contracted consultants); (b) knowingly solicit the employment in any capacity of any person who was employed by the other Party within the immediately preceding six (6) month period, whether or not that person was directly involved with the work effort under this Agreement; or (c) induce or attempt to influence any hospital, other health care facility, any physician or any other professional with a referring relationship with EHR to alter that relationship in any way. Customer shall not directly or indirectly knowingly employ any person then employed or retained by

EHR during the Term of this Agreement. This Section shall not apply to individuals responding to (i) a recruiter's solicitation (provided that a Party does not specifically direct the recruiter's solicitation of such other Party's personnel), or (ii) general solicitations, such as a public websites, mass mailers, or employment advertisements.

2.5 **Compliance with Law.** Each Party represents and warrants that it will comply in all material respects with all applicable federal, state and local laws and regulations relating to this Agreement.

2.6 **Limitation of Warranty.** With the exception of the express warranties set forth above, EHR makes no representations or warranties with respect to the EHR Services, express or implied, their quality, performance, merchantability or fitness for a particular purpose. Customer acknowledges and agrees that no oral or written information or advice provided by EHR or any of its employees or agents shall constitute a representation or a warranty, unless such information or advice is incorporated into this Agreement by mutual written agreement of the Parties.

3. Insurance. During the Term, EHR shall maintain, at a minimum, the insurance and coverage limits listed below for each of the following: general liability insurance, excess/umbrella insurance, professional liability insurance (Errors and Omissions insurance), and workers' compensation insurance. Additionally, EHR agrees not to terminate its coverage, as stated below, during the Term.

3.1. A policy of general liability insurance with limits of up to One Million Dollars ($1,000,000) for each occurrence, and an annual aggregate limit of Three Million Dollars ($3,000,000).

3.2. A policy of excess/umbrella insurance with limits of up to Five Million Dollars ($5,000,000) for each occurrence, and an aggregate limit of Five Million Dollars ($5,000,000).

3.3. A policy of professional liability insurance with limits of up to Five Million Dollars ($5,000,000) for each occurrence, and an aggregate limit of Five Million Dollars ($5,000,000).

3.4. A policy of workers' compensation insurance policy in accordance with state law with coverage in each state where EHR retains employees.

3.5. A policy of property insurance that provides "special form" coverage on a blanket basis for business personal property, including the property of others. Property Insurance includes a business income and extra expense limit of Five Million Dollars ($5,000,000).

4. Limitation of Liability and Indemnification.

4.1. **Indemnification.** EHR shall indemnify, defend and hold the Customer, its directors, officers, employees and agents harmless from and against any and all claims, actions, liabilities, judgments, losses, costs, fees and expenses (collectively, the "Losses") to the extent such Losses are incurred in the defense or settlement of a third party lawsuit or other third party action (or in satisfaction of a judgment or order arising therefrom), where a final judgment has determined that such damages arose out of EHR's material breach of this Agreement.

Customer shall indemnify, defend and hold EHR, its directors, officers, employees and agents harmless from and against any and all claims, actions, liabilities, judgments, losses, costs, fees and expenses (collectively, the "Losses) to the extent such Losses are incurred in the defense or settlement of a third party lawsuit or other third party action (or in satisfaction of a judgment or order arising therefrom), where a final judgment has determined that such damages arose out of Customer's material breach of this Agreement.

4.2. **Limitation of Liability.** Notwithstanding anything to the contrary contained in this Agreement, (a) EHR shall not be liable for any special, indirect, incidental or consequential damages of any kind (including, without limitation, loss of business profits, business interruption, loss of business information, and the like arising out of this Agreement, even if EHR has been advised of the possibility of such damages or such damages are reasonably foreseeable, and (b) the liability of EHR in the aggregate under this Agreement, whether for negligence, breach of contract, breach of warranty, or otherwise, shall not exceed the amounts actually paid by the Customer to EHR hereunder for the invoices issued during the three (3)-month period immediately preceding the event that first gave rise to liability.

The Parties acknowledge and agree that the disclaimers and limitations of liability set forth in this Agreement are essential elements of this Agreement between the Parties and that the Parties would not have entered into this Agreement without such disclaimers and limitations of liability.

5. Arbitration.

5.1. Any controversy or claim between the Parties concerning any breach or alleged breach of this Agreement or performance or nonperformance of any obligation under this Agreement which cannot be resolved by negotiation between the Parties will be resolved by binding arbitration under this section 5 and the then-current Commercial Rules and supervision of the American Arbitration Association (the "AAA"). If any part of this section 5.1 is held to be unenforceable, it will be severed and will not affect either the duty to arbitrate or any other part of this section 5.1. The arbitration will be held in Westchester County, New York before a sole disinterested arbitrator who is knowledgeable in healthcare and reimbursement issues, and experienced in handling commercial disputes. The arbitrator shall be appointed jointly by the Parties hereto within thirty (30) days following the date on which the arbitration is instituted. If the Parties are unable to agree upon the arbitrator within such thirty (30)-day period, then either party may authorize the AAA to select such arbitrator within fifteen (15) days thereafter. The arbitrator's award will be final and binding and may be entered in any court having jurisdiction. The arbitrator will not have the power to award punitive or exemplary damages, or any damages excluded by or in excess of, any damage limitations expressed in this Agreement. Issues of arbitrability will be determined in accordance solely with the federal substantive and procedural laws relating to arbitration; in all other respects, the arbitrator will be obligated to apply and follow the substantive law of the State of New York notwithstanding any conflict of laws doctrines to the contrary.

5.2. Notwithstanding section 5.1 above, neither Party will be required to arbitrate any dispute relating to actual or threatened unauthorized disclosure of Confidential Information or violation of any non-solicitation obligations. Each Party will be entitled to receive in any court of competent jurisdiction injunctive, preliminary, or other equitable relief in addition to damages, including court costs and fees of attorneys and other professionals, to remedy any actual or threatened violation of its rights with respect to which arbitration is not required hereunder.

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6. **Taxes.** If Customer is a tax exempt organization, then upon execution of this Agreement, Customer shall provide EHR with a certificate of such exemption. For as long as Customer remains a tax exempt organization, Customer will not be invoiced for taxes, assessments, fees, and other governmental charges related to the EHR Services from which tax exempt organizations are exempt. If Customer is not a tax exempt organization then Customer shall be responsible for any taxes legally imposed upon the Customer with respect to its purchase and use of EHR Services, including, but not limited to, taxes, assessments, fees, and other governmental charges of any kind (including, without limitation, sales, use, excise, value-added, business license and gross receipts taxes) (collectively, "Taxes"). Notwithstanding the above, neither Party shall have any obligation for any tax upon the other Party's real, personal or intangible property, or upon the other Party's net income.

7. **Travel Expenses.** EHR will not charge Customer for any travel expenses related to sales or account management activity. EHR will charge only reasonable and actual costs of travel to and from the Customer location for implementation services or other services requested by Customer. Airfare will always be at the *Coach Class* fare and will be purchased in advance, when possible/practical. Lodging will be booked at national business travel chains. Customer authorizes EHR to request Customer's rates and to use such rates when available to EHR as possible/practical. Car rentals will be made with national business car rental companies. Customer authorizes EHR to request Customer's rates and to use such rates when available to EHR and possible/practical. Mileage will be charged at the IRS rate then in effect at the time of travel for use of personal vehicles. All other expenses such as local transportation, meals and parking will be charged at reasonable and actual rates. Upon request, EHR will provide Customer with evidence of individual expenses over $25.

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EXHIBIT D

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "BAA") is made and entered into as of date of last signature by and between Executive Health Resources, Inc. (hereinafter referred to as "Business Associate"), and Sound Shore Health System, Inc. (hereinafter referred to as "Covered Entity"). This BAA is effective as of the Effective Date of the Standard Services Agreement between Business Associate and Covered Entity.

WHEREAS, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder ("HIPAA Regulations") Covered Entity is interested in disclosing certain information to Business Associate, or, if applicable, to allow Business Associate to create or receive information on behalf of Covered Entity pursuant to the terms of this BAA, certain of which may constitute Protected Health Information ("PHI"), as defined under HIPAA and the HIPAA Regulations;

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this BAA in compliance with HIPAA and the HIPAA Regulations, and other applicable laws;

WHEREAS, Business Associate is required to comply with the HIPAA Privacy Rule and the Security Rule (specifically 45 CFR §§ 164.308-164.316 of the Security Rule) as promulgated by HHS pursuant to the HIPAA Regulations, and the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Title XIII of Division A and Title IV of Division B (the "Health Information Technology for Economic and Clinical Health" ("HITECH Act")) and other applicable laws; and

WHEREAS, the purpose of this BAA is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, as the same may be amended from time to time.

NOW, THEREFORE, in consideration of the foregoing recitals and mutual covenants herein contained and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound, agree as follows:

1. **Definitions**. Terms used, but not otherwise defined in this BAA, shall have the same meaning as those set forth in the HIPAA Privacy Rule.

a. **Business Associate**. A person or entity that performs a function for or assists a Covered Entity involving the use or disclosure of individually identifiable health information.

b. **Breach**. The acquisition, access, use, or disclosure of protected health information in a manner not permitted under HIPAA, which compromises the security or privacy of the protected health information.

c. **Covered Entity**. A health plan, health care clearinghouse or health care provider.

d. **Protected Health Information ("PHI")**. All individually identifiable health information transmitted or maintained by a Covered Entity, regardless of form. This includes, without limitation, all information, data, documentation, and materials, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

e. **Unsecured PHI**. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of the HITECH Act.

2. **Obligations and Activities of Business Associate**. Except as otherwise limited in this BAA, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal or contracted

responsibilities of Business Associate. Additionally, Business Associate agrees:

a. Not to use or disclose PHI other than as permitted or required by this BAA or as required by law.

b. To use appropriate safeguards to prevent use or disclosure of the PHI other than as provided in this BAA.

c. To report to Covered Entity any use or disclosure of the PHI not provided for by this BAA of which it becomes aware.

d. To ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information.

e. To use or disclose only the "Minimum Necessary" amount of information, as such term is defined in the HIPAA Regulations, required to conduct the authorized activities herein.

f. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA.

g. To comply with any requests for restrictions on certain disclosures of PHI pursuant to 45 CFR § 164.522, as amended by the HITECH Act, to which Business Associate has agreed and of which Business Associate is notified by Covered Entity.

h. To comply with the prohibition on the sale of PHI, as stated in section 13405(d) of the HITECH Act, and the marketing restrictions, as stated in section 13406(a) of the HITECH Act.

i. To use PHI to provide Data Aggregation services to Covered Entity, as permitted by 45 CFR § 164.504(e)(2)(i)(B).

j. To enable Covered Entity to comply with sections 164.524, 164.526 and 164.528 of HIPAA, to make available to the Covered Entity PHI for the purpose of facilitating the Covered Entity's compliance with such sections.

k. To make its internal practices, books and records relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of the United States Department of Health and Human Services ("Secretary"), for purposes of determining the Covered Entity's compliance with HIPAA.

l. To obtain reasonable assurance from any person to whom PHI was disclosed and that it will remain confidential and used or further disclosed only as required by law or for the purpose of this BAA.

m. Business Associate acknowledges that sections 164.308, 164.310, 164.312, and 164.316 of Title 45 of the Code of Federal Regulations shall apply to Business Associate in the same manner in which such sections apply to the Covered Entity. The additional requirements of Title XIII, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), that relate to security and are made applicable to Covered Entity shall also be applicable to Business Associate and incorporated into this BAA. In the event of a violation of such provisions, Business Associate acknowledges that 42 U.S.C. §§ 1320d-5 and 1320d-6 shall apply to Business Associate with respect to such violation in the same manner in which such sections apply to Covered Entity. The requirements contained in this Section shall become effective as of the date of execution of this BAA or the effective date identified in the HITECH Act, whichever is later.

3. **Notification of Breach.** Business Associate shall, following the discovery of a breach of unsecured PHI, as defined in the HITECH Act or implementing regulations, notify Covered Entity of such breach pursuant to the terms of 45 CFR § 164.410; such a breach shall be treated as discovered by Business Associate as of the first date on which such breach is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate will provide such notification to Covered Entity without unreasonable delay and in no event later than sixty (60) calendar days after discovery of the breach. Such notification will contain the elements required in 45 CFR § 164.410. Business Associate will report to Covered Entity

any successful Security Incident (as defined in the Security Rule) of which it becomes aware.

4. **Indemnification.** Business Associate hereby agrees to indemnify, defend and hold harmless Covered Entity and its shareholders, directors, officers, partners, members, employees, agents and/or contractors (collectively "Indemnified Party") against any fines, penalties, costs or expenses (including reasonable attorneys' fees) which may be imposed upon the Covered Entity by reason of any third party claim or proceeding by a government body, which results from the Business Associate's breach of this BAA, including, but not limited to failure to comply with the terms and requirements of the Privacy Regulations by the Business Associate, its shareholders, directors, officers, partners, members, employees, agents and/or contractors. This obligation of the Business Associate to indemnify Covered Entity shall survive the termination of this BAA for any reason.

Covered Entity hereby agrees to indemnify, defend and hold harmless Business Associate and its shareholders, directors, officers, partners, members, employees, agents and/or contractors (collectively "Indemnified Party") against any fines, penalties, costs or expenses (including reasonable attorneys' fees) which may be imposed upon Business Associate by reason of any third party claim or proceeding by a government body which results from the Covered Entity's breach of this BAA, including, but not limited to failure to comply with the terms and requirements of the Privacy Regulations by the Covered Entity, its shareholders, directors, officers, partners, members, employees, agents and/or contractors. This obligation of the Covered Entity to indemnify Business Associate shall survive the termination of this BAA for any reason.

5. **Term and Termination.**

a. This BAA shall become effective upon commencement of the Parties' relationship and shall continue in effect so long as Business Associate continues to perform certain functions on behalf of and/or provides certain services that qualify it as Covered Entity's "business associate" pursuant to 45 CFR § 160.103, unless terminated as provided in this Section.

b. A material breach by Business Associate of this BAA shall provide grounds for termination of this BAA or business between Covered Entity and Business Associate if Business Associate fails to cure such breach within thirty (30) days after written notice of such breach by Covered Entity, which shall state with particularity the nature of the alleged breach. If the Business Associate has not cured the material breach within such cure period, or if cure is not possible, then the Covered Entity shall either: (a) immediately terminate this BAA, if feasible; or (b) if termination of this BAA is not feasible, Covered Entity shall report Business Associate's breach to the Secretary.

c. Upon termination of this BAA, Business Associate shall return or destroy all PHI received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form. If such return or destruction is not feasible, Business Associate will extend the protections of this BAA to such PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible. The duties hereunder to maintain the security of PHI shall survive the discontinuance of this BAA.

6. **Miscellaneous.**

a. **Amendment**. This BAA may be amended or modified only in writing signed by the Parties.

b. **Assignment**. Except as provided in the Standard Services Agreement, neither party may assign (by operation of law or otherwise) this BAA (or any of its rights and obligations under this BAA) without the written consent of the other party.

c. **Waiver of Breach.** The waiver by either party hereto of a breach or violation of any provision of this BAA shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof, and no waiver shall be effective unless made in writing and signed by an authorized representative of the waiving party.

d. **Severability**. If any provision, clause or condition of this BAA is held by any court of competent jurisdiction or by an arbitrator to be void, invalid, inoperative or otherwise unenforceable, such defect shall not affect any other provision, clause or condition, and the remainder of this BAA shall be effective as though such

defective provision, clause or condition had not been a part of this BAA.

e. **Interpretation**. Any ambiguity in this BAA shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with the Privacy Rule and Security Standards. In addition, any reference in this BAA to a section in the Privacy Rule, Security Standards, or other law or regulations means the section as in effect or as amended.

f. **Notices**. Any notices required under this BAA shall be in accordance with the notice provisions set forth in the Standard Services Agreement between the Parties.

g. **Headings**. The headings of sections are inserted solely for purposes of convenience and shall not alter the meaning of this BAA.

h. **Entire Agreement**. This BAA, together with any underlying written agreements, attached exhibits or amendments, if applicable, which are fully completed and signed by authorized agents of both Parties while this BAA is in effect, constitutes the entire agreement between the Parties with respect to the PHI and supersedes all previous written or oral understandings, negotiations, commitments, and any other writing and communication by or between the Parties with respect to PHI.

i. **No Third Party Beneficiaries**. Except as expressly stated herein or the HIPAA Privacy Rule, the Parties to this BAA do not intend to create any rights in any third parties.

j. **Full Authority**. Each party hereto represents and warrants to the other party that it has the legal power and authority to enter into and perform its obligations under this BAA without violating the rights or obtaining the consent of any third party.

IN WITNESS WHEREOF, each Party hereto has executed the BAA as of the date set forth below such Party's name.

BUSINESS ASSOCIATE

By: Kirk Schultz (May 1 2013)

Name: Kirk Schultz

Title: Chief Administrative Officer

Date: 4/29/2013

COVERED ENTITY

By: JPMamangakis

Name: John P Mamangakis

Title: Sr Vice President

Date: April 29, 2013

EHR®
EXECUTIVE HEALTH RESOURCES

HOSPITAL ADDENDUM 1

THIS Hospital Addendum 1 to the Standard Services Agreement (the "Hospital Addendum") is made and entered into as of April 29, 2013 (the "Hospital Addendum Effective Date") by and between Executive Health Resources, Inc., a Pennsylvania corporation ("EHR"), and Sound Shore Medical Center of Westchester, a New York non-profit corporation (the "Hospital"). EHR and the Hospital may be individually referred to as a "Party" or collectively as the "Parties".

WHEREAS, Sound Shore Health System, Inc. (the "Customer") and EHR entered into a Standard Services Agreement (the "Agreement") on April 29, 2013;

WHEREAS, EHR and the Customer have agreed to add the following Hospital to the Agreement and the Hospital has agreed to be become a party to the Agreement and this Addendum:

Legal Name of Hospital:	Sound Shore Medical Center of Westchester
Hospital Provider ID:	330184
Is Provider ID Shared with Any Other Hospital:	___ Yes √ No (please check one)
Minimum Monthly Number of Cases:	0

WHEREAS, the Hospital agrees to be bound by the terms of the Agreement, including all Exhibits and Attachments, and specifically this Hospital Addendum; and

WHEREAS, the Hospital agrees to be obligated to refer to EHR the Minimum Monthly Number of Cases, as defined above in this Hospital Addendum.

NOW, THEREFORE, in mutual consideration for the services performed herein, the receipt of which is hereby acknowledged, the Parties intending to be legally bound agree as follows:

1. **Services Requested.** Hospital hereby requests that EHR provide the EHR Services listed in the following Table 1 for the Hospital and EHR agrees to provide such EHR Services to the Hospital:

Table 1

	EHR Services Requested
	Commercial Payers: Managed Medicare Admission Review (with or without Delegated UR) - Concurrent Commercial Admission Review (with or without delegated UR) – Concurrent Length of Stay Management (Concurrent/Post Discharge)
	Medicare (Concurrent/Post Discharge): Admission Review and Compliance Continued Stay Review and Compliance Readmission Review and Compliance Other Procedural Setting Review and Compliance MRI Inpatient Utilization Review Bed Management / Transfer Center Management
	Medicaid (Concurrent/Post Discharge): Admission Review and Compliance Continued Stay Review and Compliance Readmission Review and Compliance Other Procedural Setting Review and Compliance
	Specialty Procedural Review (All Payers, Concurrent/Post Discharge): Cardiology Procedure Review – Post Procedure Vascular Procedure Review – Post Procedure Kyphoplasty / Vertebroplasty Procedure Setting Review Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent
	LTAC (Long Term Acute Care) Reimbursement Denials Review and Appeal – Retrospective (All Payers)
√	**Government Denials Review and Appeals (Medical Necessity and Coding)** **Concurrent Reimbursement Medical Necessity Denials Review and Appeals** **Retrospective Reimbursement Denials Review and Appeals (Medical Necessity and Coding)** **Outcomes Option:** _____ (select 1, 2, 3, 4, or 5 – if none selected, Option 5 shall apply)
	Document Retrieval Services
	RAC Data Tracking Service: Data Entry
	Analysis and Review Services: Conditions of Participation: Quarterly Review of Services, Quarterly Tier ___ (select 1, 2, or 3)
√	Compliance Integrity Benchmarking and Analytics
√	Implementation

2. **Term and Termination.**

a. Initial Term and Renewal Terms. This Hospital Addendum shall commence on the Go Live Date and shall continue for an initial term of two (2) years (the "Initial Term"). At the end of the Initial Term, this Hospital Addendum may renew for additional, consecutive one (1) year terms (each, a "Renewal Term") upon mutual written agreement of the Parties, unless and until terminated in accordance with this Hospital Addendum.

b. Termination. Either Party may terminate this Hospital Addendum at the end of the Initial Term or any Renewal Term by providing the other Party with written notice of such termination at least ninety (90) days prior to the expiration of such Initial Term or Renewal Term. In addition, either Party may terminate this Hospital Addendum by providing the other Party with thirty (30) days' prior written notice in the event of a breach of a material provision of the Agreement or this Hospital Addendum by the other Party, if such breach

remains uncured to the reasonable satisfaction of the non-breaching Party at the end of such thirty (30) day period.

4. **Authority to Act.** The Parties hereto warrant and represent that they have the power and authority to enter into this Hospital Addendum, to make the representations and promises contained herein and have been duly authorized to execute this Agreement.

IN WITNESS WHEREOF, each Party hereto has executed this Hospital Addendum as of April 29, 2013.

EXECUTIVE HEALTH RESOURCES, INC.

By: Kirk Schultz (May 1, 2013)
Name: Kirk Schultz
Title: Chief Administrative Officer
Date: 4/29/2013

SOUND SHORE MEDICAL CENTER OF WESTCHESTER

By: JPMamangakis
Name: John P Mamangakis
Title: Sr Vice President
Date: April 29, 2013

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EXECUTIVE HEALTH RESOURCES

HOSPITAL ADDENDUM 2

THIS Hospital Addendum 2 to the Standard Services Agreement (the "Hospital Addendum") is made and entered into as of April 29, 2013 (the "Hospital Addendum Effective Date") by and between Executive Health Resources, Inc., a Pennsylvania corporation ("EHR"), and The Mount Vernon Hospital, a New York non-profit corporation (the "Hospital"). EHR and the Hospital may be individually referred to as a "Party" or collectively as the "Parties".

WHEREAS, Sound Shore Health System, Inc. (the "Customer") and EHR entered into a Standard Services Agreement (the "Agreement") on April 29, 2013;

WHEREAS, EHR and the Customer have agreed to add the following Hospital to the Agreement and the Hospital has agreed to be become a party to the Agreement and this Addendum:

Legal Name of Hospital:	The Mount Vernon Hospital
Hospital Provider ID:	330086
Is Provider ID Shared with Any Other Hospital:	___ Yes √ No (please check one)
Minimum Monthly Number of Cases:	0

WHEREAS, the Hospital agrees to be bound by the terms of the Agreement, including all Exhibits and Attachments, and specifically this Hospital Addendum; and

WHEREAS, the Hospital agrees to be obligated to refer to EHR the Minimum Monthly Number of Cases, as defined above in this Hospital Addendum.

NOW, THEREFORE, in mutual consideration for the services performed herein, the receipt of which is hereby acknowledged, the Parties intending to be legally bound agree as follows:

1. **Services Requested.** Hospital hereby requests that EHR provide the EHR Services listed in the following Table 1 for the Hospital and EHR agrees to provide such EHR Services to the Hospital:

Table 1

	EHR Services Requested
	Commercial Payers: Managed Medicare Admission Review (with or without Delegated UR) - Concurrent Commercial Admission Review (with or without delegated UR) – Concurrent Length of Stay Management (Concurrent/Post Discharge)
	Medicare (Concurrent/Post Discharge): Admission Review and Compliance Continued Stay Review and Compliance Readmission Review and Compliance Other Procedural Setting Review and Compliance MRI Inpatient Utilization Review Bed Management / Transfer Center Management
	Medicaid (Concurrent/Post Discharge): Admission Review and Compliance Continued Stay Review and Compliance Readmission Review and Compliance Other Procedural Setting Review and Compliance
	Specialty Procedural Review (All Payers, Concurrent/Post Discharge): Cardiology Procedure Review – Post Procedure Vascular Procedure Review – Post Procedure Kyphoplasty / Vertebroplasty Procedure Setting Review Medicare Inpatient Rehabilitation Post-Admission Review – Concurrent
	LTAC (Long Term Acute Care) Reimbursement Denials Review and Appeal – Retrospective (All Payers)
√	**Government Denials Review and Appeals (Medical Necessity and Coding)** **Concurrent Reimbursement Medical Necessity Denials Review and Appeals** **Retrospective Reimbursement Denials Review and Appeals (Medical Necessity and Coding)** **Outcomes Option:** _____ (select 1, 2, 3, 4, or 5 – if none selected, Option 5 shall apply)
	Document Retrieval Services
	RAC Data Tracking Service: Data Entry
	Analysis and Review Services: Conditions of Participation: Quarterly Review of Services, Quarterly Tier ___ (select 1, 2, or 3)
√	Compliance Integrity Benchmarking and Analytics
√	Implementation

2. **Term and Termination.**

a. Initial Term and Renewal Terms. This Hospital Addendum shall commence on the Go Live Date and shall continue for an initial term of two (2) years (the "Initial Term"). At the end of the Initial Term, this Hospital Addendum may renew for additional, consecutive one (1) year terms (each, a "Renewal Term") upon mutual written agreement of the Parties, unless and until terminated in accordance with this Hospital Addendum.

b. Termination. Either Party may terminate this Hospital Addendum at the end of the Initial Term or any Renewal Term by providing the other Party with written notice of such termination at least ninety (90) days prior to the expiration of such Initial Term or Renewal Term. In addition, either Party may terminate this Hospital Addendum by providing the other Party with thirty (30) days' prior written notice in the event of a breach of a material provision of the Agreement or this Hospital Addendum by the other Party, if such breach

remains uncured to the reasonable satisfaction of the non-breaching Party at the end of such thirty (30) day period.

5. **Authority to Act.** The Parties hereto warrant and represent that they have the power and authority to enter into this Hospital Addendum, to make the representations and promises contained herein and have been duly authorized to execute this Agreement.

IN WITNESS WHEREOF, each Party hereto has executed this Hospital Addendum as of April 29, 2013.

EXECUTIVE HEALTH RESOURCES, INC.

By: Kirk Schultz (May 1, 2013)

Name: Kirk Schultz

Title: Chief Administrative Officer

Date: April 29, 2013

THE MOUNT VERNON HOSPITAL

By: John P Mamangakis

Name: John P Mamangakis

Title: Sr Vice President

Date: April 29, 2013

EXHIBIT B

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re: SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.,	Chapter 11 Case Case No. 13- 22840 (RDD)
Debtors.	(Jointly Administered)

ORDER PURSUANT TO 11 USC § 365 APPROVING REJECTION OF EXECUTORY CONTRACTS

Upon the motion dated August 26, 2013 (the "**Motion**")[1] of Sound Shore Medical Center of Westchester ("**SSMC**") and its affiliated debtors, as debtors in possession in the above captioned chapter 11 cases (collectively, the "**Debtors**), for entry of an order pursuant to section 365(a) of title 11, United States Code (the "**Bankruptcy Code**") and Rules 6006 and 9014 of the Federal Rules of Bankruptcy Procedure, authorizing the Debtors to reject their contract with Executive Health Resources, Inc. (the "**EHR Executory Contract**"), all as more fully described in the Motion; and it appearing that the Court has jurisdiction to consider this matter, and it further appearing that due and proper notice of the Motion has been given and that no other or further notice need be provided; and it further appearing that the relief requested in the Motion is necessary and is in the best interest of the Debtors, the Debtors' estates and their creditors, and all parties in interest; and after due deliberation and good and sufficient cause appearing therefor,

IT IS HEREBY ORDERED THAT:

1. The Motion is granted to the extent set forth herein.

[1] Capitalized terms used but not defined herein shall have the meaning ascribed to them in the Motion.

2. Pursuant to section 365(a) of the Bankruptcy Code, rejection of the EHR Executory Contract, as set forth herein (1) constitutes an exercise of sound business judgment by the Debtors, made in good faith and for valid business reasons, (2) is appropriate and necessary under the circumstances described in the Motion, and (3) is warranted and permissible under sections 105 and 365 of the Bankruptcy Code and Bankruptcy Rule 6006.

3. Pursuant to section 365 of the Bankruptcy Code and Bankruptcy Rules 6006 and 9014, the rejection of the EHR Executory Contract and any related amendments and supplements thereto, is hereby authorized and approved, *nunc pro tunc*, effective upon the earlier of (i) the date on which the respective agreement was terminated or (ii) the filing of this Motion.

4. This Court shall retain jurisdiction to hear and determine all matters arising from or related to the implementation, interpretation and/or enforcement of this Order.

Dated: September __, 2013
White Plains, New York

HONORABLE ROBERT D. DRAIN
UNITED STATES BANKRUPTCY COURT JUDGE

GARFUNKEL WILD, P.C.
111 Great Neck Road
Great Neck, New York 11021
Telephone: (516) 393-2588
Facsimile: (516) 466-5964
Burton S. Weston
Afsheen A. Shah
Adam Berkowitz

Counsel for the Debtor and Debtor-in-Possession

Hearing Date: September 13, 2013 at 10:00 a.m.
Objection Deadline: September 6, 2013 at 10:00 a.m.

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

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In re:

SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.

Debtors.

Chapter 11
Case No. 13-22840 (RDD)

(Jointly Administered)

----------x

NOTICE OF HEARING ON MOTION FOR ENTRY OF AN ORDER PURSUANT TO SECTIONS 365 OF THE BANKRUPTCY CODE AUTHORIZING DEBTORS TO REJECT AN EXECUTORY CONTRACT, *NUNC PRO TUNC,* TO THE DATE OF TERMINATION OR THE FILING DATE OF THIS MOTION, WHICHEVER IS EARLIER

PLEASE TAKE NOTICE that upon the annexed Motion of Sound Shore Medical Center of Westchester ("**SSMC**" or "**Debtor**") and certain of its affiliates, as Chapter 11 debtors and debtors in possession herein (each a "**Debtor**" and collectively the "**Debtors**")[1], dated August 26, 2013, a hearing will be held before the Honorable Robert D. Drain, United States Bankruptcy Judge for the Southern District of New York, at the United States Bankruptcy Court, Southern District of New York, 300 Quarropas Street, White Plains, New York 10601, on the 13th day of September, 2013 at 10:00 o'clock in the forenoon of that day, or as soon thereafter as

[1] The debtors in these chapter 11 cases, along with the last four digits of each debtors' federal tax identification number include: Sound Shore Health System, Inc. (1398), Sound Shore Medical Center of Westchester (0117), The Mount Vernon Hospital, Inc. (0115), Howe Avenue Nursing Home d/b/a Helen and Michael Schaeffer Extended Care Center (0781), NRHMC Services Corporation (9137), the M.V. H. Corporation (1514) and New Rochelle Sound Shore Housing, LLC (0117). There are certain additional affiliates of the Debtors who are not debtors and have not sought relief under Chapter 11.

counsel can be heard, to consider the entry of an Order, pursuant to 11 USC Section 365 Approving Rejection of Executory Contracts, and granting such other and further relief as is just and proper.

PLEASE TAKE FURTHER NOTICE, that objections to the relief requested shall be made in writing, shall state with particularity the grounds for the objection, and shall be and filed with the Bankruptcy Court, in electronic format, by utilizing the Court's electronic case filing system at www.nysb.uscourts.gov, or if the same cannot be filed electronically, by manually filing same with the Clerk of the Court together with a cd-rom containing same in Word, Wordperfect or pdf format, with a hard copy provided to the Clerk's Office at the Bankruptcy Court for delivery to the Chambers of the Honorable Robert D. Drain and upon (i) Garfunkel Wild, P.C., 111 Great Neck Road, Great Neck, New York 11021, attention Burton S. Weston, Esq., and Afsheen A. Shah, Esq., counsel for the Debtors; (ii) Alston & Bird, LLP, 90 Park Avenue, New York, New York 10016, Attn: Martin G. Bunin, Esq., counsel to the official committee of unsecured creditors; (iii) MidCap Financial, LLC, 7255 Woodmont Avenue, Suite 200, Bethesda, MD 20814, attention: Lisa J. Lenderman, Esq., Deputy General Counsel, counsel to Debtors' postpetition lender; (iv) Togut, Segal and Segal, One Penn Plaza, New York, New York 10019, attention Frank Oswald, Esq., and Scott Griffin, Esq, counsel to Montefiore Medical Center; and (v) Office of the United States Trustee, 201 Varick Street, Room 1006, New York, New York 10014, Attn: Susan Golden, Esq., so as to be received no later than September 6, 2013 at 10:00 a.m.

PLEASE TAKE FURTHER NOTICE that the hearing on the Motion may be adjourned without further notice except as announced in open court on the Hearing Date, or at any adjourned hearing.

Dated: Great Neck, New York
August 26, 2013

Respectfully submitted,

By: _____

Burton S. Weston
Afsheen A. Shah
Adam Berkowitz
GARFUNKEL WILD, P.C.
111 Great Neck Road
Great Neck, New York 11021
Telephone: (516) 393-2200
Facsimile: (516) 466-5964

Attorneys For Debtor
and Debtor in Possession