DIMENSIONS HEALTHCARE SYSTEM
BRIEFING TO PRINCE GEORGE'S COUNTY COUNCIL BOARD OF HEALTH

"UPDATE ON LAUREL REGIONAL HOSPITAL"

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President & CEO

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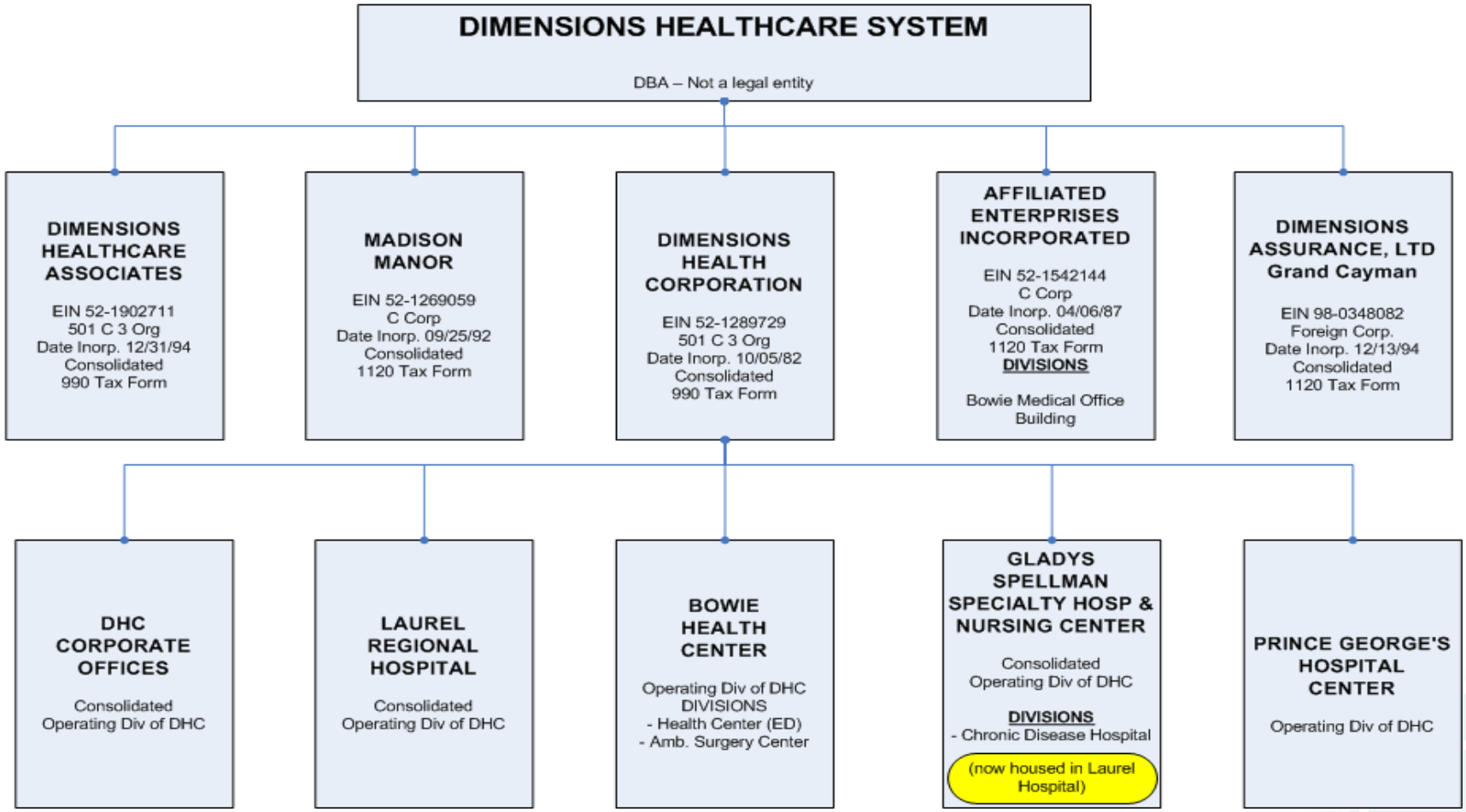
Dimensions Healthcare System

Review of Dimensions Organizational Structure

Dimensions Organizational Structure

Dimensions Healthcare System

Organizational Structure



Healthcare Commentary On Changes We Are Facing

Introduction To Kaufman Hall

Healthcare Commentary
National Outlook

- National Focus on the “Triple Aim”.
  - Improve health of the population
  - Improve quality care & the patient experience
  - Reduce the per-capita cost of healthcare
- Revenues of healthcare providers transitioning from volume-based to value-based reimbursement.
- More emphasis on population health management initiatives to direct healthcare towards less expensive modalities.
- More emphasis of hospitals/health systems to develop stronger alignments with other community health providers to coordinate patient care.

Healthcare Commentary
State / Regional Healthcare Outlook

- Maryland hospitals are adapting to new HSCRC Global Rate methodology (GBR) payment system.
  - New rate system focusing hospitals to seek operational efficiencies, prevent unnecessary/ avoidable admissions, reduce variations of care processes, and improve the quality of care delivered.
  - Shifting care from inpatient to ambulatory (outpatient) care.

- Significant need for additional primary care physicians in Prince George's County.
  - This was one of the key findings of the University of Maryland School of Public Health Impact Study.
  - Health system must focus more resources on community-baes primary and ambulatory care and coordinate such care among community providers.

Changing Healthcare Environment

- Because of challenging changes within our industry, Dimensions obtained national expertise to examine the local healthcare marketplace and determine what steps it should take to transition into a more efficient and effective delivery system that can ascertain long-term viability within this changing healthcare environment.

- Dimensions engaged Kaufman Hall, a national healthcare consulting firm.

Introduction to Kaufman Hall

- Kaufman Hall provides a wide range of strategic and corporate finance services and related software analytical tools to healthcare providers.
- Established in 1985.
- Offices based in Chicago, Atlanta, Boston, Los Angeles, Portland and New York, with clients throughout the United States.
- Over 220 full-time professionals.
- Impeccable industry credentials; AHA endorsed.
- Very knowledgeable of the Maryland healthcare environment; worked with a number of Maryland health systems including University of Maryland Medical System, MedStar, and Anne Arundel Medical Center.

Our mission is to enable our client healthcare provider organizations to reach their full business potential through the provision of high value, financially centered consulting services and software products.

Kaufman Hall Consulting Services and Software

Kaufman Hall Maintains One of the Most Active Strategic and Financial Advisory Practices in the Industry

KaufmanHall

Regional Service Delivery Planning

Dimensions Healthcare System

1 Background on Process

Planning Process

Strategic and Financial and Facilities Assessment

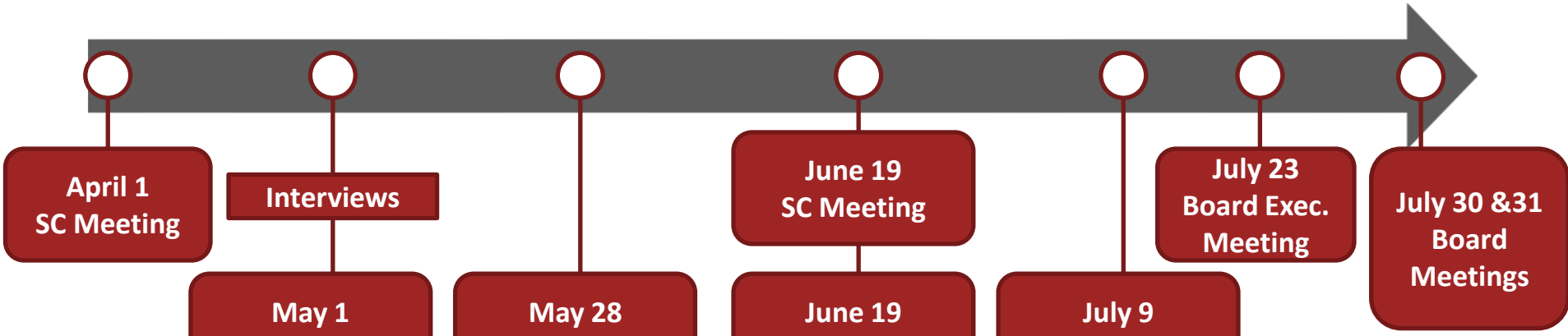
- Guiding Principles and Goal Setting
- Fact base development
- Service delivery system assessment
- Reform considerations
- Market and competitive assessment

Vision and Preliminary Service Distribution Model Development

- Regional vision creation:
  - Care delivery vision
  - Prioritization of service mix and distribution
  - Linkages to other service centers

Facility Strategy Development and Service Distribution Refinement

- Facility Strategy development
- Resource requirements
- Scenario analysis
- Financial impact analysis and long range projections
- Strategic and financial plan finalization



DHS Network Delivery Planning Steering Committee

Name	Affiliation
Harbhajan Ajrawat, MD	Board Member, DHS & PGHC; President PGHC Medical Staff
Ulric Donawa	Board Member, LRH
The Honorable Barbara Frush	Board Member, Secretary, DHS
The Honorable Tawanna Gaines	Board Member, Vice Chair, DHS; Chair, PGHC
Daniel Griffen, III, MD	Board Member, LRH
The Honorable Andrea Harrison	Board Member, DHS
The Honorable Tom Hendershot	Board Member, Chair Finance Committee
M. Ali Khan, MD	Board Member, PGHC
The Honorable C. Philip Nichols, Jr.	Board Member, Chair, DHS Board
Bradford Seamon	Board Member, DHS
Frederick Smalls	Board Member, Chair LRH Board
Benjamin Stallings, MD	Board Member, Treasurer, DHS
Neil J. Moore	President & CEO, DHS
Carnell Cooper, MD	SVP & CMO, DHS; VP Medical Affairs, PGHC
Lisa Goodlett	SVP & CFO, DHS
John Spearman	Interim COO, DHS; President & COO, LRH
Jeffrey L. Johnson	Interim Strategy Officer/Consultant

2 National Trends

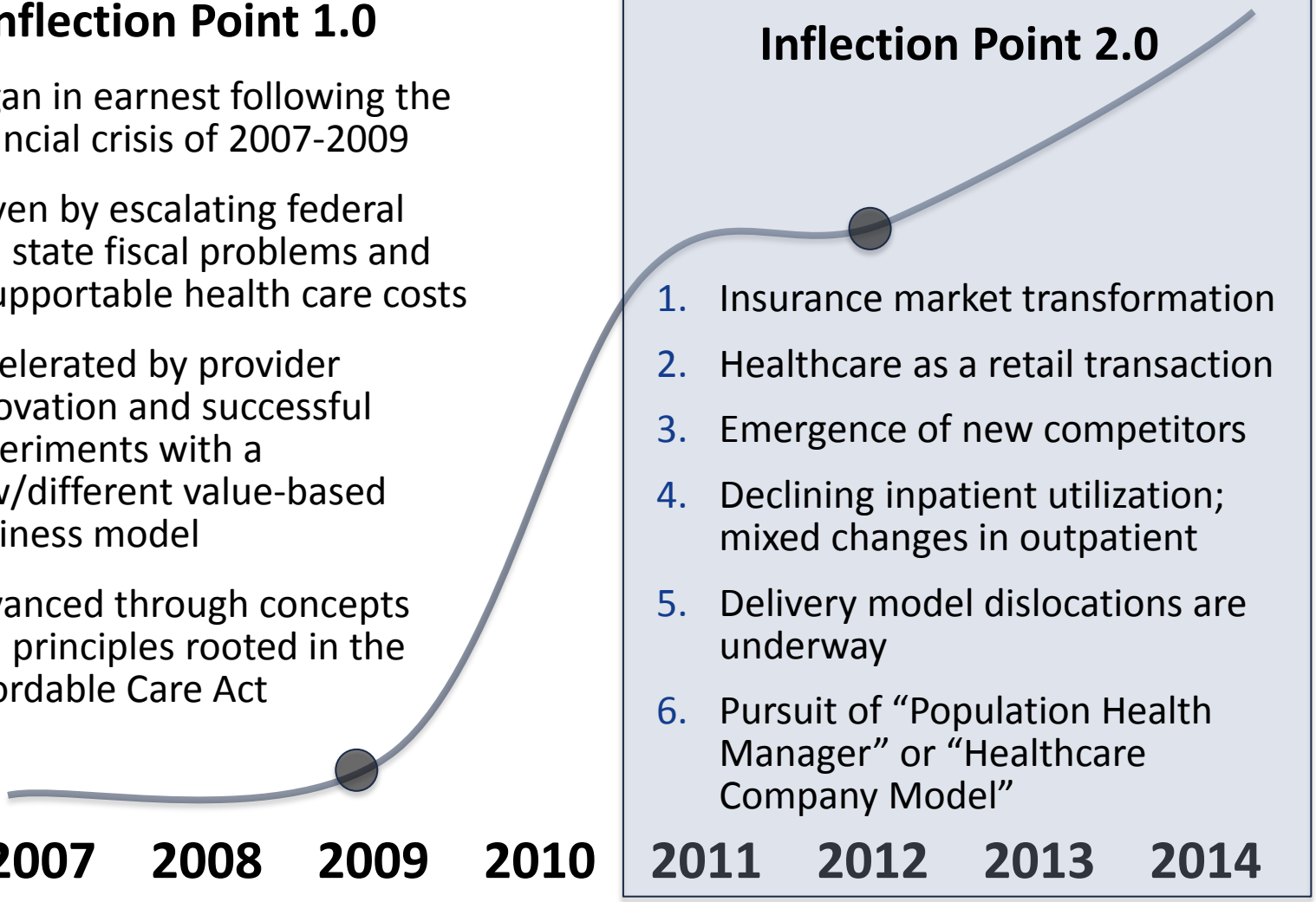
Health Care Has Experienced Two Inflection Points in the Underlying Business Model

Inflection Point 1.0

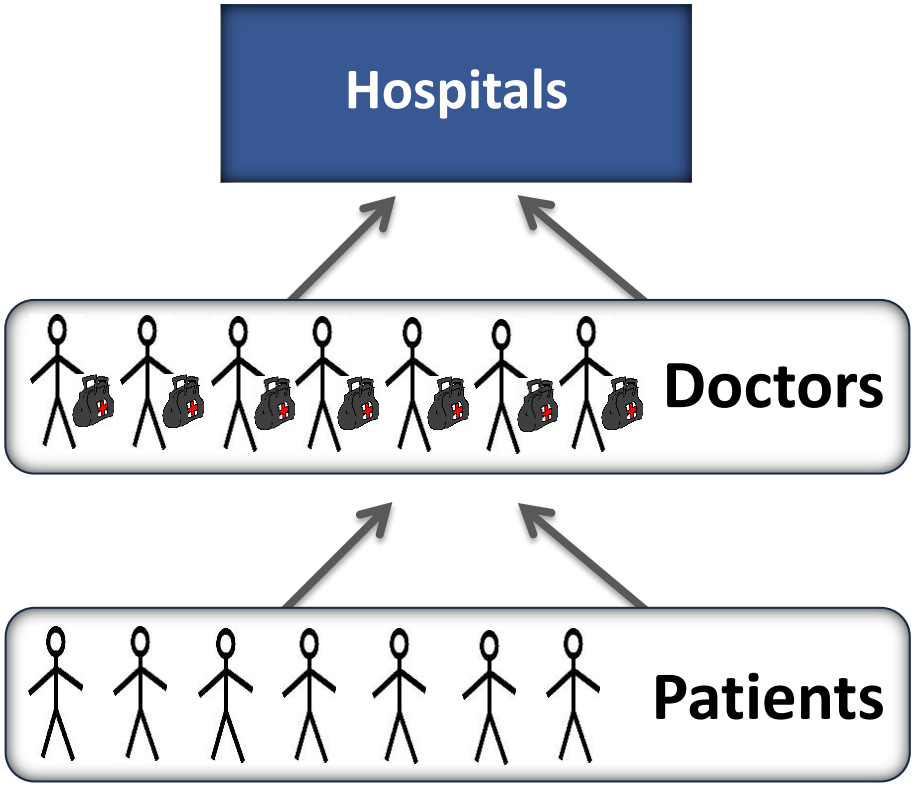
- Began in earnest following the financial crisis of 2007-2009
- Driven by escalating federal and state fiscal problems and insupportable health care costs
- Accelerated by provider innovation and successful experiments with a new/different value-based business model
- Advanced through concepts and principles rooted in the Affordable Care Act

Inflection Point 2.0

1. Insurance market transformation
2. Healthcare as a retail transaction
3. Emergence of new competitors
4. Declining inpatient utilization; mixed changes in outpatient
5. Delivery model dislocations are underway
6. Pursuit of "Population Health Manager" or "Healthcare Company Model"



How Healthcare Has Been…



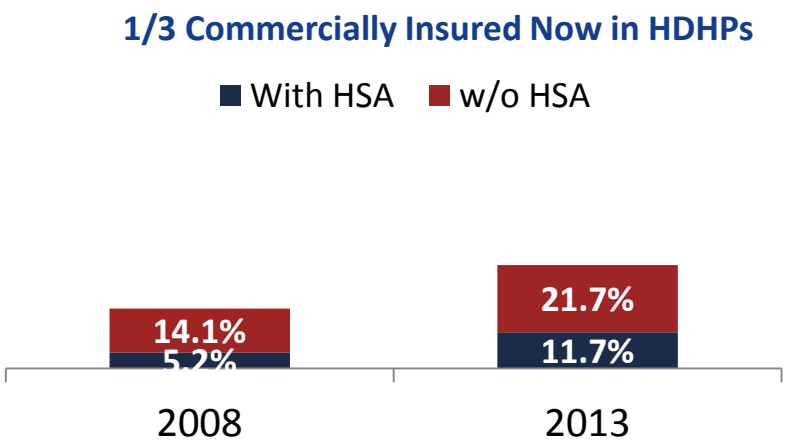
Industry Transformation Is Driving a Set of Key Challenges Facing Providers

- Insurance market transformation
- Healthcare as a retail transaction
- A new basis of competition
- Pursuit of “population health management” or “healthcare company” status
- Declining inpatient utilization; mixed changes in outpatient services
- Delivery system dislocations
- Retooling of the healthcare workforce

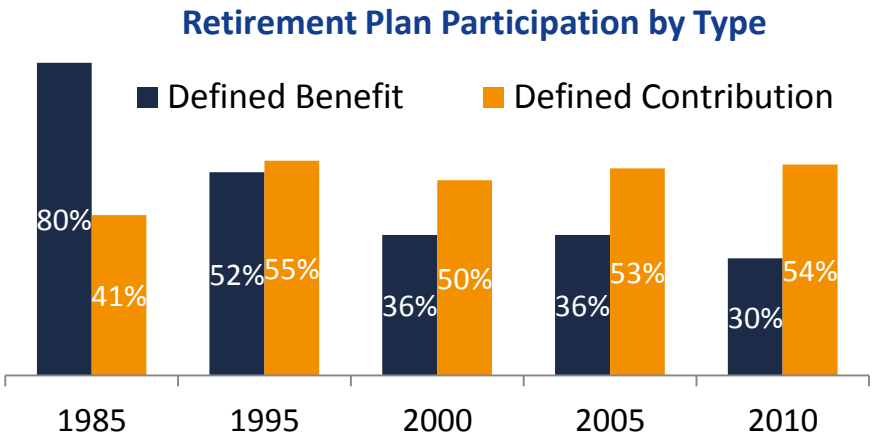
Our discussion today will focus on certain of these drivers that are most pertinent to the Dimensions Healthcare situation

Insurance Market Transformation

High Deductible Health Plans (HDHPs) Continue to Gain Steam and Governmental Beneficiaries Are Increasing Enrollment in Managed Care Programs



Essentially, a Shift from "Defined Benefit" to "Defined Contribution"

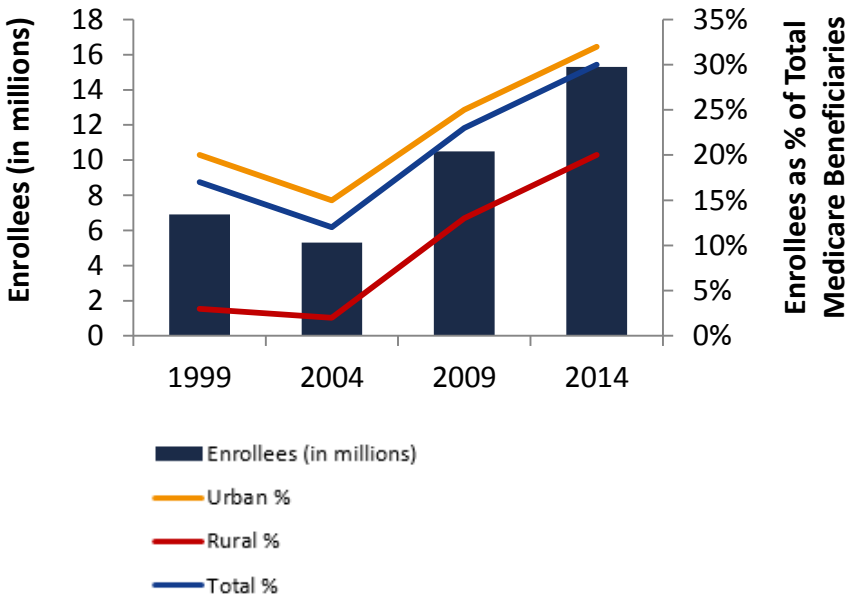


This Type of Shift Is Not Without Precedent: Retirement Plans

Source: CDC/NCHS, National Health Interview Study via MCOL Daily Factoid (3/27/14); EBRI Databook on Employee Benefits, Chapter 10, Updated May 2011. Notes: Enrollment includes both aged and disabled beneficiaries. Gold, M., et al.: "Medicare Advantage 2013 Spotlight: Enrollment Market Update." Issue Brief, Kaiser Family Foundation, June 2013. Smith, V.K., Rudowitz, R., Snyder, L., et.al: *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*. Kaiser Family Foundation Report, Oct. 2013

Insurance Market Transformation (continued)

Medicare Advantage Enrollment Growth



Growth in Managed Medicaid

% Beneficiaries Enrolled in MCOs or PCCMs	
1991	9%
2000	51%
2011	74%

Managed Care Organizations (MCOs) – risk-based, capitated Medicaid health plans – and Primary Care Case Management (PCCM) programs are the most common forms of Medicaid managed care

Source: CDC/NCHS, National Health Interview Study via MCOL Daily Factoid (3/27/14); EBRI Databook on Employee Benefits, Chapter 10, Updated May 2011. Notes: Enrollment includes both aged and disabled beneficiaries. Gold, M., et al.: "Medicare Advantage 2013 Spotlight: Enrollment Market Update." Issue Brief, Kaiser Family Foundation, June 2013. Smith, V.K., Rudowitz, R., Snyder, L., et.al: *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*. Kaiser Family Foundation Report, Oct. 2013

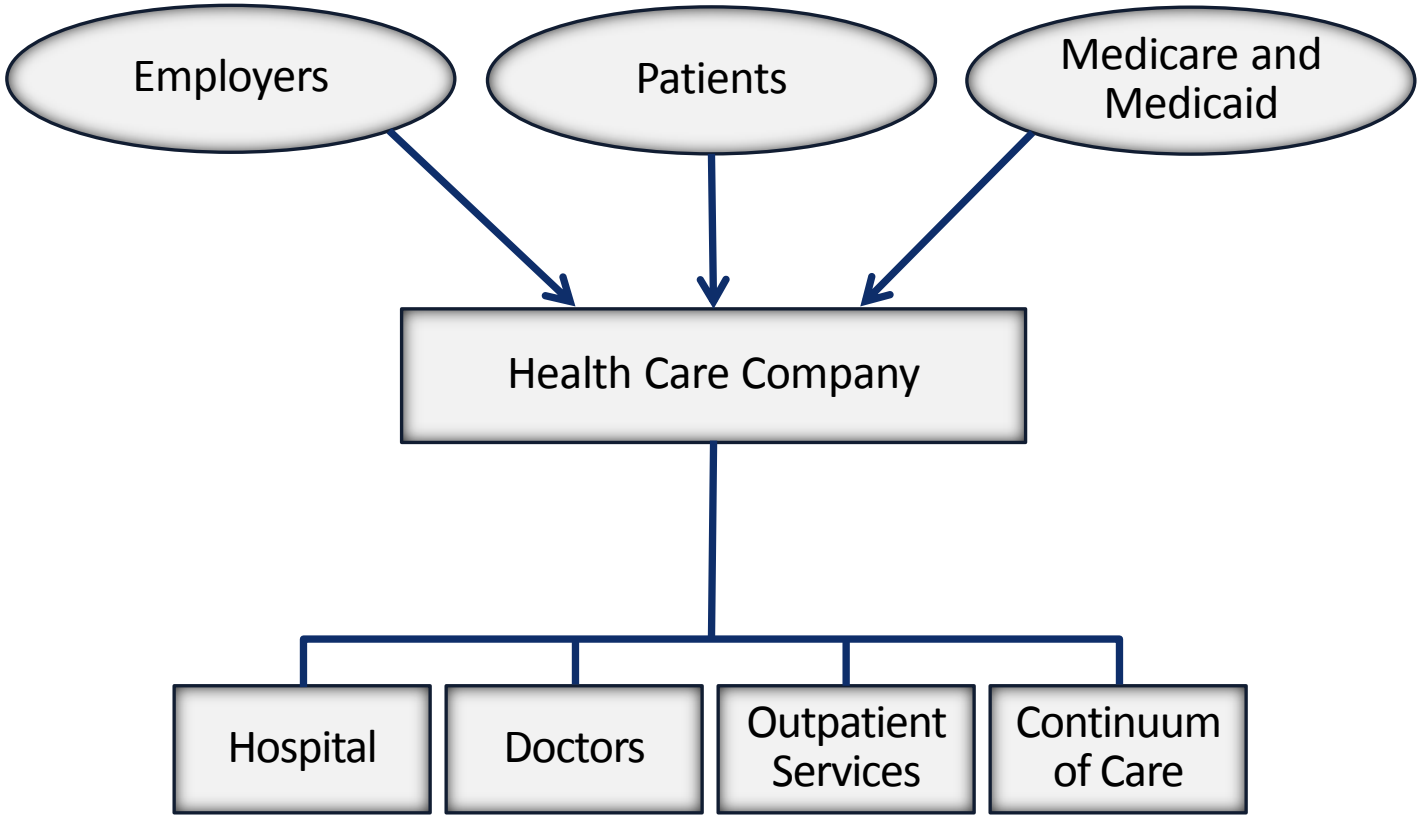
Healthcare as a Retail Transaction

Healthcare Is Moving to a Retail Model; Individual Choice Will Be More a Factor Than Ever

Wholesale Construct	Retail Construct
• Employer selects a health plan from an insurer that contracts with a broad spectrum of providers • Medicare and Medicaid establish a benefit plan and set payment rates for providers • Individuals have limited plan choices but can access most providers for the same cost to the individual • Individuals bear little economic consequence for provider selection for a specific procedure and follow the physician direction	• Employers and governmental payers define a fixed dollar benefit per employee/family/individual • Individuals select a health plan or a private or public exchange and bear the cost over the fixed dollar benefit • Individuals have broader health plan choices but in most cases more limited provider access and/or economic consequences for going out of network • Individuals bear significant economic consequence for provider selection and actively debate/challenge physician direction

Pursuit of a "Population Health Manager" or "Healthcare Company" Model

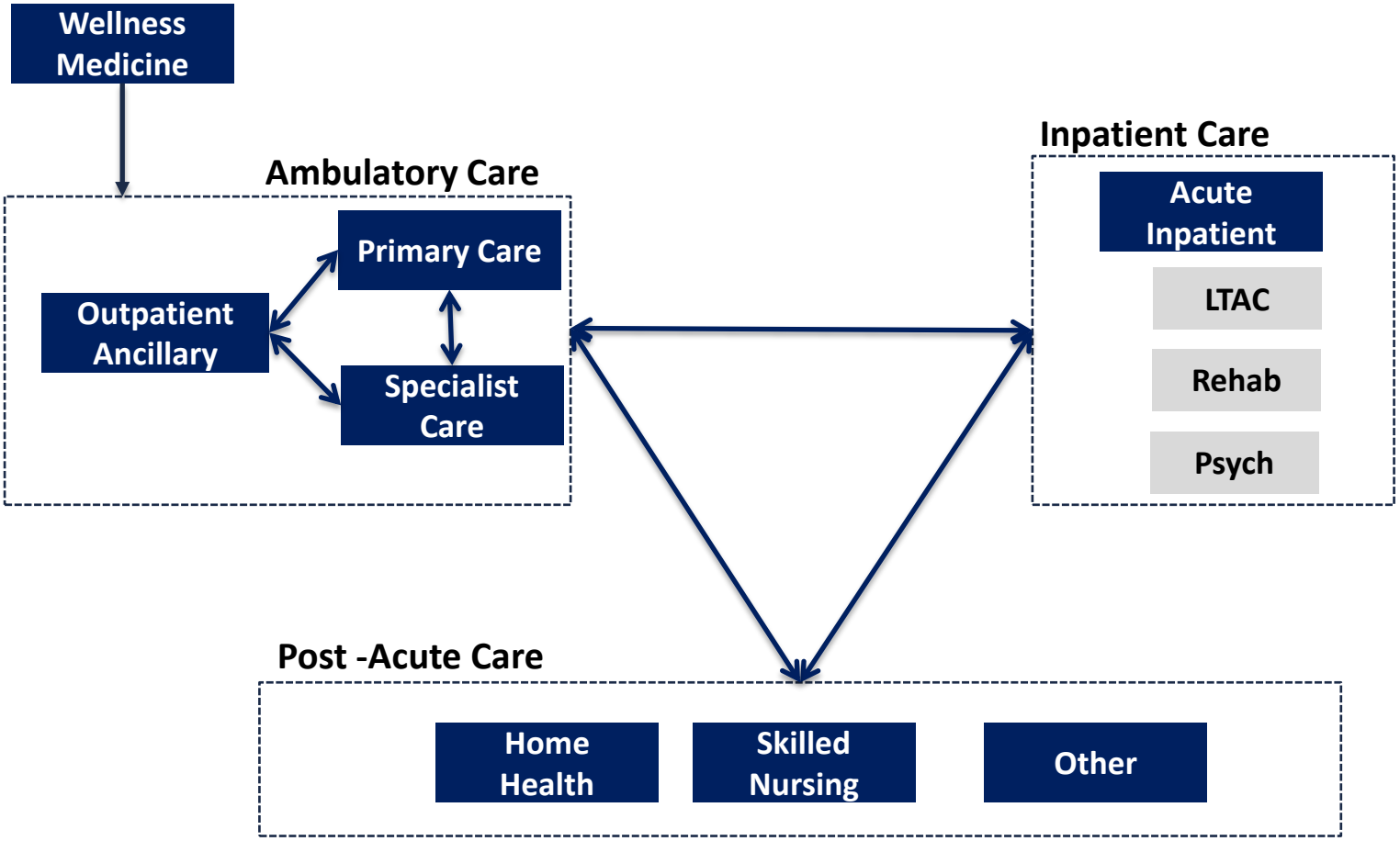
The New Healthcare Business Model?



Source: Kaufman, Hall & Associates, Inc.

Pursuit of a "Population Health Manager" or "Healthcare Company" Model (continued)

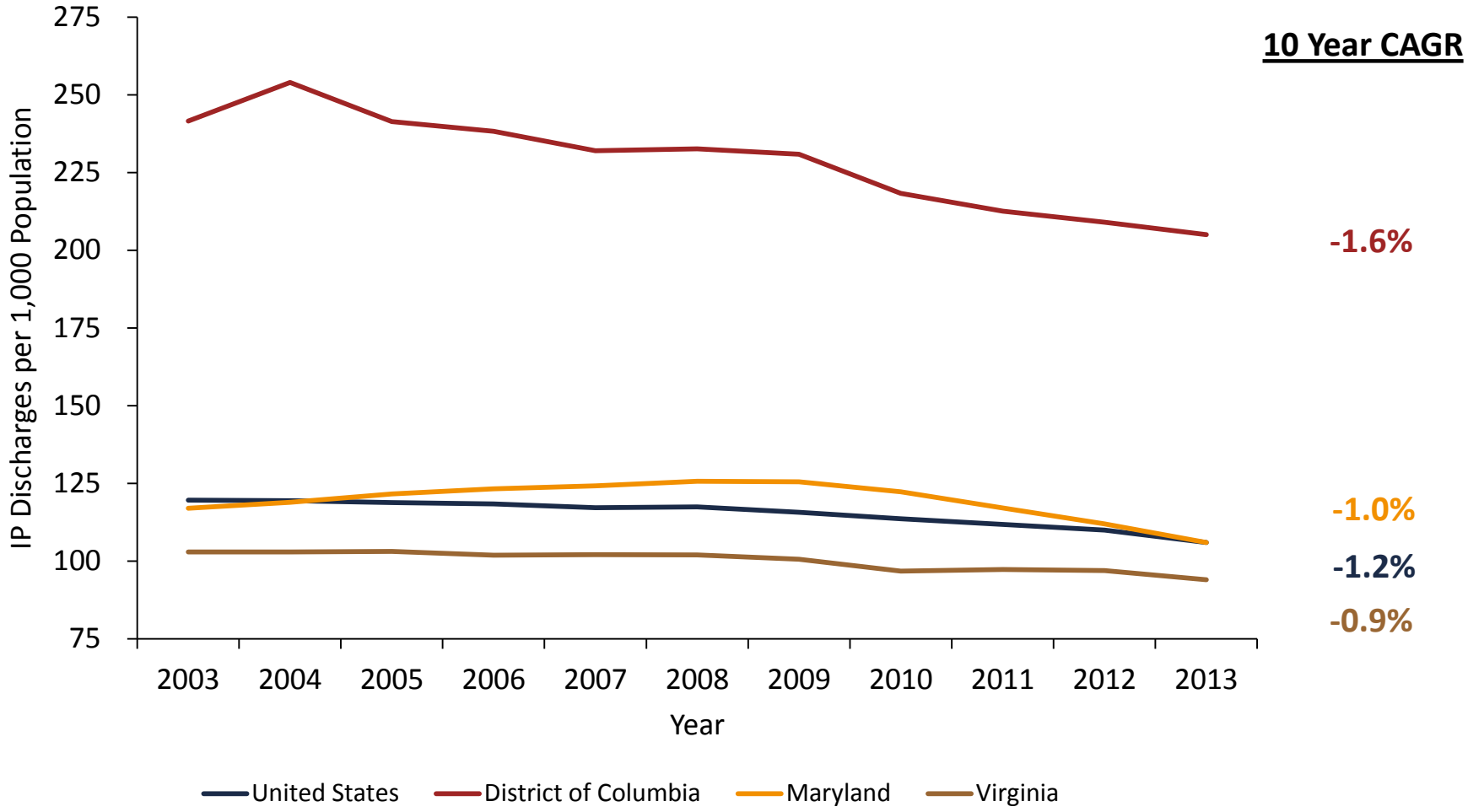
Increasing Focus and Concern with the Full Continuum of Care



The HSCRC Is A Unique Force In Maryland That Accelerates Market Evolution

- From 2014 to 2018, CMS and HSCRC will limit hospital cost increases to the lesser of 3.8% or 0.5% less than the national acute care growth rate.
- Some reductions will come from focus on reducing readmissions.
- Biggest driver of changes will be the changes to the annual rate-setting procedures of the HSCRC.
  - Limit the incentive for increasing acute care volume
  - Portions of payments will be withheld unless cost growth is contained to annually set limits
- Incentive for health systems will change.
  - Proactive management of cases to reduce readmissions
  - Push low complexity cases to outpatient

Historically, Maryland Use Rate Has Been Similar to the National Use Rate While Washington DC Use Rate Has Been Much Higher

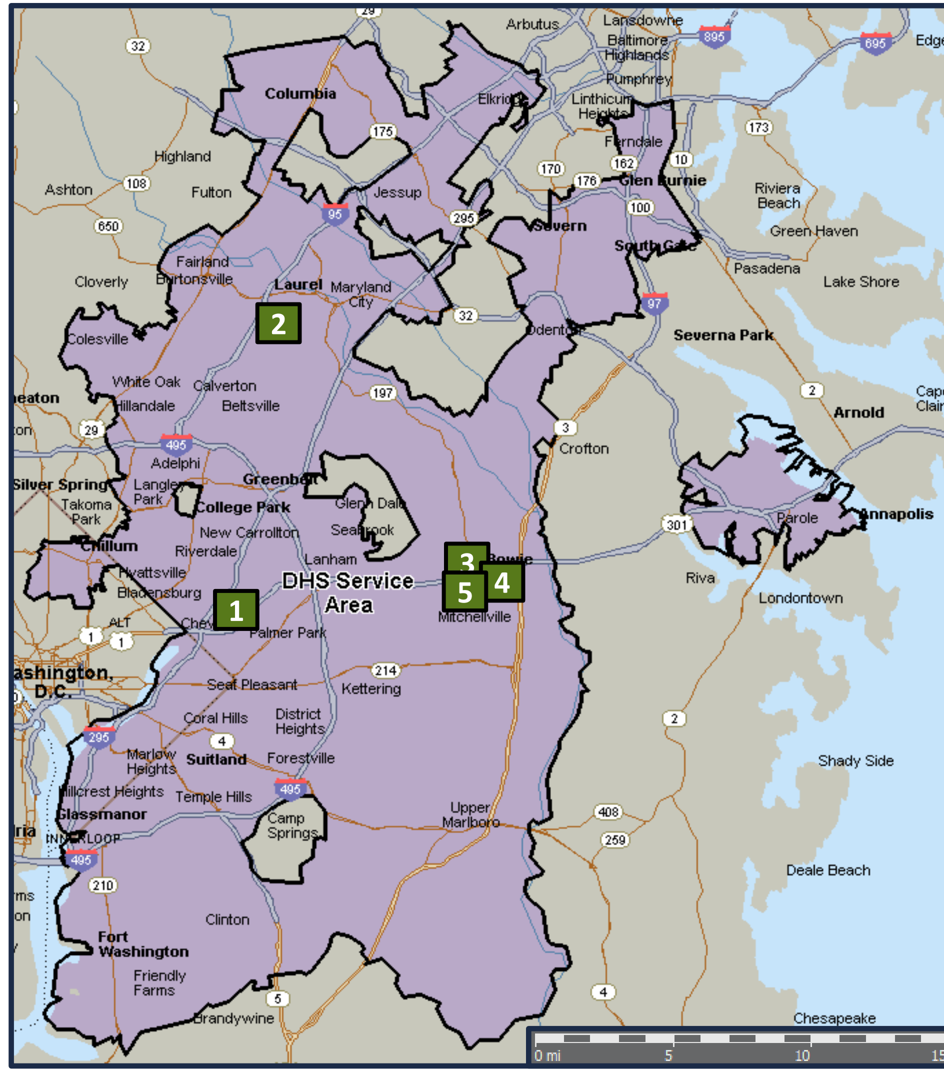


Source: Kaiser State Health Facts

3 Dimension's Healthcare System's Current State

DHS Operates Acute and Ambulatory Facilities in a Well Defined Service Area

- The DHS service area is defined as the origin for the top 85% of PGHC and LRH discharges
- DHS' major facility network:
  - 2 Hospitals
  - 1 Freestanding ED
  - 1 Freestanding ASC
  - 1 LTACH



Map Key

1 **Prince George's Hospital Center**

2 **Laurel Regional Hospital**

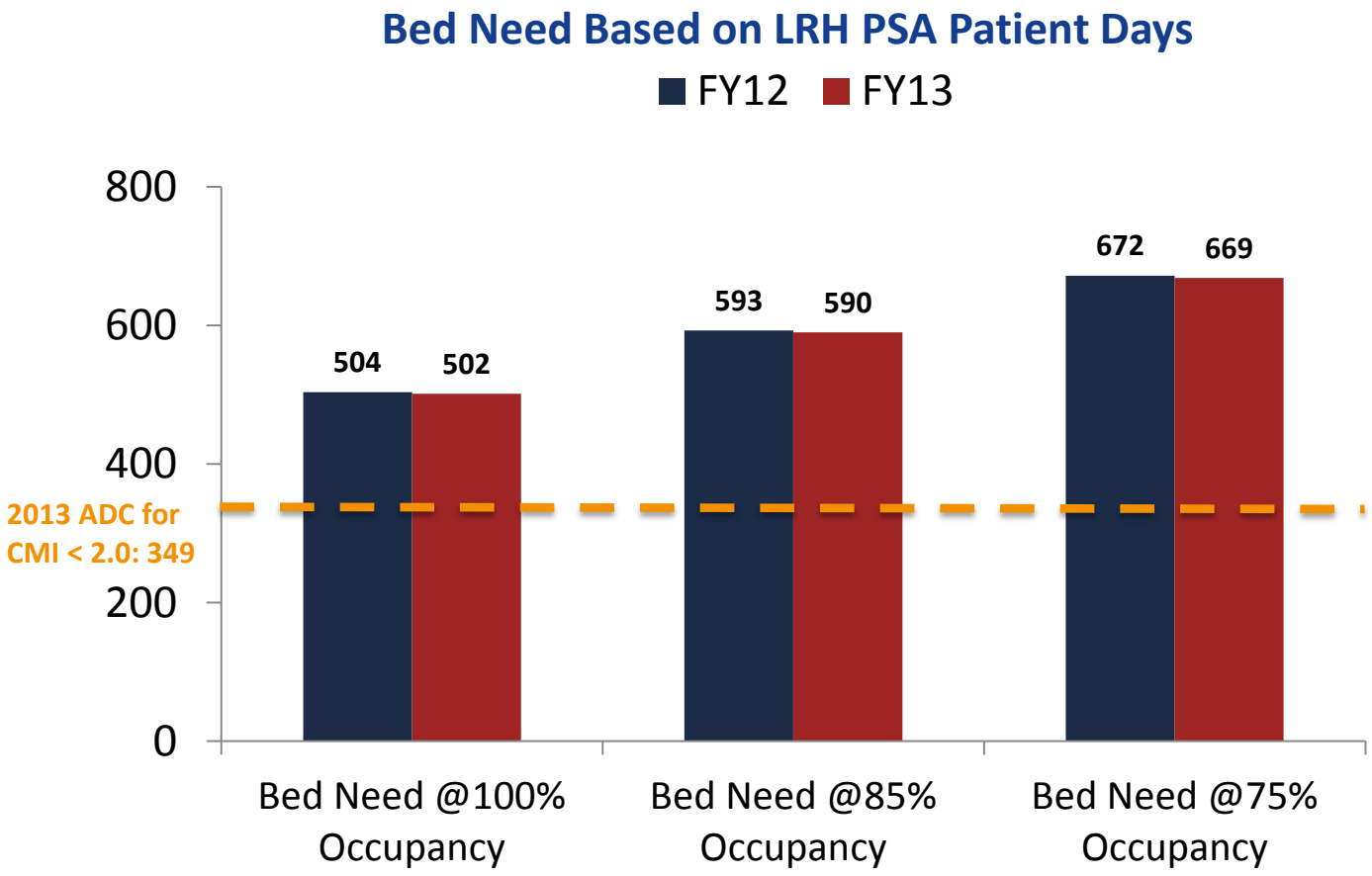
3 **Bowie Health Center (Freestanding ED)**

4 **Dimensions Surgery Center (Freestanding ASC)**

5 **Larkin Chase Center (LTACH)**

Source(s): Client facilities list, DHS service area definition

PSA Bed Supply Appears to Exceed the Need of Lower Acuity Market Cases, and Many Large Hospitals Operate Near the PSA



PSA Staffed Adult Beds

170 – PGHC
58 – LRH
198 – Doctor's

426 – Total

Nearby Staffed Adult Beds

397 – Holy Cross
674 – WHC

1,497 – Nearby + PSA

Hospitals account for 55% of PSA IP Care

Note: excludes normal newborns, neonatal services, psych, and rehab DRG's
Source: Maryland, Washington DC, and Virginia Inpatient Databases; DHS Internal Summary Statistics; Definitive Healthcare

Significant Numbers of Patients Leave the Service Area to Access Care Predominately at Holy Cross and Washington Hospital Center

High Complexity (CMI > 3) Outmigration

Specialty	Cases	Case Mix
Surgery	1,420	6.8
Neonatal	1,189	3.9
Cardiac Surgery	719	5.8
Spine-Back/Neck Procedure	615	4.9
Vascular Surgery	467	3.8
Neuro surgery	424	4.7
Other	1,710	4.9
Total	**6,544**	**5.1**

Health System	Cases
Washington Hospital Ctr	1,198
Holy Cross	950
University of Maryland Medical	733
Johns Hopkins	632
Washington Adventist Hospital	572
Georgetown Univ Hosp	432
All Other	2,027
Total	**6,544**

Moderate Complexity (CMI 2-3) Outmigration

Specialty	Cases	Case Mix
Orthopaedics	1,957	2.2
Surgery	1,080	2.5
Interventional cardiology	487	2.2
Neonatal	433	2.1
Spine-Back/Neck Procedure	325	2.5
Neuro surgery	302	2.5
Other	1,463	2.4
Total	**6,047**	**2.3**

Health System	Cases
Washington Hospital Ctr	940
Holy Cross	658
Washington Adventist Hospital	544
Johns Hopkins	442
Georgetown Univ Hosp	404
University of Maryland Medical	360
All Other	2,699
Total	**6,047**

Low Complexity (CMI < 2) Outmigration

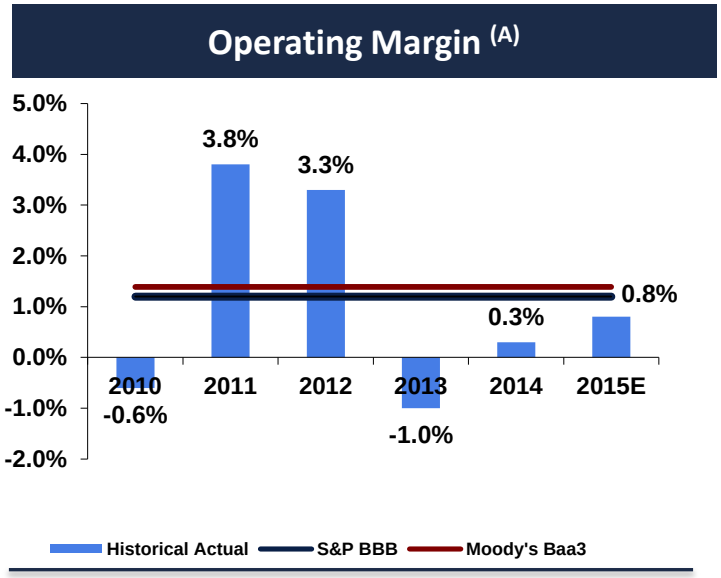
Specialty	Cases	Case Mix
Obstetrics	10,020	0.7
Medicine	6,296	1.1
Respiratory	4,055	1.0
Cardiology	3,672	1.1
Neurology	3,324	1.1
Gastroenterology	3,283	1.0
Medical Oncology/ Hemat	2,832	1.1
All Other	19,054	N/A
Total	**52,536**	**N/A**

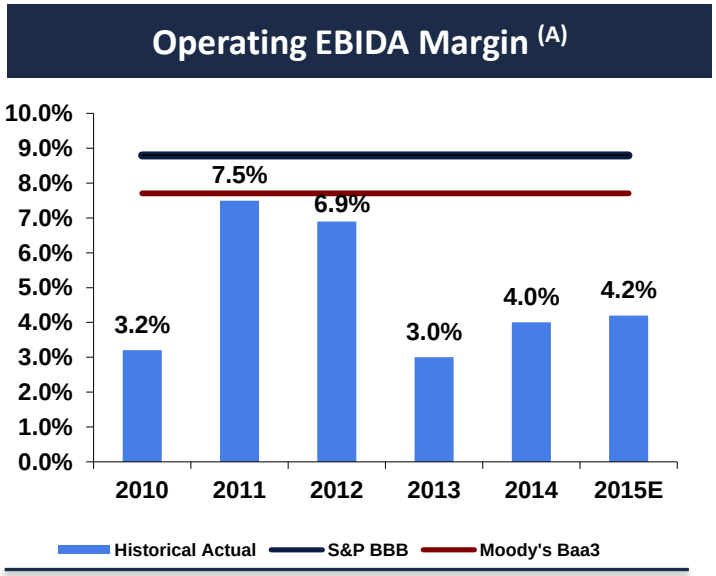
Health System	Cases
Holy Cross	11,493
Washington Hospital Ctr	6,624
Washington Adventist Hospital	6,119
Children's Medical Center	3,928
Johns Hopkins	2,893
University of Maryland Medical	2,595
All Other	18,884
Total	**52,536**

Notes: analysis excludes normal newborns; Outmigration defined as discharges originating in the DHS SA and leaving the entire service area for care
Source: Maryland, Washington DC, and Virginia Inpatient Databases

DHS Profitability Has Been Inconsistent, Especially Since FY 2013

Profitability





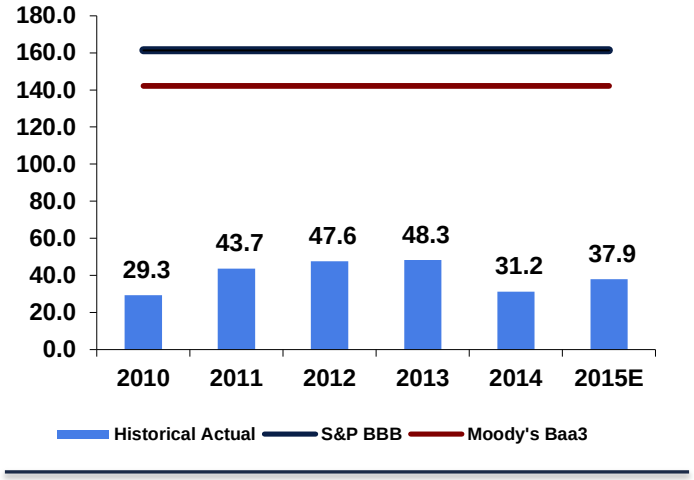
- Operating performance has been inconsistent over the last six years, driven by modest patient service revenue growth (2.5% CAGR from FY2010-FY2015) and system-wide increases in operating costs

Note (A) – Light blue bars in graphs shown above represent DHS's historical financial metrics (grants included above operating income); dark blue line represents S&P 2014 "BBB" median rating level; red line represents Moody's 2014 "Baa3" median rating level.
Other Notes – DHS is currently unrated. For comparative purposes, operating EBIDA margins are below that of the S&P "BBB" and Moody's "Baa3" median levels. Outside grants received are included in Operating Income for purposes of the margin calculations consistent with DHS reporting.

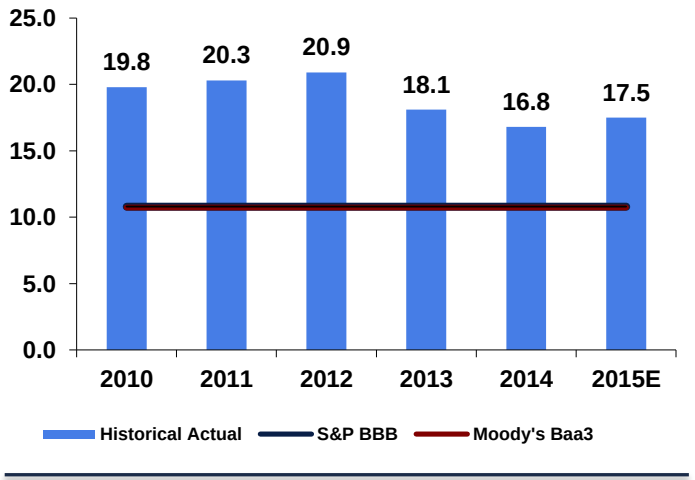
The Weakness of DHS' Balance Sheet Limits its Ability to Fund Needed Reinvestment

Liquidity and Other

Days Cash on Hand (A)



Average Age of Plant (A)



- Inconsistent and insufficient operating performance has prevented DHS from improving its balance sheet (in particular its liquidity position). A such, its ability to provide funding for needed reinvestment is extremely limited.

Note (A): Light blue bars in graphs shown above represent DHS' historical financial metrics (grants included in operating income); The dark blue line represents S&P 2014 "BBB" median rating level and the red line represents Moody's 2014 "Baa3" median rating level, included for comparison purposes even though DHS is currently unrated.

Additional Financial Position Observations

- In 2014, DHS' long-term debt was extinguished, which has improved the debt metrics substantially.
- 2014 was the first year in which Net Assets were positive (mainly due to the debt extinguishment).
- As stated earlier, operating results have been inconsistent, ranging from losses of 1.0% to positive margins of 3.8% in the past 5 years.
  - To help support operations, operating grants were recorded in other income ranging from $22.7 and $31.3 million annually. Without these grants, operations would have run deficits of between $17 million and $34 million over the past 5 years.
- Liquidity (measured in days cash on hand) is extremely low at 31 days in 2014. This assumes that approximately $42 million of investments held for self insurance are restricted.
- Due to low liquidity, capital spending has been depressed. Capital spending has exceeded annual depreciation in only one of the past five years. This has resulted in an extremely high average age of plant.

4 Dimension's Strategic Imperatives

Strategic Imperatives

- Dimensions must continue to meet the healthcare needs of the communities in which it is an essential institution.
- Though DHS does not have a viable, long-term independent strategy, it must position itself to be a contributing and financially sustainable component of any larger system it enters.
  - The working assumption is that DHS will become a part of the University of Maryland Medical System ("UMMS")
- The Regional Medical Center ("RMC") is a critical enabler for DHS to meet its mission and serve the broader healthcare needs of Prince George's County.
- In a contracting inpatient market, DHS needs to ensure that all of its inpatient assets are well utilized and fully optimized; Specifically, the current configuration of LRH is unsustainable.

Projections of a "Status-Quo" Future Scenario Support the Need to Alternative Strategies to Achieve Long-Term Sustainability

- A DHS "status-quo" scenario, including the construction of the new RMC, is unsustainable due to continued top-line revenue pressures, dependency on external revenue funding and ongoing general expense inflation.
- Of most notable concern is the challenge with LRH operations given the mix and scale of services offered at that site.
  - LRH's operating losses are projected to persist throughout the projection period, with the loss of $15 million growing to ~$21 million by FY2022
- DHS cannot "grow its way" out of its poor performance.
  - By FY2022, to reach a 1% System operating income margin, DHS would need 9% annual volume growth at LRH. In order to achieve 3% System operating income margin, 12% annual volume growth at LRH, or 5% across the entire System, would be required.

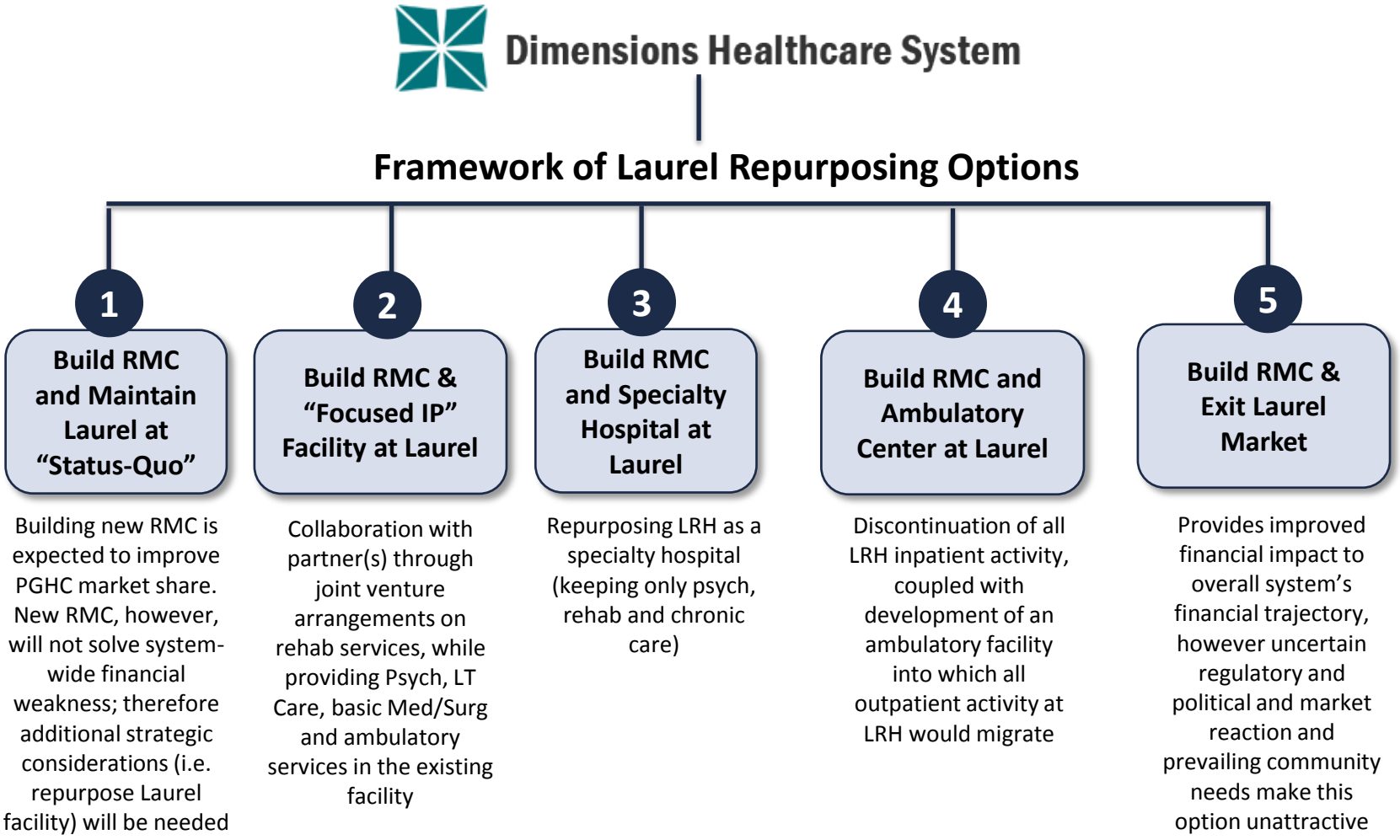
The Laurel market is significant to both DHS and UMMS, and will continue to be attractive, but the market is increasingly competitive. DHS will need to reconfigure its presence in the Laurel market, focusing on long-term financial viability while meeting community needs.

5 DHS Laurel Market – Alternative Strategic Scenarios

Continued Operation of More Streamlined Services at LRH Was Preferred, But Only Subject to Rigorous Analysis – Potentially a Bridge Strategy and Not Long-Term Financial Solution

- Kaufman Hall worked with DHS management to study the viability of a preferred scenario including a smaller, more focused set of inpatient services at LRH.
- This scenario was preferred as it would be much less disruptive to the Laurel community and to DHS.
- This Scenario, designated #2, would include:
  - Very low complexity medical and surgical services (transition year)
  - Psych, Rehab and Chronic
  - Ambulatory Services and ED
  - Mothballing of vacant space to decrease operating costs
- Pursuit of this scenario, however, is conditioned by evaluation of its impact on DHS and the ability of DHS to support the associated financial requirements.

Given DHS' Current Position, What Options Are Available For LRH?



Why Not Pursue Scenario 5?

- Dimensions has repeatedly stated that it is committed to serving the Laurel market.
- The market is over supplied with inpatient beds, a fact that would diminish the value of LRH as a continuing hospital operation. Especially given expectations for continued decreases in IP demand, the most likely acquisition strategy would be to buy and close LRH to remove a competitor from the market.
- The current state of the LRH facility would require significant capital investment for an acquiring organization wanting to continue full IP operations. This would create additional fixed costs that would further limit LRH's attractiveness to a hospital operator.
- The acquirer of LRH will be faced with significant competition for inpatient services, especially with the development of the new Washington Adventist hospital.
- From the perspective of the burgeoning relationship with UMMS, sale of LRH would cede a significant, growing market that would complicate, and potentially undermine, the broader regional strategy for Dimensions and UMMS in Prince George's County.

Evaluation of Scenario #4

Strategic Implications	• Rebranding opportunity for DHS and LRH in northern Prince George's County • Competitive risk associated with an increasingly competitive OP landscape • Consumerism and retail forces will continue to increase; development of a purpose-built ambulatory facility may begin to transition DHS toward a more consumer-focused orientation • Potential to incorporate specialty clinics in behavioral health or other specialty programs based at future partner sites (e.g., Doctor's Hospital)
Community Response	• Expect a mixed reaction • Likely more difficult to communicate vision and merits
Financial Evaluation	• Additional capital required ($24 million for the new ambulatory facility) which will further strain DHS' balance sheet if it cannot find the external funding • **Provides long-term financial solution for both LRH and DHS**
Risks and Other Considerations	• Maintaining/developing competitiveness in the market • Ensuring timely and efficient execution; will need to quickly execute given financial pressures • Transition risk to current LRH business between announcement and opening

Planned Scope of Services For New Laurel Ambulatory Medical Center

- Full-service 24/7 Emergency Services with Board-certified emergency medical physicians.
- Possibly outpatient observation service if regulatory and licensing environment allows.
- Ambulatory surgical center.
- Diagnostic services including imaging services (CT / MRI / other imaging services).
- Other types of diagnostic testing including some laboratory services.
- Based on needs identified by School of Public Health Impact Study, outpatient clinics and programs to address public health issues including asthma/chronic pulmonary disease, diabetes, chronic heart conditions, and behavioral health.
- Health education conference room.

New Ambulatory Facility at Laurel and Financing Options

- Many funding options exist and should be examined to fund expected $24M capital need for new facility.
  1. Dimensions Health funds project through its own balance sheet (cash) which is currently contemplated in the strategic plan
  2. Banks and other funding sources (or combination between Dimension's own balance sheet and third party debt)
     - Dimensions has had several conversations with banks and other companies, and these entities have expressed preliminary interest
  3. Contributions / donations from 3rd party stakeholders
  4. Funding source through self-generated cash flows from operational savings
     - Identified $10M in annual operating savings at Laurel is below that of $24M capital need to build new facility
- Timing and successful execution of this strategic initiative will be completed in the next two to three fiscal years and be appropriately managed by the coalition.

6 Recommendations and Concluding Thoughts

Recommendations

- Both DHS Management and Kaufman Hall agree that addressing the financial challenges at LRH with the least amount of disruption or change to the current mix of services is the preferred direction.
- However, the critical driver of LRH's challenges is its underutilized facility. Given its current performance and position in the market, LRH will not be able to grow its way to profitability.
- Kaufman Hall recommends DHS pursue development of a freestanding ambulatory care facility at LRH as described in Scenario #4
  - Maintains an ongoing presence in a growing market
  - Provides the community a purpose-built health care facility
  - Mitigates financial risk at LRH and enhances the System's position for long-term financial viability without ongoing governmental grants
  - Enables DHS to focus resources and energy on the execution of the RMC (which is critical for the System's long-term success)
- We recognize Scenario #2 as an aspirational scenario which would maintain current services in the market. However, it is not feasible given the DHS' financial position.

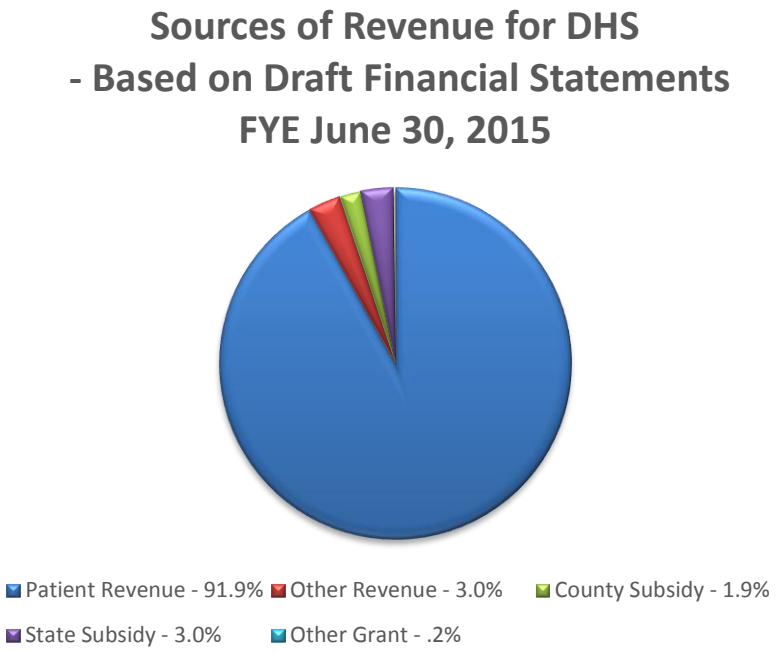
Concluding Thoughts

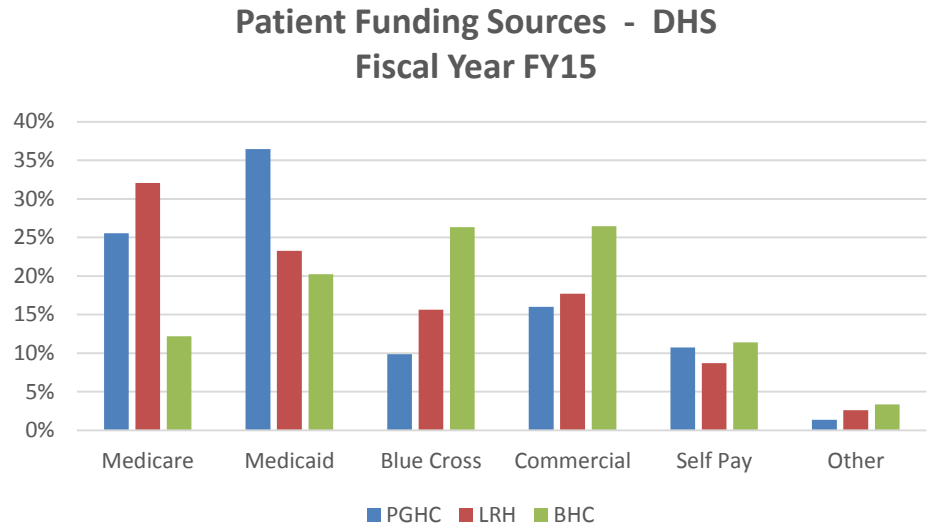
- Laurel is an important strategic market for DHS within the context of its regional presence.
- LRH has the potential to provide accretive operating performance to DHS while maintaining a strong presence to support the needs of the Laurel community.
- Successful execution on the new ambulatory facility is critical to the System's success and will need to be aggressively managed.
  - Continued implementation of identified revenue optimization and cost opportunities to enhance DHS' financial position in the short-term
  - This will enable the System to support access to external capital for the RMC and ambulatory facility
- Once DHS is able to solidify its financial and market position, the System should evaluate the possibility of expanding services in Laurel as feasible and sustainable.

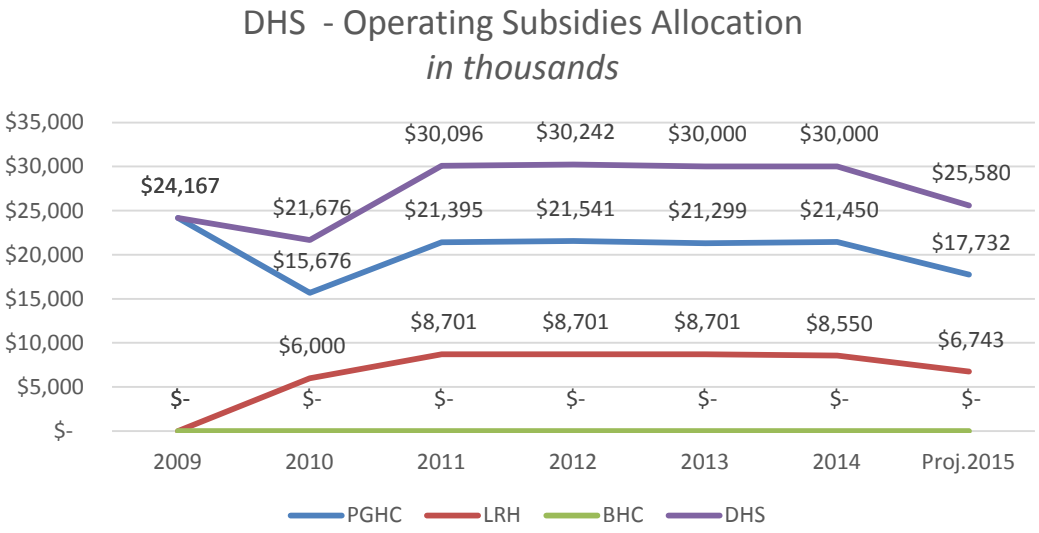
Additional Financial Information On Dimensions Healthcare System

Financial Information

Dimensions Healthcare System







This funding enabled DHS to have physicians available to help provide access to care for approximately 2.0 M people during a 15 year period.

DHS physician subsidies of last three fiscal years were:

- $32.8 million (FY2013)
- $34.1 million (FY2014)
- $41.2 million (FY2015)

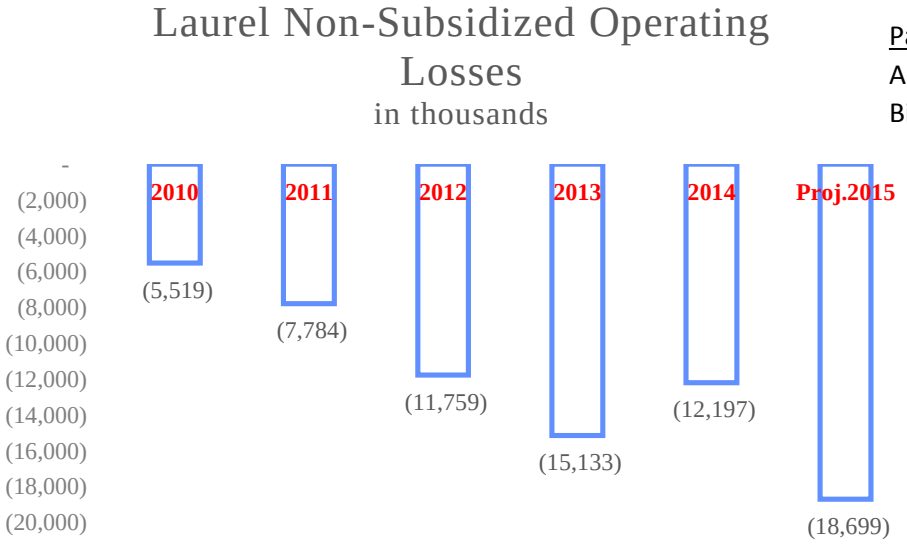
Transparency of Financial Information

Dimensions Healthcare System

- DHS manages each facility as separate business units within the system. All patient accounting and accounting activity is separate within each business unit.
  - On a monthly basis, DHS accounting staff and key financial stakeholders conduct a detailed financial review of all organizations.
  - Financials are then posted and shared within three systems for further review – the budget system, the accounting system and "Basecamp" which finance uses for publication and distribution internally.
  - A final, higher level review occurs monthly with the management cabinet and other organizational leaders who assess financial performance and review expense allocations.
  - Monthly Financial information and the Annual Audit is then made available for public access on the HSCRC website.
- Estimates are used in preparing the financials in some areas. Processes and transparent communication support these areas that are then subject to audit. Elements used in these processes include the following:
  - Historical data, current trends and patterns as well as comparison to state and national averages reference points in areas where estimates are utilized.
  - Each area where a material estimate is utilized is audited ranging from one to three times depending on the scope of each audit.
- The financial statements for DHS are audited by multiple certified public accounting firms (CPA firms) on an annual basis. These audits occur year round for various purposes. These audits include the following:
  - Annual Audit – Dixon Hughes Goodman CPA Firm
  - HSCRC Special Audit Procedures – PGHC, LRH, BHC – Dixon Hughes Goodman CPA Firm
  - Pension and Retirement Plan(s) Audit – Bert Smith and Company CPA Firm
  - Use of County Operating Subsidies – Dixon Hughes Goodman CPA Firm
  - Use of State Operating Subsidies – Dixon Hughes Goodman CPA Firm
  - Dimensions Assurance Limited – KPMG, LLP CPA Firm
- Allocation of corporate expenses within DHS are made through a transparent, consistent process that is reviewed and adjusted on a continuous schedule and involves the full DHS management team. This is a best practice across the nation in other healthcare providers.

Laurel Information

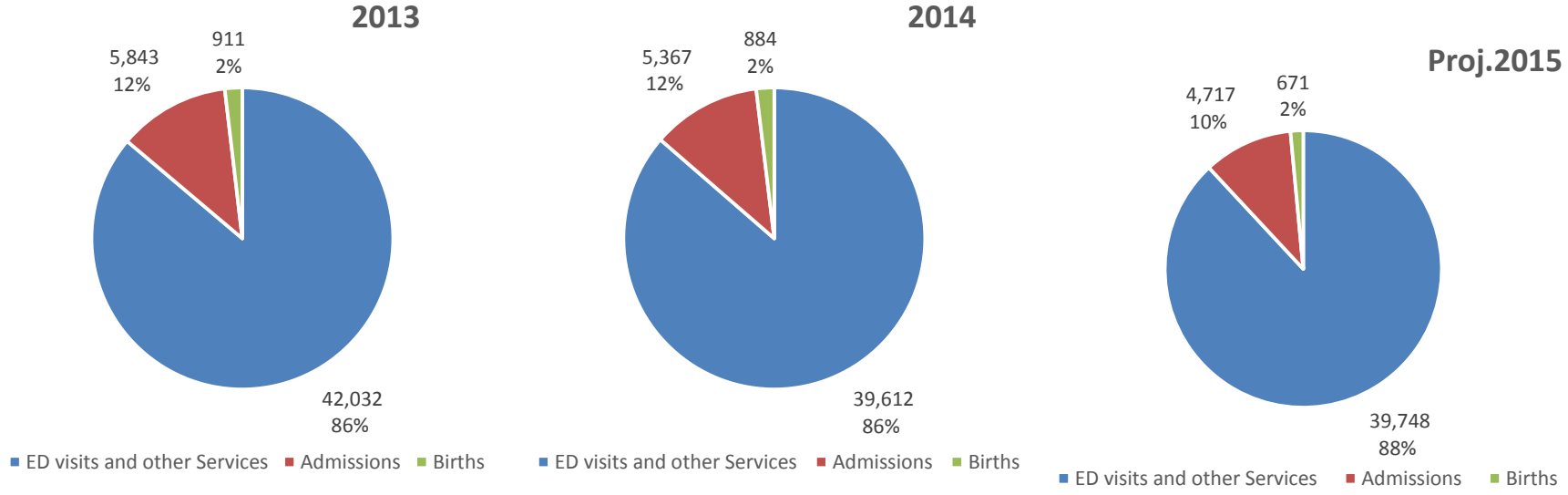
Dimensions Healthcare System



Patients Using Laurel's Inpatient Services	2013	2014	Proj.2015
Admission	5,843	5,367	4,717
Births	911	884	671

- Less than 10% of the population in Laurel's service area use the facility
- Less than 2 births a day occur on average at Laurel compared to 12 a day at Holy Cross and 5 a day at PGHC from Laurel's service area.

Number and percentage of patients using Laurel's services by type of service.



Summation of Transition To Modernized Healthcare

- Transitioning to a new ambulatory care medical center over the next 24-36 months.
- Ambulatory services including emergency services will remain.
- Approximate size of facility estimated to be approximately 43,000 square feet.
- Examples of what ambulatory centers look like follow:

Examples of Ambulatory Medical Centers

40,000 SF ASC / future ED in Kansas

50,000 SF Surgical Hospital with ED
Oklahoma

Queenstown, Maryland Ambulatory Facility

Queenstown, Maryland Ambulatory Facility

Questions