Accretive Health, Inc.
Form 10-K
June 23, 2015

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

ý ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2014
OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number 001-34746
Accretive Health, Inc.
(Exact name of registrant as specified in its charter)

Delaware	02-0698101
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
401 North Michigan Avenue Suite 2700 Chicago, Illinois	60611
(Address of principal executive offices)	(Zip Code)
(312) 324-7820	
Registrant's telephone number, including area code	

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	Name of each exchange on which registered:
None	None

Securities registered pursuant to Section 12(g) of the Act:
Common Stock, $0.01 par value

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No ý

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No ý

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ¨ No ý

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ¨ No ý

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ý

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ý	Accelerated filer o	Non-accelerated filer ¨	Smaller reporting company o	(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No ý

Aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based on the last sale price for such stock on June 30, 2014: $454,304,464.

As of June 1, 2015, the registrant had 97,948,301 shares of common stock, par value $0.01 per share, outstanding.

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PART IV

FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements, within the meaning of the federal securities laws, that involve substantial risks and uncertainties. You should not place undue reliance on these statements. All statements, other than statements of historical facts, included in this Annual Report on Form 10-K regarding our strategy, future operations, future financial position, future revenue, projected costs, prospects, plans, objectives of management and expected market growth are forward-looking statements. The words “anticipate”, “believe”, “estimate”, “expect”, “intend”, “may”, “plan”, “predict”, “project”, “would” and similar expressions are intended to identify forward-looki statements, although not all forward-looking statements contain these identifying words. These forward-looking statements include, among other things, statements about:

- our ability to regain a listing on a national securities exchange;
- our ability to attract and retain customers;
- our financial performance;
- the advantages of our solutions as compared to those of others;
- our plans to incorporate our value based reimbursement capabilities within our revenue cycle management service offering;
- our ability to establish and maintain intellectual property rights;
- our ability to retain and hire necessary employees and appropriately staff our operations; and
- our estimates regarding capital requirements and needs for additional financing.

We may not actually achieve the plans, intentions or expectations disclosed in our forward-looking statements, and you should not place undue reliance on our forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in the forward-looking statements we make. We have included important factors in the cautionary statements included in this Annual Report, particularly in “Part I - Item 1A - Risk Factors,” that could cause actual results or events to differ materially from the forward-looking statements that we make. Our forward-looking statements do not reflect the potential impact of any future acquisitions, mergers, dispositions, joint ventures or investments we may make.

You should read this Annual Report and the documents that we have filed as exhibits to the Annual Report completely and with the understanding that our actual future results may be materially different from what we expect. We do not assume any obligation to update any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law.

PART I

Unless the context indicates otherwise, references in this Annual Report to "Accretive Health," "Accretive," the "company," "we," "our," and "us" mean Accretive Health, Inc. and its subsidiaries.

Item 1. Business

Overview

Accretive Health is a leading provider of revenue cycle services that help healthcare providers generate sustainable improvements in their operating margins and cash flows while also enhancing patient, physician and staff satisfaction for our customers.

We achieve these results for our customers through an integrated approach encompassing our end-to-end revenue cycle management service offering and physician advisory services. We do so by deploying a unique operating model that leverages our extensive healthcare site experience, innovative technology and process excellence. We also offer modular services, allowing clients to engage us for only specific components of our end-to-end revenue cycle management service offering.

Our primary service offering consists of revenue cycle management, or RCM, which helps healthcare providers to more efficiently manage their revenue cycles. This encompasses patient registration, insurance and benefit verification, medical treatment documentation and coding, bill preparation and collections from patients and payers. We assist our RCM customers in increasing the portion of the maximum potential services revenue they receive while simultaneously reducing their revenue cycle operating costs. Together, these benefits can generate significant and sustainable improvements in operating margins and cash flows for our customers. Our management and staff supplement each customer’s existing RCM process and staff, and help operate our customers’ processes. We educate and empower our customers’ employees so that over time we can jointly deliver improved results using the proprietary technology included in our applications. Once implemented, our technology applications, processes and services are deeply embedded in our customer’s day-to-day operations. We believe this service offering is adaptable to meet an evolving healthcare regulatory environment, technology standards and market trends. Importantly, our RCM agreements typically provide that we and our customers share in the benefits that are derived on behalf of our customers, particularly revenue increases and, in most cases, cost savings resulting from the application of our solutions. We believe that this sharing of benefits aligns our objectives and interests with those of our customers (including patient satisfaction).

Our physician advisory services, or PAS, offering, which we incorporated into our RCM offering in the third quarter 2014, assists hospitals in complying with payer requirements regarding whether to classify a hospital visit as an in-patient or an out-patient observation case for billing purposes. This offering consists of both concurrent review and retrospective chart audits to help our customers achieve compliant and accurate billing. We also provide customers with retrospective appeal management service support for both governmental and commercial payers. Our physicians conduct detailed retrospective reviews of medical records to identify medical necessity for hospital services and the required documentation to appropriately support an appeal. We employ trained physicians to deliver these services.

We offered our population health solutions, or PHS, services on a standalone basis until the third quarter of 2014. This offering was designed to enable healthcare providers to more effectively manage the health of a defined patient population by identifying those individuals who are most likely to experience an adverse health event and, as a result, incur high healthcare costs in the coming years. In the fourth quarter of 2014, we began integrating capabilities from this offering into our core RCM offering in order to enhance our value-based reimbursement capabilities for our RCM customers and to prepare our customers for future changes in healthcare. We currently do not serve any customers for PHS.

We develop and refine our offerings based in part on information, processes and management experience garnered through working with some of the largest and most prestigious hospitals and healthcare systems in the United States, as well as in anticipation of regulatory and market changes that impact our customers. Our customers typically are single or multi-hospital healthcare systems, including faith-based healthcare systems, community healthcare systems, academic medical centers and their respective affiliated ambulatory clinics and physician practice groups, certain of which have common affiliations to larger umbrella healthcare organizations that are also parties to our customer contracts with their respective affiliates. We have developed strategic, long-term relationships with our customers and focus on providers that we believe understand the value of our operating model and have demonstrated success in both clinical and operational outcomes.

Our Strategy

We strive to be the partner of choice for U.S. healthcare providers in RCM, a strategically important service that aligns clinical, financial and administrative functions, allowing providers to focus on delivering quality care with ever-increasing efficiency. Key elements of our strategy include:

- Delivering tangible, long-term results through an integrated offering. Our solutions are designed to help our customers achieve sustainable economic value through improvements in their operating margins and cash flows, which provides us with performance-based revenues. Our integrated offerings address the financial impact on our clients arising from the quality of clinical documentation and the efficient administration of certain clinical or quasi-clinical functions. Our integrated offerings also alleviate the need for our customers to purchase services from multiple sources, saving them time, money and integration challenges in their efforts to improve their revenue cycle activities.
- Developing, utilizing and enhancing effective and proprietary operational processes to improve our customers' revenue yield. We have developed and continue to design proprietary processes intended to help our customers to increase net revenue yields on amounts owed to them. To help improve revenue collection from payers and patients, we have developed proprietary algorithms to assess risk for all of our customers' receivables. Our methodology is designed to enable nearly 100% of outstanding claims to be reviewed, prioritized and appropriately pursued. We believe that our focus on collecting revenue from a broader range of outstanding claims and reducing the average time to collect differentiates our RCM services.
- Seeking to expand the scope of services to existing customers and diversify our customer base. We benefit from long-term relationships with some of the nation's largest health networks such as Ascension Health, which was our founding customer and remains our largest customer, as well as Intermountain Healthcare and Trinity Health. We seek to expand the scope of our services to healthcare providers within the network of our existing customers' hospital systems. We also focus on marketing to other healthcare providers and seek to leverage our relationships with existing customers as references to continue to attract business from new customers.
- Developing enhanced service offerings that are designed to enable our customers and prospects to improve their operations and to effectively participate in new payment models. We plan to introduce new services that we believe will be attractive to both existing and prospective customers. These include offerings to support the movement toward value-based reimbursement, or VBR, that is being driven through a confluence of government regulation, payer programs and benefit plan designs advanced by large employers and payers. These new payment models are intended to shift the utilization of healthcare resources away from volume-based episodic care of patients who are sick or have chronic conditions to the pro-active management of patient populations to promote wellness and provision of care in lower acuity settings. We believe that the impact on providers, including our customers, will be that they will increasingly bear financial risk in clinical outcomes. Our VBR services within our RCM offering are designed to provide operational support to help providers assess their risk as they engage in value-based-reimbursement arrangements. We also may selectively pursue acquisitions and/or strategic relationships that will enable us to broaden our service offerings.

Our Services

Drawing on our combination of our extensive healthcare-site expertise, innovative technology and process excellence, we seek to deliver measurable economic value to our customers across our revenue cycle management and physician advisory solutions.

Revenue Cycle Management Offering

Our primary RCM service offering consists of comprehensive, integrated technology and RCM services, which address the full spectrum of revenue cycle operational issues faced by healthcare providers.

To implement our integrated solution, we supplement each customer's existing RCM process and staff with our qualified experienced RCM specialists, leaders and staff and connect our proprietary technology and analytical applications to each customer's existing technology systems. Our employees have significant experience in healthcare management, revenue cycle operations, technology, quality control and other management disciplines. Our solution is adapted to the hospital's organizational structure to minimize disruption to existing operation and staff. We seek to integrate our technology, personnel, our accumulated body of knowledge and our culture within each customer's revenue cycle activities, with the expectation that we will enjoy a long-term collaborative relationship with each customer. We deliver technology and operational support in the form of both on-site management and centralized staffing to deliver improved efficiency and quality across all RCM functions.

Our RCM agreements generally provide us with the opportunity to earn two types of performance-based fees associated with achieved efficiencies and improvements in our customer's revenue cycle processes: net operating fees and incentive fees.

Net operating fees represent the gross base fees we charge our customers for operating the revenue cycle processes included in our agreements less corresponding costs of customers' revenue cycle operations which we undertake to pay pursuant to our RCM agreements. For some customers, the amount of our net operating fees is reduced by an agreed upon percentage of such difference, representing the customer's share of cost reductions resulting from our services. We help our customers reduce their revenue cycle costs by implementing new operational practices, optimizing their technology suite and deploying more efficient processes. In certain cases, we work with our customers to transfer aspects of their revenue cycle operations to our shared services centers, which typically results in lower operating costs than operating those aspects of the revenue cycle at the customers' site.

We have modified a portion of our RCM agreements to eliminate the gross base fees along with our financial obligation to pay our customers' revenue cycle operation expenses.

Incentive fees represent our negotiated share of the increases in our customers' operating revenues and are earned by improving their net revenue yield. We help many of our customers improve their collection of amounts owed by payers and patients for healthcare services. We refer to this as net revenue yield. We use our proprietary technology or other financial metrics to calculate their improvement in net revenue yield. When using the method of calculating this improvement that employs our proprietary technology, we compare the customer's actual cash collections for a given instance of care to the maximum potential cash receipts that the customer should have received from the instance of care. We then aggregate these calculations for all instances of care and compare the result to the aggregate calculation for a defined period before we began to provide our services to the customer. When using other financial metrics to calculate this improvement, we typically employ metrics that are already being tracked by, or easily calculated from, our customers' respective accounting systems and compare the results of those metrics against the results for the same metrics for a defined period before we began to provide our services to the customer.

We seek to improve our customers' processes using a variety of techniques including:

- Gathering Complete Patient and Payer Information. We focus on gathering complete patient information and validating insurance eligibility and benefits so patient care services can be recorded and billed to the

appropriate parties. For scheduled healthcare services, we educate patients as to their potential financial responsibilities before receiving care. Through our systems we maintain an automated electronic scorecard which measures the efficiency of up-front data capture, authorization, billing and collections throughout the life cycle of any given patient account. These scorecards are analyzed in the aggregate, and the results are used to help improve work flow processes and operational decisions for our customers.

- Improving Claims Filing and Payer Collections. Through our proprietary technology and process expertise, we identify, for each patient encounter, the amount our customer should receive from a payer if terms of the applicable contract with the payer and patient policies are followed. Over time, we compare these amounts with the actual payments collected to help identify which payers, types of medical treatments and patients represent various levels of payment risk for a customer. Using proprietary algorithms and analytics, we consider actual reimbursement patterns to predict the payment risk associated with a customer's claims to its payers, and we then direct increased attention and time to the riskiest accounts.
- Identifying Alternative Payment Sources. We use various methods to find payment sources for uninsured patients and reimbursement for services not covered by payers. Our patient financial screening technology and methodologies often identify federal, state or private grant sources to help pay for healthcare services. These techniques are designed to ease the financial burden on uninsured or underinsured patients, increase the percentage of patient bills that are actually paid, and improve the total amount of reimbursement received by our customers.
- Employing Proprietary Technology and Algorithms. We employ a variety of proprietary data analytics and algorithms. For example, we identify patient accounts with financial risk by applying proprietary analysis techniques to the data we have collected. Our systems are designed to streamline work processes through the use of proprietary algorithms that focus revenue cycle staff effort on those accounts deemed to have the greatest potential for improving net revenue yield or charge capture. We adjust our proprietary predictive algorithms to reflect changes in payer and patient behavior based upon the knowledge we obtain from our entire customer base. As new customers are added and payer and patient behavior changes, the information we use to create our algorithms expands, increasing the accuracy, reliability and value of those algorithms.
- Using Analytical Capabilities and Operational Excellence. We draw on the experience that we have gained from working with some of the best healthcare provider systems in the United States to train our customers' staff about new and innovative RCM practices. We use sophisticated analytical procedures to identify specific opportunities to improve business processes.
- Increasing Charge Capture. We are able to help our customers increase their charge capture by implementing optimization techniques and related processes. We use sophisticated analytics software to help improve the accuracy of claims filings and the resolution of disputed claims from payers. We also overlay a range of capabilities designed to reduce missed charges, improve the clinical/reimbursement interface and produce bills that comply with payer requirements and applicable healthcare regulations.
- Leveraging our Shared Services Centers. We help our customers increase their revenue cycle efficiency by implementing improved practices, streamlining work flow processes and outsourcing aspects of their revenue cycle operations to our shared services centers. Examples of services that can be completed at our shared services centers in the United States and India include pre-registration, medical transcription, cash posting, reconciliation of payments to billing records, and patient and payer follow-up. By leveraging the economies of scale and experience of our shared services centers, we believe that we offer our customers better quality services at a lower cost.

We believe that these techniques are enhanced by our proprietary and integrated technology, management experience and well-developed processes. Our proprietary technology applications include workflow automation and direct payer connection capabilities that enable revenue cycle staff to focus on problem accounts rather than on manual tasks, such as searching payer websites for insurance and benefits verification for all patients. We employ technology that identifies and isolates specific cases requiring review or action, using the same interface for all

users, to automate a host of tasks that otherwise can consume a significant amount of staff time. Our proprietary technology enhances the ability of our customers' revenue cycle staff to improve their interaction with patients.We use real-time feedback from our customers to improve the functionality and performance of our technology and processes and incorporate these improvements into our service offerings on a regular basis. We strive to apply operational excellence throughout our customers' entire revenue cycle.

Physician Advisory Services Offering

Our PAS offering provides concurrent level of care billing classification reviews, as well as retrospective chart audits to assist hospitals in properly billing payers for selected services. These services complement our RCM offering and our ability to provide our customers end-to-end management services, and, accordingly, some of our RCM customers are also customers of our physician advisory services offering. According to the policies of the Centers for Medicare & Medicaid Services, or CMS, the decision to classify a patient as an in-patient or out-patient observation case for billing purposes is based on complex medical judgment that can only be made after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the severity of signs and symptoms, the medical predictability of adverse events and the patient’s anticipated length of stay. Using our secure web portal, hospital customers transmit pertinent data about the case at hand to our trained physicians, who then leverage our proprietary diagnosis guidelines and the extensive information within our knowledge database to reach an informed billing classification judgment, which we then provide to our customers as a recommendation.

We also provide customers with retrospective appeal management service support for both governmental and commercial payers. Our physicians conduct detailed retrospective reviews of medical records to identify medical necessity for hospital services and the required documentation to appropriately support an appeal.

We believe that our PAS offering provides our customers with a number of operational benefits, such as

- direct physician to physician contact,
- improved service levels, and
- real-time reporting and analytics.

Population Health Solutions Offering

Our PHS services were designed to enable healthcare providers to partner with payers for the creation and implementation of payment structures based on clinical success, measured at either the individual level or among a defined population of patients, and to assist providers in maximizing their financial performance under such compensation structures. These services were designed to help healthcare providers enhance the patient and physician experience and to assist healthcare providers in capturing a share of any reduction in healthcare costs they are able to achieve under revised compensation structures by helping them negotiate contracts with payers that provide an equitable sharing of the savings in total medical costs among the payers and healthcare providers, and manage their revenue cycle process under such contracts. In the fourth quarter of 2014, we began integrating capabilities from this offering into our core RCM offering in order to enhance our value-based reimbursement capabilities for our RCM customers and to prepare our customers for future changes in healthcare payment systems. We currently do not serve any customers for our PHS and no longer offer these services on a stand-alone basis.

Market Opportunity

The market for our service offerings consists primarily of multi-hospital systems and other healthcare providers in the United States. We believe that macroeconomic, regulatory and healthcare industry conditions will continue to impose financial pressures on healthcare providers and will increase the importance of managing their revenue cycle operations effectively and efficiently. New reimbursement models in the healthcare industry measure both financial and clinical performance metrics, and increasingly shift economic risk of clinical outcomes to

providers. We believe our integrated revenue cycle offering can help providers adapt to, and improve reimbursement levels under, such risk-based compensation structures.

Segments

All of our significant operations are organized around the single business of providing end-to-end management services of revenue cycle operations for U.S.-based hospitals and other medical services providers.

We view our operations and manage our business as one operating and reporting segment. All of our net services revenue and trade accounts receivable are derived from healthcare providers domiciled in the United States. The information about our business should be read together with our consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K. See Note 11, Segments and Customer Concentrations, to our consolidated financial statements for information regarding our segment and customer concentrations.

Customers

Our customers typically are single or multi-hospital healthcare systems, including faith-based healthcare systems, community healthcare systems, academic medical centers and their respective affiliated ambulatory clinics and physician practice groups, certain of which have common affiliations to larger umbrella healthcare organizations that are also parties to our customer contracts with their respective affiliates. We seek to develop strategic, long-term relationships with our customers and focus on providers that we believe understand the value of our operating model and have demonstrated success in both the provision of healthcare services and the ability to achieve financial and operational results.

Customer Agreements

We generally provide our RCM offering pursuant to managed services agreements with our customers. In rendering our services, we must comply with customer policies and procedures regarding charity care, personnel, data security, compliance and risk management, as well as applicable federal, state and local laws and regulations.

Our managed services agreements with our RCM customers typically span three to five years. After the initial term of the agreement, many of our managed services agreements automatically renew unless terminated by either party upon prior written notice.

In general, our RCM agreements provide that:

- we are required to staff a sufficient number of our own employees on each customer’s premises and provide the technology necessary to implement and manage our services;
- our management and staff work cooperatively with our customers’ management and staff to achieve mutually specified objectives;
- we earn performance-based fees that are tied to the achievement of financial benchmarks related to increases in customer revenues and/or reductions in operating costs;
- the parties provide representations and indemnities to each other; and
- the agreements are subject to termination by either party in the event of a material breach which is not cured by the breaching party.

Our agreements for physician advisory services generally vary in length between one and three years. Generally, the agreements automatically renew after their initial term unless terminated by either party upon prior written notice. Customers pay a contractually negotiated fee for this service on a per-use basis.

Sales and Marketing

Our new business opportunities are generated through a combination of high-level industry contacts of members of our senior management team and systematic relationship building by a team of senior sales executives. Our sales and marketing process generally begins by engaging senior executives of the prospective hospital or healthcare system, typically followed by our assessment of the prospect's existing operations, and a review of the findings. We begin negotiations with a standardized contract that is customized as necessary after collaborative discussions of operational and management issues and our proposed working relationship. Our sales process for RCM managed services agreements typically lasts six to 18 months from the introductory meeting to the agreement's execution, while our sales process for our physician advisory services offering typically lasts three to four months.

Technology

Technology Development

Our technology development organization operates out of various facilities in the United States and India. We are increasing the amount of resources that we invest in the improvement of our technology in order to enhance the services that we provide our customers. All customer sites run the same base set of code. We use a beta-testing environment to develop and test new technology offerings at one or more customers, while keeping the rest of our customers on production-level code.

Our applications are deployed on a highly-scalable architecture based upon Microsoft and other industry leading platforms. We offer a common experience for end-users and believe the consistent look and feel of our applications allows our customers and staff to use our software suite quickly and easily.

We devote substantial resources to our development efforts and plan at an annual, bi-annual and quarterly release level. We employ a structured system to assess the impact that potential new technologies or enhancements will have on net service revenue, costs, efficiency and customer satisfaction. The results of this analysis are evaluated in conjunction with our overall corporate goals when making development decisions. In addition to our technology development team, our operations personnel play an integral role in setting technology priorities in support of their objective of keeping our software operating 24 hours a day, 7 days a week.

Technology Operations and Security

Our applications are hosted in data centers located in Alpharetta, Georgia; Philadelphia, Pennsylvania; and Salt Lake City, Utah; and our internal financial application suite is hosted in a data center in Minneapolis, Minnesota. These data centers are operated for us by third parties and are compliant with the Statement on Standards for Attestation Engagements, or SSAE, No. 16, Reporting on Controls at a Service Organization (formerly referred to as Statement on Auditing Standards, or SAS, 70). Our development, testing and quality assurance environments are operated from the third-party data centers in Alpharetta, Georgia and Philadelphia, Pennsylvania; with a separate server room in our Chicago, Illinois office. We have agreements with our hardware and system software suppliers for support 24 hours a day, 7 days a week. Our operations personnel also use our resources located in our other U.S. facilities, as well as our India facilities.

Customers use high-speed internet connections or private network connections to access our business applications. We utilize commercially available hardware and a combination of custom-developed and commercially available software. We designed our primary application in this manner to permit scalable growth. For example, database servers can be added without adding web servers, and vice versa.

Databases are backed-up frequently by automatically shipping log files with accumulated changes to separate sets of back-up servers. In addition to serving as a back-up, these log files update the data in our online analytical processing engine, enabling the data to be more current than if only refreshed overnight. Data and information

regarding our customers' patients is encrypted when transmitted over the internet or traveling off-site on portable media such as laptops or backup tapes.

Customer system access requests are load-balanced across multiple application servers, allowing us to handle additional users on a per-customer basis without application changes. System utilization is monitored for capacity planning purposes.We believe that this architecture enables us to scale our operations effectively and efficiently.

Our software interacts with our customers' software through a series of real-time and batch interfaces. We do not require changes to the customer's core patient care delivery or financial systems. Instead of installing hardware or software in customer locations or data centers, we specify the information that a customer needs to extract from its existing systems in order to interface with our systems. This methodology enables our systems to operate with many combinations of customer systems, including custom and industry-standard implementations. We have successfully integrated our systems with older and newer systems, with package and custom systems and with major industry-standard products and solutions.

When these interfaces are in place, we provide an application suite across the hospital revenue cycle. For our purposes, the revenue cycle starts when a patient registers for future service or arrives at a hospital or clinic for unscheduled service, and ends when the hospital has collected all the appropriate revenue from all possible sources. Thus, we provide eligibility, address validation, skip tracing, charge capture, patient and payer follow-up, analytics and tracking, charge master management, contract modeling, contract "what if" analysis, collections and other functions throughout the customer's revenue cycle. Since our databases run on generally available hardware and software, we are able to use standard applications to develop, maintain and monitor our solutions. Databases for one or more customers can run on a single database server with disk storage being provided from a shared storage area network, or SAN, with physical separation maintained between customers. In the event of a server failure, we have maintenance contracts in place that require the service provider to have the server back on-line in four hours or less, or we move the customer processing to alternate servers. Our databases and servers are backed-up in full on a weekly basis and undergo incremental back-ups nightly. The SAN is configured as a redundant array of inexpensive disks, or RAID, and this RAID configuration protects against disk failures having an impact on our operations. Database log files are stored separately from database files to reduce incidents of data loss. Data and information regarding our customers' patients is encrypted when at rest, when transmitted over the internet, and when traveling off-site on portable media such as laptops or backup tapes.

In the event that a combination of events causes a system failure, we typically can isolate the failure to one or a small number of customers. We believe that no combination of failures by our systems can impact a customer's ability to deliver patient care.

Our third-party data centers are designed to withstand many catastrophic events, such as blizzards and hurricanes. To protect against a catastrophic event in which our primary data center is completely destroyed and service cannot be restored within a few days, we store backups of our systems and databases off-site. In the event that we are required to move operations to a different data center, we would re-establish operations by provisioning new servers, restoring data from the off-site backups and re-establishing connectivity with our customers' host systems. Because our systems are web-based, no changes would need to be made on customer workstations, and customers would be able to reconnect as our systems became available again.

We monitor the response time of our application in a number of ways. We monitor the response time of individual transactions by customer and place monitors inside our operations and at key customer sites to run synthetic transactions that demonstrate our systems' end-to-end responsiveness. Our hosting provider reports on responsiveness server-by-server and identifies potential future capacity issues. In addition, we survey key customers regarding system response time to make sure customer-specific conditions are not impacting performance of our applications.

We dedicate significant resources to protecting our customers' confidential and protected health information, or PHI. Our security strategy employs various practices and technologies to control, audit and protect access to sensitive information. We received and have maintained since January 2013, a certification status from the Health

Information Trust Alliance, or HITRUST. HITRUST is a healthcare industry group focused on identifying a prescriptive set of information technology controls that are based on standards and regulations relevant to the healthcare industry. HITRUST certification is aligned with ISO 27001 and ISO 27002. Our HITRUST certification validates our continued commitment to compliance with the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations that have been issued under it, such as the HITECH and OMNIBUS regulations, which we collectively refer to as HIPAA, and to various states' security and privacy laws regarding the creation, access, storage or exchange of personal health and financial information. Our HITRUST certification status also signifies that we exhibit and are able to maintain high security standards for the management and protection of electronic PHI.

Proprietary Software Suites

Revenue Cycle Management. Our integrated suite of RCM technology provides a layer of analytics, rules processing and workflow capabilities that interface with provider systems to optimize process efficiency and effectiveness. These technologies power the detection of defects on patient accounts and enable staff workflow at point of service areas, customer sites and our shared service centers.

- "AHtoAccess" powers workflow in customer central business offices and at our scaled shared service centers for pre-registration, financial clearance, and financial counseling. The platform processes patient accounts through proprietary rules engines tuned to identify defects in demographic data, authorization processes, insurance benefits and eligibility, and medical necessity. Our rules engines in AHtoAccess are also used to calculate patient balance estimations and prior balance accounts receivables. For the uninsured, the platform helps staff triage patients to find coverage for their visit. Our technology enables staff to work on an exception basis eliminating the need for manual intervention on accounts with no exceptions identified.
- "AHtoLink" delivers all of the insight and defect detection capabilities of our proprietary rules engines in real-time to point of service emergency department and registration areas within the hospitals and clinics. When defects or inconsistent data are detected in the data entry or registration process, users receive targeted messages alerting them to resolve the issue while the patient is still in front of them.