

**ROBB EVANS & ASSOCIATES,
Receiver of Mojave Medical Group, Inc.**

P. O. Box 880
Sun Valley, California 91353

FINAL REPORT TO COURT

Prepared as of November 30, 2001

This is the third and final report since appointment as Receiver.

Background

It became evident, within days of appointment and assuming control of Mojave Medical Group, Inc. ("Mojave"), even before any detailed study of the financial and claim information or of the operation, that meaningful recovery from the sale of Mojave was possible only if sold as an operating Independent Physician Association ("IPA"). There were insignificant tangible assets. The real assets were the current and potential income streams from Health Insurance Companies ("Health Plans") contracts. The continuance of this income was predicated on contracts with the primary care and fee-for-service providers to provide medical service to the patients covered by the Health Plans. Any misunderstood action or inappropriate response to any Health Plan or provider had the potential of irreparably damaging the IPA in matter of days, if not hours. We, therefore, ensured continuity of uninterrupted care for the patients through the IPA medical board and its staff, but took over control of all other, including financial, decisions. Within a week, we determined that the financial problem faced by Mojave was not caused by fraud or extraordinary payments to officers or shareholders, but due to gross mismanagement for several years. We met, within days of taking control, with the management team of Victor Valley Community Hospital (the "Hospital"), the plaintiff in the Bankruptcy Court action, to obtain the hospital's input about the objectives mandated by the Court. The hospital management felt that it would be happy to get the top cash settlement, whatever the number could be, from Mojave's sale. However, we concluded that any sale of the IPA, without the continued support of the 247 physicians and the specialist providers, nine Health Plans, and about 11,000 patients, would not be in the best interest of the hospital or any of the parties affected by the sale of Mojave.

Two executives of the Receiver convened the last regular board meeting of Mojave, and accepted the resignation of two board members, Dr. Mario Demesa, and Mrs. Lourdes Nepomuceno, the administrator (and wife of Dr. Nepomuceno, the owner of Mojave). The rest of the board members authorized Dr. Mohinder Ahluwalia to continue as Mojave's Medical Director. The Receiver asked Dr. Ahluwalia to provide continued support and close coordination with the staff of Mojave, as the administrator was terminated. The remaining board members were advised of the few options available to the Receiver to ensure a smooth and prompt sale of Mojave as ordered by the Court.

Financial Condition and Operations

As of October 31, 1999, cash in two bank accounts totaled \$251,883 (which included the Health Plan 'mandated' Incurred But Not Reported ("IBNR") reserve balance of \$250,000). The net book value of the office equipment, furniture and fixtures excluding leasehold improvements was about \$18,000. The current liabilities stated at about \$1,066,000 included approximately \$477,000 in accrued and unpaid expenses and accounts payable and \$522,948 in medical claims payable. It became evident, later, that the liabilities were grossly under stated as physician claims for an additional \$500,000 were not entered in the accounting system. Mojave was operating on leased premises and had few tangible assets to cover even a fraction of outstanding liabilities. Reported net worth was negative (\$744,341). The medical providers threatened the medical director that they would seek for involuntary bankruptcy of Mojave if all their overdue claims were not paid within a week.

Within a month, the Receiver paid all primary care providers current, and also about \$500,000 towards specialists' (old) medical claims, and advised the fee-for-service providers regarding the claim administration procedure for the 1998 and 1999 liabilities ("specialists' claims") that totaled then about \$1.25 million. Except for those (old) specialist claims, the Receiver kept current all the administrative costs, and payments owed to primary care providers and the specialists under the then existing capitation agreements. The Receiver had to negotiate with about a hundred medical providers to caution them against forcing a bankruptcy which would benefit no one.

Sale of Mojave and Related Issues

Within two months of appointment of the Receivership, pursued three offers or expressions of interest for purchase of Mojave. One additional expression of interest surfaced but was withdrawn after preliminary discussion.

- One of the IPAs operating in Victor Valley area offered to buy Mojave for \$180,000. This offer did not include any assumption of debts, or outstanding liabilities owed by Mojave (which were in excess of \$1.25 million).
- A regional health care consulting and management firm specializing in operating IPAs valued Mojave at \$500,000. The firm also said it might have an interest, at or below that valuation, to buy Mojave without assumption of any liabilities.
- A group of physicians who were already physician providers to Mojave, and who had a long association with the hospital, formed a new entity known as "Victor Valley IPA, LLC" ("VV IPA"). This group offered to buy Mojave for \$50,000 in cash but agreed to assume a substantial amount of the liabilities owed to the fee-for-service providers.

The Receiver met with the hospital management and presented all the offers. The Receiver and the hospital, after detailed consideration, noted that the last offer, along with the Receiver's claim administration, could result in a probable 60% settlement of the outstanding liabilities to the fee-for-service providers (who were owed in excess of \$1.25 million for 1998 and 1999 claims). Both parties decided that the last offer was the best for the patients, providers, and the Health Plans for the following reasons:

- All of the offers were contingent upon Mojave's transfer of all patients and the Health Plans, intact, to the buyer. Any offer that did not take into consideration the hospital preference of the providers, or a high resolution of the liabilities owed to them, was destined to drive away the physician organization. These providers could then ask the Health Plans to move the patients to other groups they were affiliated with or wished to associate with. Without the support of the Health Plans, and their insurance plan contracts, which assured a steady stream of revenue to the primary care physicians with their 11,000 plus patients, Mojave had little to sell.
- Many of the primary care providers and fee-for-service specialist providers who contracted with Mojave were reported to be the initial investor members of VV IPA. This continuity of association, and the physicians' new proprietary interest, protected the sale value of the IPA. Any outside group, which wanted to take control of Mojave without the cooperation of most of the existing primary and specialty providers, could have immediately and dramatically reduced the sale value of Mojave.
- The hospital, which was the Court-directed beneficiary of the sale proceeds of Mojave, looked to the primary care and specialty providers of Mojave for continued patronage, uninterrupted business, and a mutually beneficial association for sustained growth. The hospital formed a new Medical Service Organization ("MSO") and hoped that any new IPA buying Mojave would join the MSO for ensuring continued financial health of the hospital. Of the three buyers, only Victor Valley IPA was agreeable to join the MSO on terms proposed by the hospital.

Reasons for Mojave's Failure and Requirements for a New IPA to Succeed

The reasons for Mojave's financial crisis are summarized here:

- Mojave had no budget system or financial plan. Financial discussions were limited to periodic reviews of monthly cash flows, which did not include analysis of the growing unpaid claims to specialist providers.

- Overall, Mojave’s referral management practices were ineffective. These practices caused authorized referrals to create fee-for-service claims that exceeded available funds provided by the Health Plans. This was evident from the unsecured liabilities in excess of \$1.47 million just for 1998 and 1999.
- Further compounding the financial collapse, there were few specialty capitation or other special fee agreements in place to limit the loss created by the ineffective referral practices, and the resulting volume of claims, some of which were avoidable.

Contrasted with the unsustainable management practices and financial condition of Mojave, the VV IPA had several elements of potential strength that could contribute to future financial and operational success. They are summarized below:

- The new owners of the IPA were primary care physicians who have been members of the (old Mojave) organization for many years and had “an owner’s perspective”. Among other things, referral management practices were committed to be followed close to the industry standards.
- The new IPA was to be well capitalized and financially supported, to ensure prompt payment of all obligations, including the assumption of a substantial percentage of the liabilities (of about \$1.27 million) owed (only) to the specialist providers. The initial capitalization offered was at least \$150,000, with promise to raise it to at least \$200,000. The organizers of the new IPA showed an in-principle offer from a local bank for a line of credit of \$1,000,000 to be put in place (upon approval of the sale of Mojave) by the Court.
- The financial plan adopted by the new IPA included capitation or other special fee arrangements for the specialist providers. Based on discussions with specialists, and some arrangements reached by then, the proposed budget assured that income would exceed expense.
- The proposed MSO was to be partly owned by the new IPA and to be operated by a dedicated Administrator or a qualified medical management company with operating experience. The physician directors-owners of the IPA agreed to provide policy and health care oversight. This arrangement was expected to bring in professional management at reduced cost and leave the physician owners’ time to concentrate on quality care and to provide the right climate for the Health Plans to grow. The new IPA and MSO agreed to make the MSO, the largest service organization in the area, with smaller IPAs in the vicinity expected to join the MSO.
- Finally, the VV IPA committed to a reasonable plan to resolve the liabilities owed to the fee-for-service specialist providers. Without an agreement for a new IPA, including a workable financial plan, and without the cooperation of the Health Plans (insurance companies) and the primary physicians, the only option for the Receiver was to liquidate Mojave. In that event, the Receiver estimated that the total realized value would only be about 20% of the total liabilities.

Health Plans and the Transfer of Contracts

The immediate task at the commencement of the Receivership was to approach the Health Plans and advise them of the options available to the Receiver in achieving the Court’s mandate and to seek their cooperation to achieve the objective with least disruption or inconvenience to patients, providers and the Health Plans. A small percentage of the providers affiliated with Mojave frequently threatened the Receiver that if their outstanding claims were not paid ahead of other creditors and also immediately, they would stop providing services without contractual notice and would demand payments directly from the Health Plans asking them to reduce the monthly capitation fees due the Receiver.

Some Health Plans and physician providers approached other providers in the area, patients, and Health Plans with incorrect information that ‘Mojave was bankrupt and it is in their interest that the patients write to the Health Plans to shift them from Mojave’. One Health Plan put Mojave on Notice of Cancellation, but after our meeting with their executives, the Health Plan officers realized that such action would force Mojave into immediate liquidation. Since liquidation was not in any one’s interest, the Health Plan allowed additional time for the Receiver to cure the default and proceed with the Court mandate. All other Health Plan executives cooperated to assure the smooth transfer of the patients, plans and providers to the new group.

Significant Events Leading to the Sale of Mojave

The Court heard the Receiver’s Motion on February 24, 2000 recommending sale of Mojave to VV IPA under certain conditions described above. A rival IPA, High Desert IPA (“High Desert”), filed an eleventh-hour Opposition to the

Receiver's Motion. The Court considered the Opposition filed by High Desert, conducted a mediation on February 29, 2000 and issued the Order ("Order") approving the sale of certain assets and liabilities of Mojave to VV IPA, and the Claim Administration Plan ("Plan") submitted by the Receiver.

As per the Order, a report was filed with the Court on March 10, 2000 confirming that VV IPA complied with the specific requirements of sale as provided in the Order. All the Health Plans were notified of the sale with a request to complete the assignment/transfer formalities to ensure that VV IPA assumes full control of the operations from April 1, 2000. While most of the Health Plans cooperated, completed the formalities and transferred the most significant asset(s), i.e., the MMG health care contract(s) to VV IPA, a couple of the Health Plans were difficult to deal with.

The Receiver paid \$50,000 to the benefit of the plaintiff Hospital, in full settlement, as per the Order.

Claims Administration and Distributions

Pending completion of the sale and assignment of contracts, the Receivership Estate continued to receive the Health Plan capitation/premium payments until May 2000, and handled all the administrative obligations and medical claims on behalf of VV IPA effective January 1, 2000. On March 30, 2000 all medical providers were provided details of the Plan approved by the Court together with the procedure to be followed by both the Receiver and VV IPA in respect of installment payment(s) under their respective obligations. All medical providers and known non-medical creditors were advised in December 1999 to provide a comprehensive list with details of their claims. A cut off date was established and all providers were advised that claims received after that cut off date would not be entertained in view of the limited resources and the approval of Plan by the Court. Total medical provider claims unpaid as of December 31, 1999 were \$1,269,518.28 and included an amount of \$81,801.87 representing 'injectables' or out-of-pocket expenses incurred by the providers. The non-medical claims from unsecured creditors totaled \$196,652.42. In accordance with the comprehensive settlement plan, the eligible injectables were approved for 100% settlement and the balances of unpaid claims were pro-rated for payment by the Receiver and VV IPA.

As per the terms of the sale and the Order, VV IPA, in addition to paying the Receiver \$150,000 in purchase consideration, also assumed \$500,000 of the pre January 1, 2000 medical provider claims and provided an irrevocable Letter of Credit for \$500,000 to guarantee payment of those provider liabilities. VV IPA paid off the assumed liabilities, in full, in twelve monthly installments commencing April 15, 2000, and monthly thereafter, regularly and on time.

The total claim resolution, paid over three installments, by the Receiver, to the unsecured creditors amounted to \$803,000 which included \$762,000 to the unsecured specialist claimants (for 1998 and 1999), and \$41,000 to all other unsecured creditors and vendors (who were owed about \$197,000).

Assignment of Contracts and PacifiCare Litigation

The assignment of contracts by the various Health Plans has been the single most time consuming exercise demanding weeks of negotiation with Health Plan executives and the respective in-house and outside counsel for the various Health Plans. While most of them agreed to comply with the implicit instructions contained in the Order and agreed to the January 1, 2000 date, as the effective date for assignment/transfer and assumption of liabilities by VV IPA, two Health Plans did not comply with the Court Order for several months.

PacifiCare of California ("PacifiCare"), the only Health Plan that placed Mojave's contract under default and had threatened termination of the provider contract, within days of the Receiver's appointment, contended on the choice of 'an effective date', and the terms of assignment that would favor its alleged rights of set-off of Pre-Receivership liabilities against Post-Receivership capitation payments. It was arbitrarily deducted (without providing details or even proper notice dictated by its own contract) about \$53,000 from January 2000 capitation payment (due VV IPA). This deduction purportedly represented the 1998 deficit in the Pharmacy Risk Pool. It also made another arbitrary deduction of about \$55,000 from March 2000 capitation payment (due VV IPA). PacifiCare advised that this second deduction was a set-off for alleged "1999 Risk Pool Deficit". Irrespective of the effective dates, we believed that PacifiCare utilized 'self-help' to satisfy Pre-Receivership debts with Post-Receivership revenue in contravention of the Order Appointing Receiver; and that PacifiCare was attempting to ignore the Plan approved by the Court. PacifiCare was not

only notified timely of the Receiver's appointment, but also was regularly advised of the developments leading to the sale, and to the March 1, 2000 Order.

VV IPA represented to the Receiver that this arbitrary deduction of \$108,000 from the capitation payments due after January 1, 2000 was not only unfair and high handed, but seriously impacted its financial condition. The Receiver represented to the Court that VV IPA's arguments were well founded as it paid \$650,000 towards purchase of specific assets and liabilities as per the Order, fulfilled the conditions of the Court Order, assumed all the liabilities of operations and other claims effective January 1, 2000 and, thus, as provided by the Order, should not be burdened with Pre-Receivership debts. The Receiver was able to hand over to VV IPA a balance of about \$250,000 (past IBNR), against an original expectation of more than \$360,000 from the special account, due to the arbitrary set-off effected by PacifiCare.

As VV IPA was unsuccessful in its representation to PacifiCare in this regard, it asked the Receiver that it be reimbursed the \$108,000 legitimately owed to it. As the Receiver had no means to do so except to demand the funds from PacifiCare and return them to the rightful owner, and as VV IPA had unpaid claims to resolve for the months of February and March 2000 and was rightfully entitled to that refund, the Receiver filed a Motion to seek appropriate relief, and was forced to litigate, regrettably adding to the cost of the Receivership which had limited resources. Concurrently, PacifiCare threatened to terminate the provider contract if the Receiver, as assignor, and VV IPA, as assignee, did not execute its assumption agreement as provided which dictated VV IPA to surrender its rights to claim the refund of \$108,000 from the Health Plan and/or the Receiver. The assignment terms also seriously affected the Receiver's ability to enforce its rights and to perform its obligations under the Court Orders.

In October 2000, the Court ruled that:

- PacifiCare should pay VV IPA the disputed withhold of about \$108,000 immediately without prejudice to PacifiCare's rights of recoupment, if any.
- PacifiCare was to file a claim under the Receiver's Claims Administrative Plan for the disputed amount. PacifiCare may file a motion seeking the recoupment of the disputed amount, but if PacifiCare elected to file such a motion, it should be filed no later than November 22, 2000.
- The Court set deadline dates for the service of any oppositions and reply papers to any motion if brought by PacifiCare and also set an evidentiary hearing for January 23, 2001 to enable the parties to present evidence via live testimony, or otherwise.

PacifiCare complied with the Court Order, and paid the disputed withheld amount but never filed a claim with the Receiver notwithstanding the Court's Order. However, under counsel's advice, the Receiver treated the above referenced payment as a claim against the Receivership Estate. The Receiver was not served with any motion by PacifiCare as directed by the Court, and therefore requested the Court to remove the hearing off the Court's calendar.

In June 2001, the Receiver paid 20.8% of PacifiCare's claim (though not formally submitted) in full and final settlement of its claim. This was the percentage of dividend paid to all the other unsecured creditors (claims totaling \$196,652.42).

Hospital and Pharmacy Risk Pool Settlements

For more than a year, the Receiver had pursued several of the Health Plans to settle the hospital and pharmacy risk pool reserves due Mojave for the years 1998 and 1999 and cautioned them against self-help and set-off and payment to a small group of disgruntled specialist medical providers who sought payment directly from the Health Plans. This follow up resulted in collection of such settlements in excess of \$80,000. This helped increase the distribution to both medical and non-medical creditors.

Pending Legal Action Against Mojave

Mojave was a defendant (for several years) in a lawsuit filed by a relative of a deceased patient against one of the providers of Mojave and the Insurance carrier. Our preliminary analysis indicated that the claim was well within the limit of the insurance coverage. While the Receiver had no hesitation in going to mediation as to Mojave, other parties

to the litigation did not at first elect to go to mediation. The Receiver advised all parties, including the Insurance carrier, that the Receiver might close the Estate long before a resolution was attempted in the litigation and that it was time to mediate and settle. The Receiver actively participated in the mediation and resolved the long drawn litigation to a total resolution (costing the Receivership Estate a couple of thousand dollars while all legal costs and expenses for more than a year were borne by the Insurance carrier).

Completion of Receivership

We submit our final report with the following summary to the Court.

- Total claim settlements to specialist medical providers were \$762,000 against total approved and unpaid claims of \$1,269,518.28 (for the years 1998 and 1999) representing a 60% recovery. All the specialists were paid 100% of their claims for injectables (out-of-pocket expenses). All primary care providers were paid 100% of their claims from November 1, 1999 until sale of the IPA to VV IPA and all specialists were paid all their eligible claims relating to periods after January 1, 2000 either by the Receiver or by VV IPA.
- Unsecured creditors were paid \$41,000 or 20.8% of their eligible claims totaling \$196,652.42.
- Total Receivership expenses over the two years of the Receivership were \$212,998.51. This includes legal expenses of about \$60,000 most of which were attributable to the unavoidable legal representation in the IPA sale hindered by a rival group, and also about a year of follow up and litigation with PacifiCare.

Final Accounting

The Receiver's final accounting is under Tab 1. It provides for a modest budget for estimated expenses from December 1, 2001 through completion. These expenses include legal, accounting, and tax return and filing fees. The Receiver has arranged and prepaid for storage of records of the Receivership Estate for three years in conformity with IRS regulations.

An amount of \$11,000 towards Receivership expenses (explained above) budgeted for the next several weeks up to completion, will be held as reserve to pay for these expenses as and when they are incurred. If the actual expenses are less than this reserve, surpluses, if any, will be remitted to VV IPA. If the actual expenses are in excess of the budget shown under Tab 1, no additional claim will be made.

Conclusion

We have completed our duties and respectfully request that the Receiver be discharged from any further duties, obligations, and liabilities whatsoever, upon the Court's approval of this report. The Receiver requests the Court for an Order:

1. Approving this final report;
2. Approving payment of the Receiver's expenses, and any fees included in the budget through completion;
3. Ratifying, confirming and approving all of the acts, transactions and forbearances by the Receiver, or his deputies, staff, counsel or other agents or representatives, as appropriate and in the best interest of the Estate and parties herein;
4. Authorizing cancellation of the Receiver's Bonds.
5. Authorizing the Receiver's abandonment of any unknown assets, claims and rights Mojave might have; and
6. Discharging the Receiver from any further duties, obligations and liabilities whatsoever.

Respectfully submitted,

Robb Evans
Robb Evans and Associates
