



Anahp observatory

national association of private hospitals

edition 5/2013 - english version

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Anahp in numbers

Revenues

11.4 billion Gross revenues of hospitals participating in the study

Average Revenue per Hospital (R\$ millions)



Revenues by Paying Source (%)

| Nature | 2011 | 2012 |
|--------------------------|------|------|
| Public Healthcare System | 0.7 | 0.5 |
| Private (Out of pocket) | 4.8 | 8.6 |
| Healthcare Plans | 94.4 | 90.8 |

Source: SINHA/Anahp.

In

2012 Anahp Member Hospitals accounted for:

9,200 beds 7.5% of private beds existing in the Brazilian supplementary health system

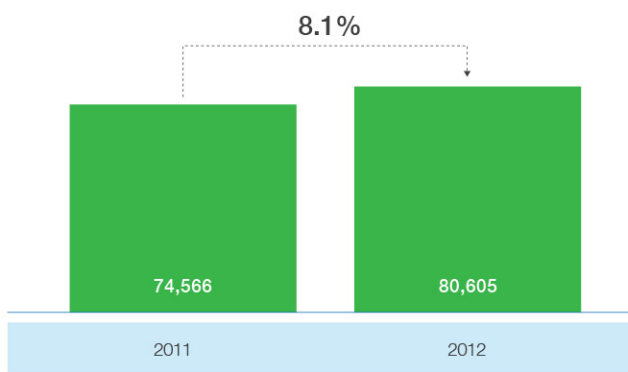
14% of total benefits payments in the Brazilian supplementary health system

16% of all surgeries performed in the Brazilian supplementary health system

9% of total hospital admissions in the Brazilian supplementary health system

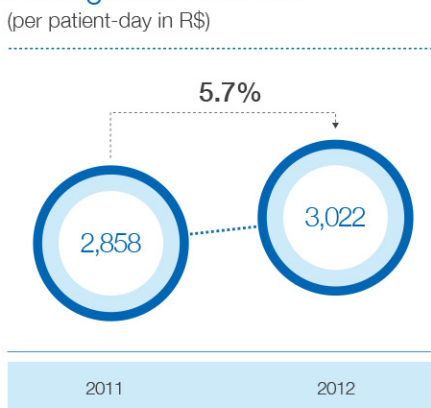
Source: Anahp/ANS - National Supplementary Health Agency.

Jobs Created



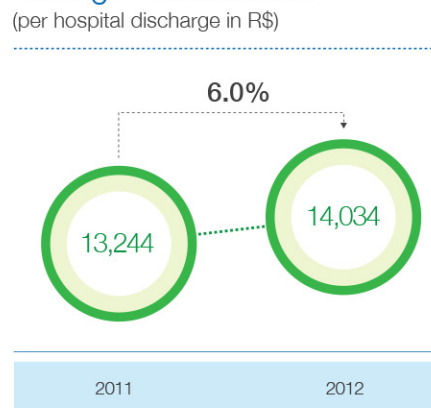
Source: SINHA/Anahp.

Average Net Revenue (per patient-day in R\$)



Source: SINHA/Anahp..

Average Net Revenue (per hospital discharge in R\$)



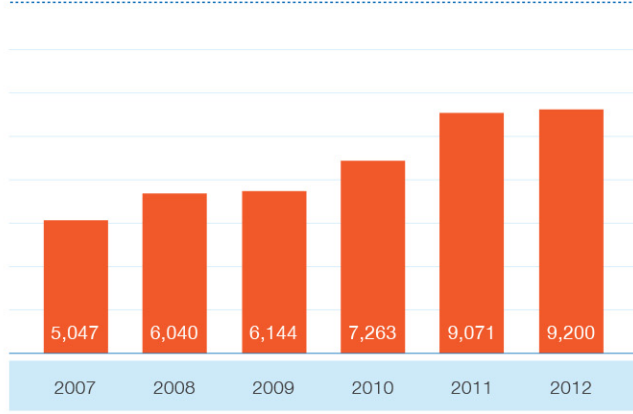
Source: SINHA/Anahp..

5.8%

2012 Inflation by IPCA (Broad National Consumer Price Index)

Source: IBGE (Brazilian Institute of Geography and Statistics)

Total Beds



Source: SINHA/Anahp.

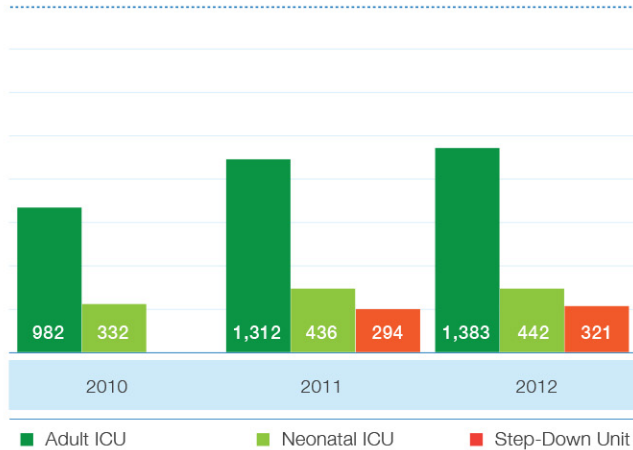
Total Beds

Occupancy Rate (%)



Source: SINHA/Anahp.

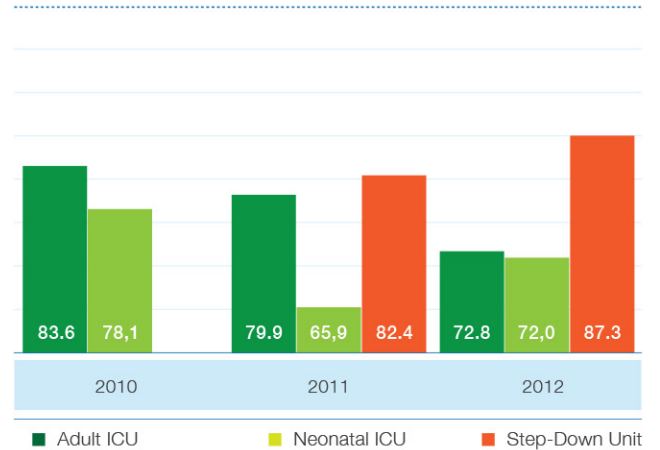
ICU and Step-Down Unit Beds



Source: SINHA/Anahp.

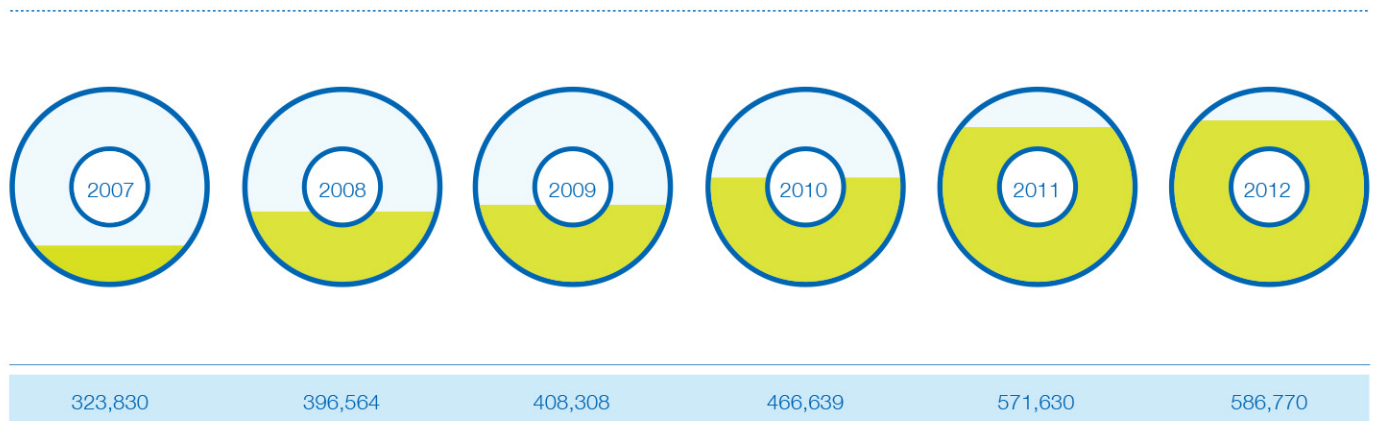
ICU and Step-Down Unit Beds

Occupancy Rate (%)



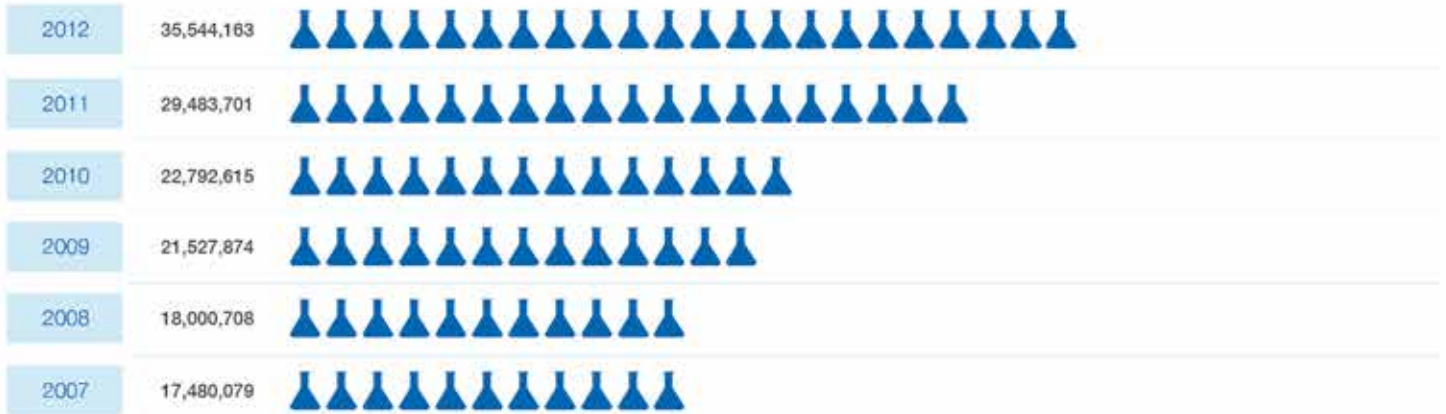
Source: SINHA/Anahp.

Total Admissions



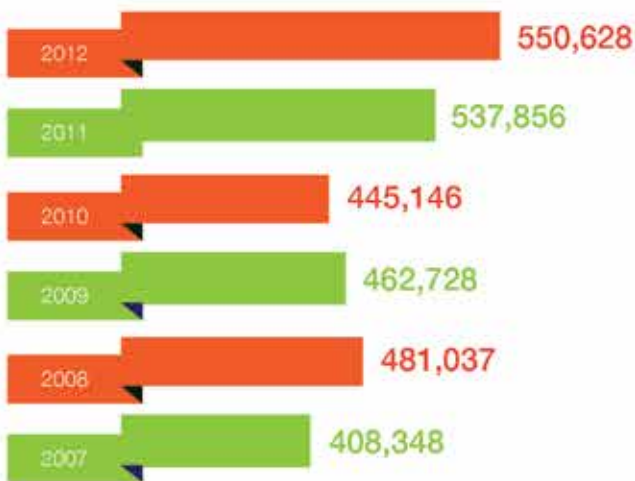
Source: SINHA/Anahp.

Total Tests – Laboratory and Imaging



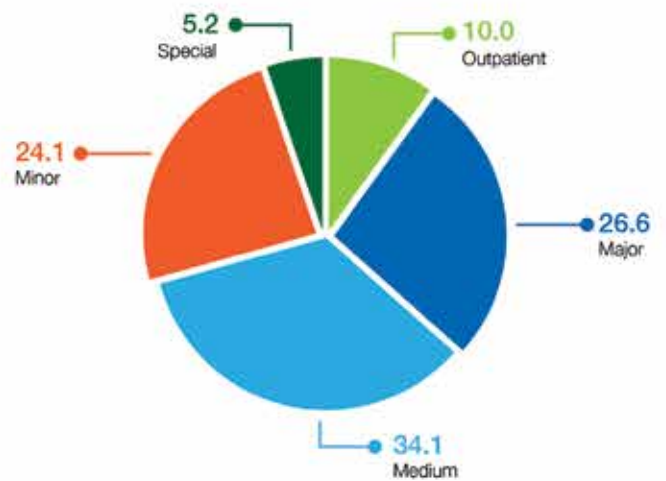
Source: SINHA/Anahp.

Total Volume of Surgeries







Source: SINHA/Anahp.

Surgeries Breakdown by Complexity (%)



Source: SINHA/Anahp.

Accreditations 2012

| | Anahp | Brasil | % Anahp |
|--|-------|--------|---------|
| National Accreditation Organization - ONA  | 38 | 187 | 20.3 |
| Accreditation Canada – AC  | 14 | 25 | 56.0 |
| Joint Commission International - JCI  | 12 | 28 | 42.9 |
| National Integrated Accreditation for Healthcare Organizations – NIAHO  | 2 | 3 | 66.7 |

Source: Anahp.

Anahp hospitals represent

27.1%
of all hospitals accreditation in Brazil.



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Anahp Observatory Masthead

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Message to the Reader

“Denying to provide information to avoid comparisons is like stopping the clock to avoid getting old”



2012 was an important year for Brazilian health, when discussions on health care issues were at the spotlight. News about the capacity of hospitals' emergency departments, the hike in the number of beneficiaries, health care plans' inefficiency, the drop in the number of beds and, more recently, the pressure to alleviate the industry's tax burden are some of the topics that made the headlines throughout the country's major media. Thanks to the intensity of the debates, we can say that there has been a change in behavior on the part of both the media and citizens' regarding health in Brazil, heralding an evolution. The population is no longer indifferent to the inefficiencies of the Brazilian health system and discussions about the topic are ever more prevalent all over the country. It is known that in 2012 health expenses accounted for almost 9% of the Brazilian GDP, amounting to approximately R\$396 billion. The industry employed more than 2.9 million people. There are 6,293 public and private hospitals, catering to a little more than 190 million people. It was high time a sector with such representativeness gained more attention from the Federal Government.

Last year, a downturn trend was pointed out by Anahp member hospitals' indicators:

- Average Hospitals' Revenue rose 4%. During the same period, Revenue of medical-hospital healthcare plan operators grew by 12.4%;
- Net Average Revenue per patient-day among Anahp institutions grew by 5.7% and inflation measured by IPCA was 5.8%;
- Average Net Revenue per Hospital Discharge in Anahp's hospitals increased 6.0% and health IPCA measured inflation was 6.3%;
- Hospital supplies share dropped vis-à-vis the institutions' revenue from 51.5% to 47.9%, i.e., down 3.6 percentage points. In the same period, the participation of the daily rates and fees grew by only 0.6 percentage point.

Some actions by the National Supplementary Healthcare Agency (ANS) showed more concern for supplemental health insurance than what we had seen in recent times. One example is the discussion about the Compensation Model for the Industry and the Program for Qualification of Health Services Providers (QUALISS). Anahp, along with other organizations, actively participates in these initiatives.

In 2012, given the recurring news about hospitals' emergency rooms, Anahp engaged in discussions about emergency care, promoting debates about the issue in several capital cities. The Association commissioned a qualitative research for São Paulo and Rio de Janeiro's metropolitan regions in order to understand patients' perspective on the

issue of hospitals' emergency room and emergency care. The results will be seen in this edition of the Anahp Observatory.

Another important factor discussed in depth among Member Hospitals is people management, a key element for the sustainable growth of the institutions. Throughout the year, in addition to workshops and meetings, the People Management Work Team realized the need to share experiences related to critical issues in hospitals. Online Discussion Forums on People Management enabled wide participation of hospitals and, as a result of this initiative, this OA issue features Anahp's recommendations as a result of the discussions.

The Healthcare Organization Work Group has also been playing an important role in the development of recommendations for the organization of the healthcare team. The objective of this initiative is to ensure service excellence, with a focus on the patient. The first stage of this work has been completed by Work Group and more details will be discussed in the following pages.

In its fifth edition, one can say that Anahp Observatory is ever more consolidated as a publication for the health market and a source of reference for the industry. In keeping with our commitment to transparency, the publication features without restrictions, our data and information, with the genuine objective of contributing to the health insurance market and the quality of health services available to Brazilian citizens. We want to do our part.

We counted on the support and efforts of our professional institutions to prepare this edition of the Anahp Observatory. We are grateful for the dedication of all those who have worked with us, recognizing them as men and women who provide an effective contribution to the health industry in Brazil. Preparing this Observatory is one of the most rewarding jobs in Anahp and developing it with dedicated people is indeed an indescribable joy.

Finally, I would like to thank the members of the Editorial Committee for their participation, especially the newcomers - Luiz Sergio Santana and Alceu Alves da Silva - Anahp's long-time friends and dedicated people. I would also like to express my respectful recognition to the authors of articles published in this issue: Bernadete Weber, Ivana Siqueira, Suzy Cortoni and Marcos Silva and our editorial team and all operational staff of the Association.

Francisco Balestrin - Chairman of the Board of Directors



Anahp hospitals sharing experiences online

Online Forum creates opportunity to discuss key topics involving people management in hospitals

This initiative provided Member Hospitals a more effective way to share best practices and discuss common problems experienced by hospitals with direct impact in managing people and institutions.

Throughout 2012, Anahp's People Management Work Group developed a series of "Online Discussion Forums" to encourage member participation and discussion in sharing common hospital experiences about key people management issues.

This initiative fostered an effective participation by member hospitals, providing a chance to share best practices and discuss common problems that directly impact people management in hospitals. Three "Online Discussion Forums" were held during the year, addressing the topics: Generation Y, Performance Evaluation and Absenteeism. For each event, there was a moderator in charge of making a brief presentation about the topic and then stimulating discussions among those hospitals participating in the Forum, both in person and online. To participate in the discussion, hospitals need only a computer with internet access to register on the Forum's broadcast platform. The events are held quarterly, at a pre-arranged date and time.

In addition to sharing information, there is an e-newsletter, which is sent to Human Resources managers and superintendents of hospitals, containing participants' advices about each topic. Next you have the recommendations by the People Management Work Group, regarding the topics discussed in 2012.

Generation Y: How to deal with generation differences in hospitals?

Generation Y is the mirror image of an era in which technological breakthroughs come at an ever faster pace, expanding and enabling global interaction, flexible schedules, stronger collaborative groups. Keeping track of the technological evolution is a pre-requisite to stay in the market. But when it comes to Generation Y, organizations are moving to understand and develop new possibilities and forms of adaptation, to strike a balance that will allow for the coexistence of the different generations (Y, baby boomers, X generation), taking into consideration their particular profiles and objectives, as well as the interests of the institutions themselves.

Recommendations

Acknowledge and accept differences between generations

This is not an easy task, but knowing how to deal with the generational conflict in the workplace is key for management performance. Oftentimes, people attempt to force changes in attitude and impose their desired standards. This attitude however, evidences a certain resistance and is not accepting of the behavior, especially younger generation's.

First of all, one must identify the structure of the generations within the organizations and how this structure is broken down among baby boomers, X and Y generations. This is important to help align management's expectations, to develop a clear knowledge of the work environment and to structure suitable retention and relationship measures.

Striking a balance between new generations and the organization

Understanding the expectations of new generations, learning what hospitals can offer and what these employees require is of the essence to align the expectations of both parties.

An alternative, which has proven to yield good results, is to adopt principles of management by competency modeling during the selection process. In this model one may map out not only knowledge, skills and attitudes, but also the expected performance on the job.

Harmonize the work environment with the new generations.

The idea here is to use creativity. Providing assistance is itself a rigorous procedure, critical to ensure the technical quality standards. But this does not mean that there is no room for creativity, innovation, pursuing new techniques, new forms of work organization, new forms of integration between teams and work and practice debates and inclusion.

To better cope with young professionals' much valued expectations of informality, managers should seek ways to ease

the tension that naturally stems from health care environments, not only in the day-to-day relationship with the team, but also promoting moments for socializing, seeking more attractive capacity-building methodologies or conducting work meetings in innovative ways. These simple initiatives may render the work environment more interesting for those talents.

Clear, transparent and constant dialogue between managers and staff

The intention is to align the generations' expectations regarding career, work environment and job performance, which do not always coinciding with what hospital organizations may offer. Promoting this dialogue and a fluid communication between the parties is a big step to minimize differences and frustrations, providing a trustworthy environment conducive to reliable and creative solutions, reinforcing relationships and strengthening leadership.

After all, misunderstandings and misaligned expectations generate bad work atmosphere, increasing the sense of injustice and adversely affecting the productivity of the entire team.

Developing the skills of leadership educators

It is important to offer the necessary conditions for leaders to know and identify the characteristics of each member of their team and to make the most of what each member has to offer. This practice encourages people, allowing them to obtain the best out of each professional.

To turn this into a reality we must develop and promote a positive and proactive work environment, where generational differences are evened out. One solution relies in opening up more space for moments for exchanges, through meetings, discussions and conversations with the team.

This practice brings managers together, creating opportunity for employees who know what they think and expect. This is essential to integrate the differences in the generations profile team.

Absenteeism: A worker's health or engagement problem?

The term absenteeism or truancy is used to designate the employees' absence from work for several reasons: illness, accidents, legal rights (maternity leave etc.), social factors (illness of relatives, for example) and cultural factors (long weekends).

High absenteeism rates may indicate some kind of rejection by the employees, due to their dissatisfaction relative to compensation, company policies or working conditions. It can be also directly linked to social problems, of a financial or emotional nature.

Main reasons for absenteeism

The most common causes for absenteeism are: health problems, desire to pursue new job opportunities, lack of motivation, and especially dissatisfaction.

It must be highlighted that the leaders need to be involved in this process, as absenteeism is not a Human Resources' problem. Managers need to understand this metric so that the best possible actions may be designed.

Another issue raised during the Management Work Group discussions refers to occupational medicine in the hospital industry, an issue that is overlooked by people management and leadership. There is a high rate of "sick leaves" and one cannot be sure whether such claims are due to real diseases or caused the employee's lack of motivation.

Lack of respect and recognition by the leadership is a unanimous complaint heard in exit interviews. In those areas where the leadership establishes a relationship of respect and care, absenteeism is lower and there is greater employee commitment.

Consequences of Absenteeism

Absenteeism results not only in direct costs to hospitals, but also in indirect costs, such as lower productivity levels, disruption of work schedules, administrative problems, limited performance, obstacles to managers. It may also compromise patient safety due to absences of employees in social assistance.

When the employee is absent from the workplace for any reason, the financial impact to the company is not always limited to the activities performed by the absent employee; it often resonates throughout the organization, especially if the employee belongs to a department where service has immediate implications over the schedule, as is the case with nursing rotation schedule.

Recommendations

The most important step is to find out why employees' absenteeism or late arrivals occur. To help institutions suffering from high rates of absenteeism, Anahp's Group listed out some initiatives that can contribute to motivate and promote workers' commitment, as well as to reduce absenteeism.

Acknowledgement

Leaders must make clear to employees how important their work is to the institution. Some actions geared to the recognition of employee's work, such as performance targets linked to bonuses, career plans, and other initiatives, are key.

Engagement

If workers are motivated, they will hardly fail to come to work and put the burden on their fellow workers. The leader may prevent absenteeism motivating the team, working on behavioral issues and, most of all, improving internal processes.

Transparent dialogue. Feedback (both positive and negative) is a key element in the relationship between leaders and employees. Managers should state clearly what is expected

from the employees, advising when necessary and expressing recognition for a job well done. Expectations regarding employee growth opportunities, compensation and position changes should also be clearly addressed by the leaders so that the employees do not build expectations that will not come true, leading to frustration and lack of motivation.

Occupational Health

Initiatives aimed at improving the quality of worksites, such as benches and chairs, ergonomic evaluation and professional guidance on the correct back posture, exercises and other practices are simple actions that can significantly reduce absenteeism. In the hospital setting, the guidelines regarding work accidents involving biological risk are also important.

Quality of Life

Programs aimed at encouraging life quality improvement at home and at work contribute significantly to mitigate other factors leading to absenteeism, such as job dissatisfaction, alcoholism, domestic problems and diseases. These problems can be tackled by initiatives such as lectures, eco tours, hiking in groups etc. involving all employees and their family members. Prevention campaigns against diseases such as hypertension, respiratory tract diseases, breast cancer, cholesterol and diabetes are also important.

Education

Training courses and other incentives for improvement are also key. Employees feel valued and understand that the company cares about their development in the workplace. This item may be a great managers' ally.

Growth outlook

When one is pursuing new job opportunities, the possibility to growth in the company is usually more important than compensation. For this reason, betting on career plans and making clear the prospect for growth in the company can be an important step towards retaining talent and hiring new workers, as well as keeping workers motivated and engaged in the work environment.

Performance Evaluation: What is its real contribution?

Performance evaluation is a people management tool used by companies with the main purpose of analyzing the performance of individual employees or groups of employees. This process identifies, diagnoses and analyses employee behavior, taking into account their professional attitude, their expertise and their relationship with other professionals in the workplace.

If correctly conducted, performance evaluation can foster professional and personal growth. It is also an important tool for making decisions about bonuses, salary increases, layoffs, training needs, and other aspects.

Performance evaluation benefits

There are several performance evaluation methods (tools) available in the market, all of them aiming at guiding managers in making decisions, guiding and measuring the development of training sessions, facilitating the process of providing feedback to employees, and, finally, providing a critical analysis of the organization by identifying its negative and positive aspects.

Thus, performance evaluation provides many benefits and promotes positive changes in terms of people management to organizations, whatever their size. Performance evaluation allows managers to better assess their subordinates, to improve the work climate, invest in employee training, improve productivity etc. Everyone wins with adequate team evaluation.

Difficulties in Performance Evaluation

Despite recent advances in management tools, as a result of hospitals' professionalization process, performance evaluation is still being used in the traditional format, based only on core behaviors applicable to all employees. According to the experiences shared, management still has some difficulty to understand the tool's usefulness and holds an oversimplified view of the evaluation process. Perhaps this tendency is explained by the distance between Human Resources department and the actual reality of healthcare which, coupled with the difficulties faced by managers in mobilizing the staff, makes for a generic instrument, which is restricted to the leader's assessment and, therefore, incapable of adequately reflecting the performance expected by different areas of the hospital.

Thus, performance evaluation is often seen as a bureaucratic procedure, one which is not given continuity throughout the year. This wrong perspective by managers also contaminates the employees' perspective about the importance and usefulness of performance evaluation.

Recommendations

In order to change managers' and employees' perception on performance evaluation one must address some important points:

Sensitize users to the tool

A clear communication about the importance and usefulness of performance evaluation is key, as is training, so that the tool's maximum potential can be reached. Managers need to understand the benefits of the tool. Additionally, the assessment must be associated with the company's strategic planning, seen as an integral part of other people management policies. If there is no clear understanding, employees will tend to restrict the use of performance evaluation to the contexts of layoffs or promotions.

Participation

Performance evaluation tools provide inputs so that organizations can assess employee productivity and engagement and, after that, work on points that may be improved. However, it is

important that managers engage in dialog and be part of the employees' daily lives, since good performance management will result in positive assessments or, at least, in evaluations that will not come as a surprise to the appraised. Performance evaluation must not be seen only as a test applied once a year.

Goals

An alternative that maybe helpful in the performance evaluation criteria is to identify targets - by function area etc. - but this process is highly dependent on each manager. Alternatives must be found so that evaluations are not exclusively associated to promotions and compensation.

Involvement

The Human Resources department must be actively involved in searching feasible performance appraisal alternatives. Human Resource managers and other leaders must be willing to help to find solutions in order to build an instrument that actually reflects the manager's performance perspective, as well as the organization's needs. One of the cases suggested building specific institutional competencies that approximate as much as possible the deliveries and behaviors expected for the different areas.

Feedback

This is an extremely important aspect to be developed by the institutions. Managers usually have great difficulties when it comes to giving and receiving feedback. However, the purpose of performance evaluation is to improve employee performance. If employees are not informed about the outcome, the assessment process loses its purpose, the tool loses credibility among the employees who will not have an opportunity to develop their own competencies. Finally, all managers should be trained on the proper way to give feedback, i.e. being able to recognize good performance and appropriate behavior by employees and, where necessary, provide constructive criticism, guided by facts and data. Managers should also be equipped to build feasible career development plans together with the employees, based on the consensus of the evaluation results.



Anahp survey approaches clients' perception in emergency and urgency care

Dedication and support of physicians and healthcare professionals in urgency and emergency cases are determining factors for good evaluation

The survey was held with men and women that used the private healthcare system in the past six months.

The care, support and dedication of physicians and professionals in the emergency department of Anahp associated hospitals are determining factors for the positive assessment of the services by users. Conversely, lack or poor information in the triage services and long waiting times in the emergency departments (ED) are the main negative issues referred by the patients. The conclusions were drawn by a qualitative study ordered by Anahp and carried out in October 2012 by Atelie de Pesquisa in Sao Paulo and in Rio de Janeiro to assess the ED services of associated hospitals in these two cities.

The survey was held with men and women in three different age ranges: 25 to 39 years, 40 to 59 years, and 60 to 75 years, named "younger", "intermediate" and "older" age ranges, respectively. The respondents belonged to social economic classes A, B and C and were seen (or were accompanying family members) at Anahp associated hospitals in both cities in the past 6 months.

There were a total of ten groups – five in Sao Paulo and five in Rio de Janeiro, comprising nine participants in each group. The distribution of each group complied with representation criteria (age and social classes) and intra-groups issues (there was at least one participant per Anahp associated hospital in each group). A standardized questionnaire with the same contents was used in all groups.

The survey results indicated that almost all respondents had gone to the emergency department that was part of their healthcare plan. According to the results, the "older" age group is the one that uses the most the healthcare plan, as they tend to search for help whenever they feel any symptom. This group has also stated that they have more time to take care of their health.

On the other side, the “younger” profile reported that they use less the healthcare plans. The exception in this group are users of healthcare plans for their children. Among genders, women tend to search more for medical care, especially with regular gynecological visits.

The survey has also found a considerable number of people who avoid going to medical visits, take tests or emergency care because they think they do not need them or because they are afraid of finding any problem. As a respondent said: “when you

look, you find”.

Concerning the healthcare plans, organizations and professionals associated with them, the users many times confused those three pillars as if they were the same thing and they did not differentiate their specificities, especially when they had had an unexpected incident or had had some problem with any of the three. If they had been satisfied with the care, they could differentiate each ones’ efficiency better.

The hospital choice has complied with the following criteria:

- Associated with the healthcare plan
- Close to home or work
- Known/ famous
- Indicated by someone known and/or professional
- Good clinical staff

The survey has also detected that, regardless of who was seen by the service, if the respondent or someone he had accompanied, the care was followed by some type of tension. The respondents have frequently indicated some situation of stress, concern or exacerbation of feelings, which were increased as the patient’s severity worsened. On the other hand, it is assumed that the hospital will counterbalance it: Normalcy, calmness and balance to handle vulnerable clients. If these expected behaviors have not been observed, there are problems and tension in the relationship.

To better understand these statements, a projection technique was used to make people express their experiences and perceptions through a tool. In our survey, photos were used. Hospital users were prompted using a 50-photo deck with pictures of people in different situations and mood conditions. The respondents had to choose the photos/pictures that better “expressed their feelings” when they were gone to the hospital and what they “had thought about the care” itself.

Most chosen pictures showed a feeling of welcome by a major part of the respondents. The main conclusion is that they felt welcomed by the hospital and received attention, care, cordiality and good conditions for their service. In other words, they felt they were supported and the initial stress was soon gone, which make us conclude that most visited hospitals provided favorable conditions for successful treatment.

Conversely, there were some people who also stated negative feelings experienced by the patients and/or accompanying people in the emergency department. The most prevalent symptoms were: Hopelessness, anxiety, uncertainty and distress caused by pain, waiting or lack of information about

the general health status. Respondents stated that in the experience they had they were sensitive, concerned, impotent, lost and delivered to third-party care, given that they no longer could take care of themselves.

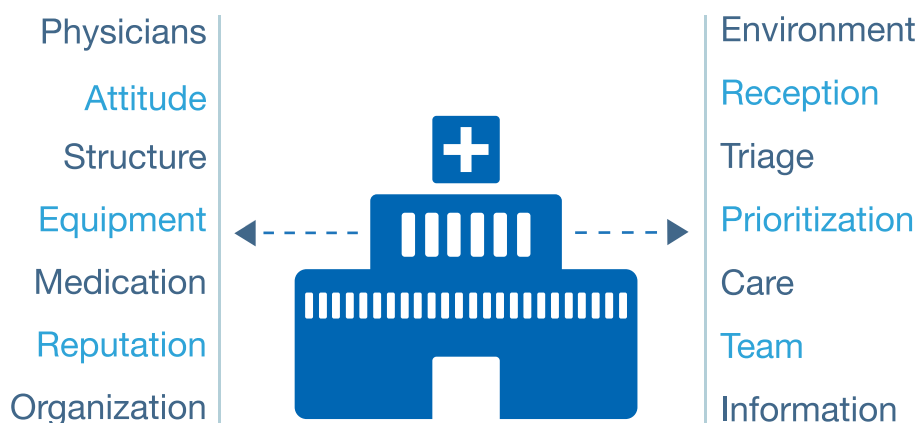
The images have indicated that when the survey respondents pointed to sloppiness, confidence breach, disorganization, random actions, and fight for power (client x hospital) they became dissatisfied and criticized the lack of support and inappropriate behaviors, which caused the feeling that they were segregated and solitary in that space.

The received care and the waiting time were decisive to define the quality of perceptions experienced by the respondents. The attention they got, support, welcome and dedication of professionals (especially physicians) were considered as factors that motivated positive perception by respondents. They understood that in most cases these professionals were accountable and committed in dealing with vulnerable and frail patients, who were seen and taken care as being unique and different.

Whereas attention dedicated by the professionals resulted in positive perception, the waiting time was the factor that generated more dissatisfaction among users. Many of the participants pointed as negative issues the lack of interest that clerks have for waiting patients, the long waiting time and poor communication and lack of information about the reason for delays by the reception and the triage teams. Poor signage and inappropriate information about priority care at some hospitals increased stress during waiting.

In general, we can state that there is too high an expectation about the quality of the services provided by a hospital – especially at the ED. To better understand how emergency department users think the quality of care should the interviewers asked them to

indicate the elements necessary to ensure quality. The results have indicated that more than quality, users expect excellence in this segment. The chart below indicates the mentioned aspects:



We can state that the expectation is huge. In some aspects, it is even idealized and difficult to realize. The need to create a “perfect hospital” seems to compensate the great weakness of someone who goes to the emergency department searching for help and solutions. There is here a psychological projective mechanism: If patients and accompanying people are not “working fine”, the caregiver (the hospital) should work perfectly. Out of all referred items, triage, reception and information are the most problematic items in the ED of Anahp member hospitals. How are they now and how should they be to satisfy users?

Triage and Reception: According to some clients, our current EDs do not have fully staffed units with competent professionals to speed up care and understand patients’ problems. They would have to be able to differentiate different patient status for appropriate referral. If possible, the presence of a physician or a registered nurse in triage would minimize this part of the problem.

Information: Communication in EDs is not considered appropriate by most of the respondents. Among the points mentioned, there is lack of information about where to go, who will see them, the medical specialty, and what the likely waiting time is.

Also among negative factors there is lack of clarification about questions, complaints and doubts made while waiting. Hospital networks do not grow as fast as healthcare plans. Obviously, even though hospitals have carefully dealt with their increasing demand and quality of care, there is still room for improvement to ensure higher satisfaction rates.

A frequent complaint already pointed before relates to waiting time in the ED. Hospitals receive more people in search for quick care and demand is not always meeting the expected quality. So why do these users come to the ED rather than the medical offices to have their problems solved?

To try to answer this question, the chart will show the differences perceived between ED and medical office care:

Emergency Department

- + Situation of emergency / urgency
- + Immediate care
- + Even having to wait, it happens on the same day. If being absent from work is required, it will be only once
- + There are devices / tests done on the spot
- + No need to worry about the specialty

- The visit is quick, in a hurry
- No time to talk /not much attention
- "Commoditized" care
- Diagnosis may be precise, but it is necessary to double check
- Does not know the physician, but he / she may become the regular physician

Medical Office Care

- Situation of routine / care
- Need schedule
- May take months to be scheduled
- People have to be absent from work more than once
- The examination must be performed externally
- Difficult to know what specialist to go

- + More time for the visit
- + People are more at ease to talk / receive more attention
- + Personalized care
- + Diagnosis tends to be precise
- + Physicians are indicated / recommended

A type of care seems to be the opposite of the other. Both have positive and negative aspects and both have room for improvement. However, despite the fact that there are many advantages perceived in the ED, some users are aware that:

Emergency departments are replacing, in some dimensions, the care that could have been provided by physicians in their offices;

The medical care in the physicians' office is more detailed and careful than good care provided by the emergency department, which may be only palliative.

So that there is migration from ED visits to medical offices, users need some changes to happen:

Shorter time to schedule visits, which would avoid lack of hope and evasion from offices;

Greater availability in physicians' schedule, favoring readiness in care;

Faster test turnaround to ensure quicker returns;

Offices that have similar structure of that in hospitals, which would optimize patients' time (in some cases, it would avoid the need to return): Tests and equipment at the visit site;

Greater range of options of associated physicians in healthcare plans to reduce full schedules;

Physicians with greater availability of schedules outside regular working hours could be an option for avoiding ED visits.

Moreover, it is essential that people would create the habit to take more frequent care of their health, visiting the doctor even when it is not a case of urgency.



Anahp hospitals develop recommendations for Clinical Care Organization

The key intention of the work is to encourage the organization of the clinical care team to ensure excellence of patient-focused services

The proposal of the Work Group was built on three pillars: Clinical Care Model, Competences and Processes.

The services related to direct care of patients involve most professionals and actions performed at the hospitals. It is formed by a wide range of knowledge and common and specific activities that need to be developed in an integrated and efficient way, so as to ensure the compliance with desirable and necessary excellence standards.

There has been a constant inflow of professionals into the healthcare area to integrate teams that used to be formed basically by physicians, nurses and some few dietitians and physical therapists.

This new shape requires great management initiatives, so as to include the knowledge from each area, respecting the limits of each role, and sharing power and team-spirit. It should all be obtained within a model that keeps the patient at center stage in the clinical care process. All in all, it is a process of transformation of a group of people into a team, which can eventually benefit care.

Anahp, among its many initiatives, has proposed the creation of a Clinical Care Work Group that integrates the Program of Innovation and Management. The key intention of the Group is to encourage the organization of the clinical care team to ensure excellence of patient-focused services.

The proposal of the Work Group was built on three pillars: Clinical Care Model, Competences and Processes. The Clinical Care Model provides the direction of the multiprofessional work. Competences sediment the consistency of actions and humanize care. Processes enable quality, safety and efficiency standards.

In discussing these topics, a survey was applied to get to know the reality of the organizations associated with Anahp. In general, it was observed that hospitals have or try to have a clinical care model as a guideline for safe and efficient care and it favors integration of the multiprofessional team. In the analysis of the survey data, it was possible to observe that there are some difficulties to conceptually understand what a clinical care model is in fact. Competence-based management and the design of critical processes consider the interface

of many different professions. Such information confirms the relevance and opportunity brought by this topic. This year of work of the Group has enabled the build-up of a set of experiences, scientific revisions and searches for new practices, which led to a first document with a set of recommendations that may serve as an aligned basis for clinical care team organization. The suggested assumptions for clinical care work organization are:

- Have a Patient and Family-Focused Clinical Care Model
- Work on Team Competences Focusing on Integration
- Get to know the Process Matrix Focusing on Work Safety and Division

Have a Patient and Family-Focused Clinical Care Model

A Clinical Care Model is the way how things are organized in a given society, the healthcare actions, involving technological and clinical aspects. In other words, it is how the organization and the articulation among available physical, technological and human resources are faced to solve the health problems of a collective group¹.

Assumptions based on patient and family associated with the accreditation and certification systems have imposed some pressure on the hospitals to search for models that could systematize and manage patient-focused care.

In the literature, especially the American literature, there are five clinical care models in Nursing²:

Total Patient Care Nursing

19th century, which includes all necessary care, such as cleaning the house, cooking, give the patient a bath, give him medication. In this mode, the nurse provides care to patients in the same shift and he/ she is also responsible for all aspects of care.

Functional Method (post-war)

Based on tasks that check vital signs, administer medication, give a bath, etc. The nurse basically manages the patient, but does not care for him.

Team and Modular Nursing - Team Model (1950)

A group of support people was created to provide care under the supervision of the nurse. It still caused fragmentation of care, with great likelihood of mistakes.

Primary Nursing (1970) – The nurse is focused on providing direct care to the patient.

Care is based on relationship. The nurse is responsible for planning care.

Case Management

The nurse assesses, plans, implements, coordinates and monitors services and the options in relation to the healthcare needs of each subject.

These models suggest ways to organize nursing care and can contribute and influence the format of a multidisciplinary team. Each organization will create a model that intends to meet the needs of the community and is in accordance with the available resources.

Next we can find the recommendations referring to the implications of adopting a Clinical Care Model in view of the Clinical Team Work Organization.

Recommendations of the Clinical Care Organization Focused on Choice and Use of a Care Model

- Patient and family take center stage.
- Organizational structure with top management representation in clinical care activities.
- Clinical care model is coherent with the management model.
- Building of policies that reinforce and support multidisciplinary and interprofessional work.
- Definition of policies and clinical processes that ensure quality and safety practices.
- Definition of the necessary competences to ensure integration of the clinical care team.
- Systematic application of care that enables coordinated actions of the clinical care team.
- Incorporation of effectiveness and efficiency actions that favor rational use of resources, supplies and technologies.

Work on Team Competences Focusing on Integration

The investment on people has been performed by the organizations as a way to ensure excellence of provided services. This is a topic that is discussed by the People Management Group, also within Anahp Innovation and Management Program. To transform a group in a clinical team it is necessary to have a development plan that integrates the different areas and sectors, ensuring team unit. It is a difficult task, considering the diversity and individuality of professionals and, primarily, the difficulty to define limits in a set of actions that take place concomitantly and in a complex fashion. The limit of each professional is supported by the job attributions.

The transformation of concepts into practice is a major challenge, because it should raise managers' awareness about the importance of describing the Competences and using them to select and assess professionals. The development of Competences is an important strategy of alignment, as well as

a key tool to evidence the organization's transparency relative to what is expected from employees.

The concept of competence has evolved from CHA (Knowledge, Skills and Attitudes) into CHAVE (including Values and Environment) (CHAVE means key in Portuguese). It has incorporated new dimensions and expanded its scope and understanding. These elements renew and strengthen the concept of competence.

It is important to emphasize that Professional Categories that already have competences defined by their Professional Boards should be taken into account and known by the professionals and managers. It is also recommendable that the organizations explore this topic when thinking about the Competences of the Clinical Care Team. Thus, the recognition and analysis of Competences within the Organizational, Care and Educational dimensions broaden the general context.

Once those concepts were set, the Working Group moved on to design the Recommendations for use of Competences in the creation of a clinical care team.

Recommendations of the Clinical Care Organization that Focuses on Competence

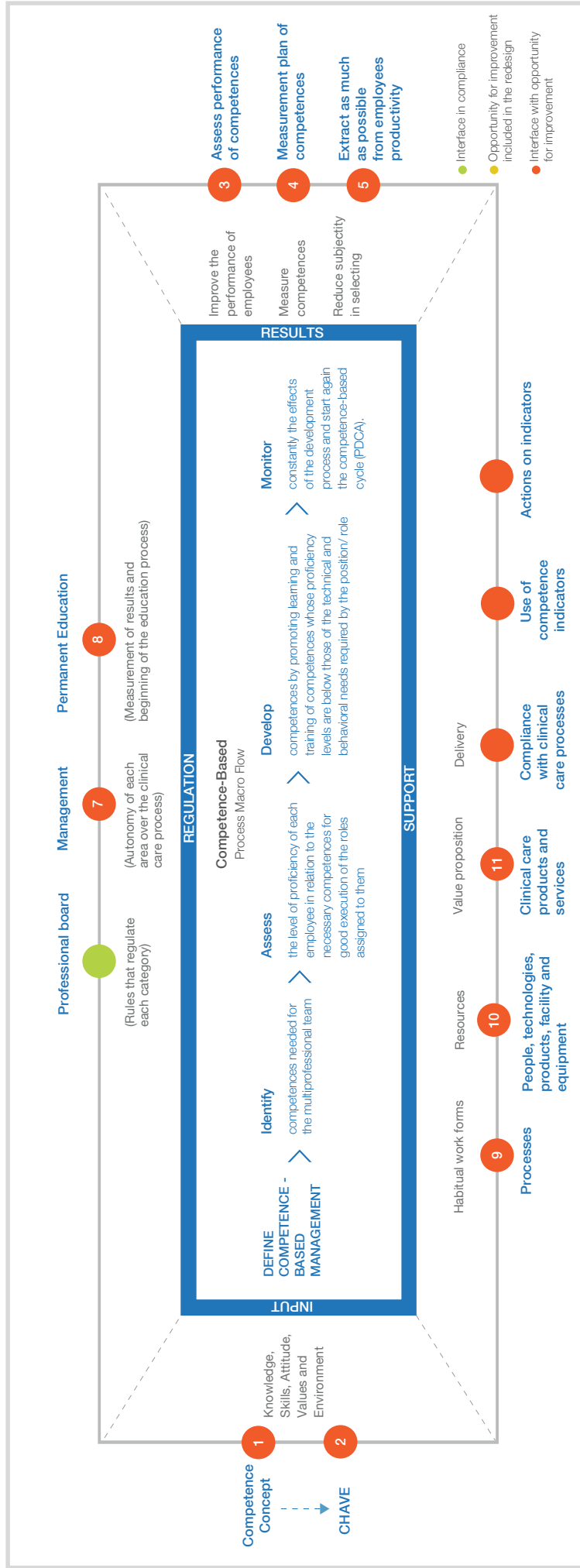
- Knowledge of competences defined by the professional board of each category.
- Unfolding of the competence model based on: Selection criteria, assessment, professional staffing and team structure.
- Identification and development of leaders capable of articulating the work of different professionals and their performance.
- Focus on quality and safety practices and the clinical care model.
- Incorporation of effectiveness and efficiency actions that favor rational use of resources, supplies and technologies.

In addition to these recommendations, a diagram was created to better understand all creation and operational processes that impact the competences.

DEIP is a diagram of scope and interfaces of the processes supported over a horizontal flow that checks the interfaces and identifies the disconnections that have to be emphasized within the process.

Clinical Care Organization

Diagram of Scope and Process Interpretation - Current Status



Clinical Care Organization

The creation was guided by the following steps:

Selection of a concept to define Competences - using CHAVE (Knowledge, Skills, Attitude, Values, Environment).

Identification of Competences necessary for a multiprofessional team to reduce the gaps between professionals of different specialties and company expectations.

Assessment of the level of proficiency of each professional in relation to the necessary competences, which may be applied to recently-hired and other employees.

Development of Competences mapped to promote learning and capacity building.

Monitoring through individual assessment.

Get to know the Process Matrix Focusing on Work Safety and Division

The objective of the Working Group was to recognize and analyze the main processes for integration of care. Thus, the

reference for recommendations was those of IHI – Institute for Healthcare Improvement, named Improvement Map, which describes 73 processes based on available knowledge to promote quality and safe care.

Processes are grouped by domains (Leadership and process management, Patient care process, Care-supported process) and objectives (Effectiveness, Efficiency, Equity, Patient-centered, Safety, Appropriate Time). The following attributes were assigned: 1) Cost for implementation; 2) Time for implementation in months or years; 3) Difficulties to implement; 4) Level of Evidence.

The purpose of this study was to contribute to the major objective of revising and rethinking the organization of the clinical care team.

Thus, the Processes were chosen based on criticality criteria for patient safety and they were grouped into four main areas: 1) Team work; 2) Care continuity; 3) Medication process; 4) Efficiency and safety in care.

Later, they were included in a correlation matrix to show the participation and integration of the multidisciplinary team involved in each of them, as presented below:

| Work efficiency and safety | | | | | | | | | | | | | |
|--|----|----|----|-------|------|----|----|-----|----------|------------|----|----------|----------|
| Process | MD | RN | PT | Pharm | Diet | ST | OT | Psy | Lab Tech | Pharm Tech | SW | Nut Tech | Nur Tech |
| Implement measures to prevent urinary tract catheter-associated infections | | | | | | | | | | | | | |
| Implement warning signs as criteria for early detection of clinical status worsening | | | | | | | | | | | | | |
| Implement bundle measures to prevent central line-associated bloodstream infection | | | | | | | | | | | | | |
| Implement a protocol for fall prevention | | | | | | | | | | | | | |
| Implement a protocol for hand hygiene | | | | | | | | | | | | | |
| Implement a clinical nutritional service that meets the specific needs of patients | | | | | | | | | | | | | |
| Implement a protocol for preoperative assessment of patients | | | | | | | | | | | | | |
| Implement a protocol for pressure ulcer prevention | | | | | | | | | | | | | |
| Implement the surgical checklist | | | | | | | | | | | | | |
| Implement a process to identify surgical complications | | | | | | | | | | | | | |
| Implement a protocol to prevent bronchoaspiration | | | | | | | | | | | | | |
| Implement a protocol to prevent and treat venous thromboembolism | | | | | | | | | | | | | |
| Implement measures to prevent ventilation-associated infections | | | | | | | | | | | | | |

Team Work/Communication

| Process | MD | RN | PT | Pharm | Diet | ST | OT | Psy | Lab | Pharm | SW | Nut | Nur |
|---|----|----|----|-------|------|----|----|-----|------|-------|----|------|------|
| | | | | | | | | | Tech | Tech | | Tech | Tech |
| Multidisciplinary round | | | | | | | | | | | | | |
| Daily plan of care (daily goals and planning) | | | | | | | | | | | | | |
| Rapid Response Team | | | | | | | | | | | | | |
| Implement a shared-decision system | | | | | | | | | | | | | |
| Temporary or permanent transfer of patients between areas/ services and handoff | | | | | | | | | | | | | |

Continuity of Care

| Process | MD | RN | PT | Pharm | Diet | ST | OT | Psy | Lab | Pharm | SW | Nut | Nur |
|--|----|----|----|-------|------|----|----|-----|------|-------|----|------|------|
| | | | | | | | | | Tech | Tech | | Tech | Tech |
| Define critical criteria for transfers to reduce number of readmissions | | | | | | | | | | | | | |
| Define patient and family-centered care, including advanced care (terminally-ill, palliative care, psychiatric care and pregnant patients in general hospital) | | | | | | | | | | | | | |
| Define internal efficient and reliable transportation services | | | | | | | | | | | | | |
| Pain management | | | | | | | | | | | | | |
| Patient flow for efficiency and safety: define contingency beds for critical periods | | | | | | | | | | | | | |

Medication Process

| Process | MD | RN | PT | Pharm | Diet | ST | OT | Psy | Lab | Pharm | SW | Nut | Nur |
|---|----|----|----|-------|------|----|----|-----|------|-------|----|------|------|
| | | | | | | | | | Tech | Tech | | Tech | Tech |
| Medication reconciliation in all transfers | | | | | | | | | | | | | |
| Use of medication | | | | | | | | | | | | | |
| Use of enteral diets | | | | | | | | | | | | | |
| Safety in high alert medication | | | | | | | | | | | | | |
| Glucose control in critical and non-critical patients | | | | | | | | | | | | | |
| Reliable and safety pharmacy | | | | | | | | | | | | | |

This matrix has provided some recommendations focused on processes that contributed to team work:

Recommendation of Care Organization with Process-focused

- Selection of critical processes for safe care
- Implementation of processes that favor multidisciplinary integration and promote team work, continuity of care, medication process and care efficiency and safety.
- Use of a correlation matrix between clinical care processes and the team, as a reference to promote multidisciplinary integration.



Private healthcare market follows the country's job creation

The participation of beneficiaries on collective contracts reached 76.9% of the total in 2012

In the same period, the number of beneficiaries on medical-hospital plans increased 2.1%, totaling 47.9 million.

Higher number of beneficiaries, mainly on corporate contracts; fall in the number of operators, with focus on business with a small number of companies; increase in revenue from services rendered, as well as in healthcare expenses. These are some of the main characteristics seen in the private healthcare market in the past years.

The participation of beneficiaries on corporate healthcare plans increased from 54.1% to 63.2% of the total number of users in the supplementary healthcare market between 2007 and 2012. If we add up this value to the number of collective contracts, we would see that 76.9% of the total number of beneficiaries are on collective contracts.

The unemployment rate measured by the Monthly Employment Study of IBGE –Brazilian Institute of Geography and Statistics (PME/IBGE) reached 5.5% in 2012 – its lowest level since the beginning of the historical series in 2002. In addition, the labor market has a trend of formalization. According to the PME/IBGE study, in 2005, 23.2% of the population in Brazil was employed in the informal market, whereas in 2012 this rate declined to 16.1%.

Labor Market: Unemployment Rate, Jobs Creation and Work Formalization



Informal workers participation in the total of employed population (%)



Source: Developed by Anahp based on the data from the Monthly Employment Study/IBGE and General Register of Employed and Unemployed/Labor Ministry.

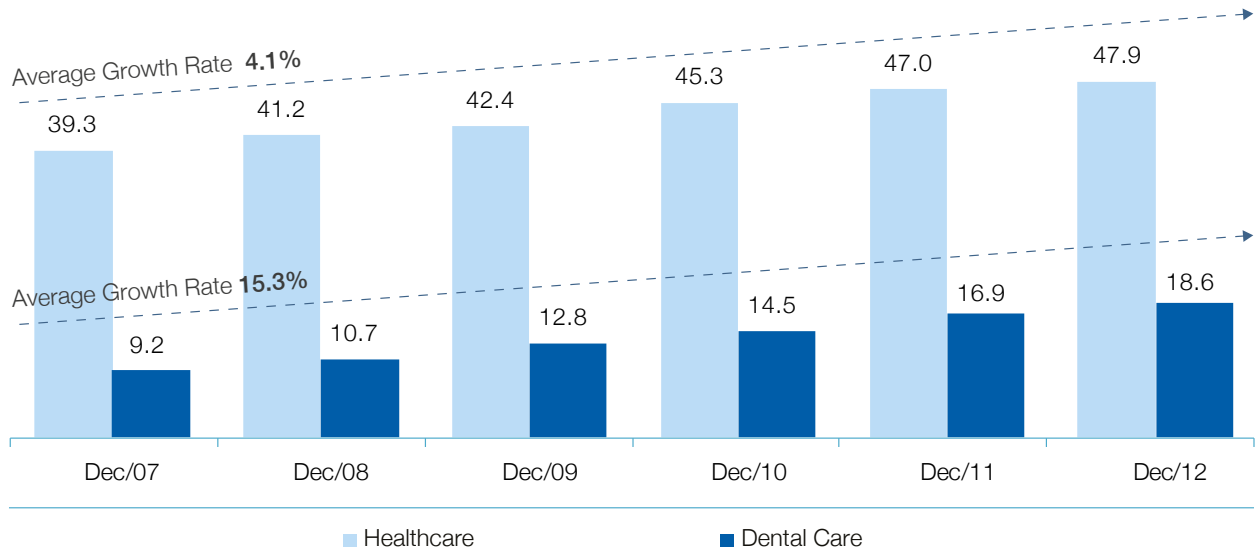
Healthcare Plan Beneficiaries

With the record creation of jobs seen in the past years, the supplementary healthcare market significantly expanded with 3.2 million new beneficiaries in 2010 and 1.8 million in 2011. However, the labor market has started to decline as only 0.9 million new jobs were created in 2012, which is half of the number of jobs created in 2011. This market performance has had a substantial impact on the supplementary healthcare market.

In 2012, the number of beneficiaries on medical-hospital plans increased 2.1%, which represents a little less than one million people, totaling 47.9 million beneficiaries.

By analyzing the market performance by modality of healthcare plan operators, we can see there has been a higher increase in the number of insurance companies in the past years in relation to other modalities. Between 2007 and 2012, the average annual growth rate in the number of insurance companies was 8.1%, which resulted in an increase from 4.3 million to 6.3 million beneficiaries. In the same period, medical cooperatives increased 6% average annually; group medicine 2.8% and philanthropy 2.6%, whereas self-management decreased 0.7%.

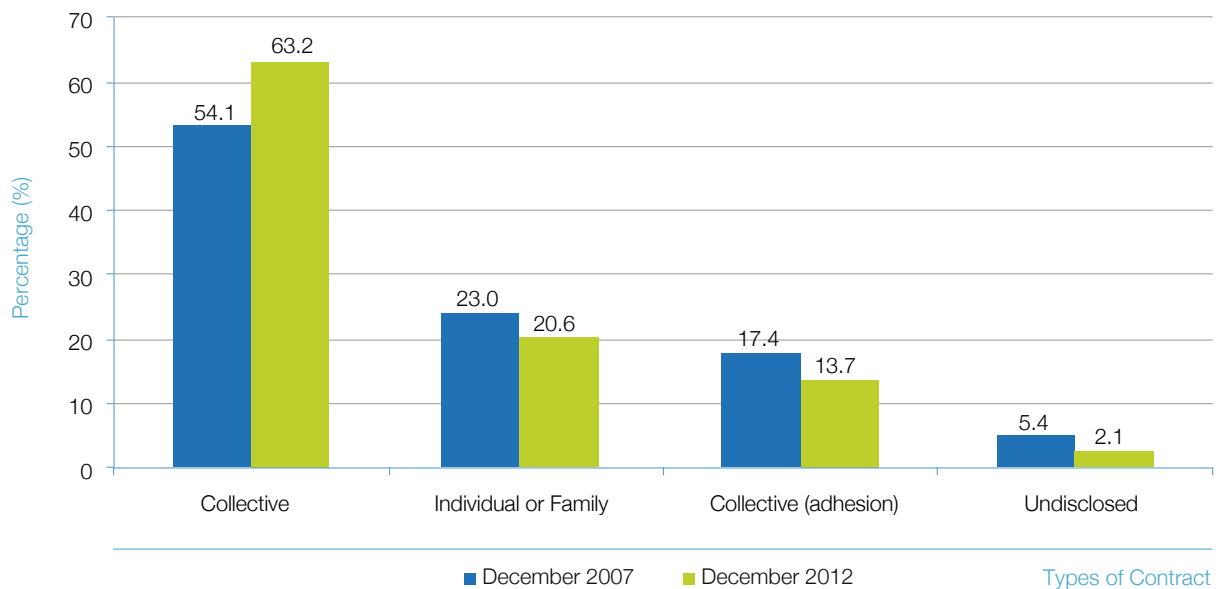
Number of Healthcare Plan Beneficiaries



Source: Developed by Anahp based on the data from the ANS (National Supplementary Health Agency).

Healthcare Plan Beneficiaries

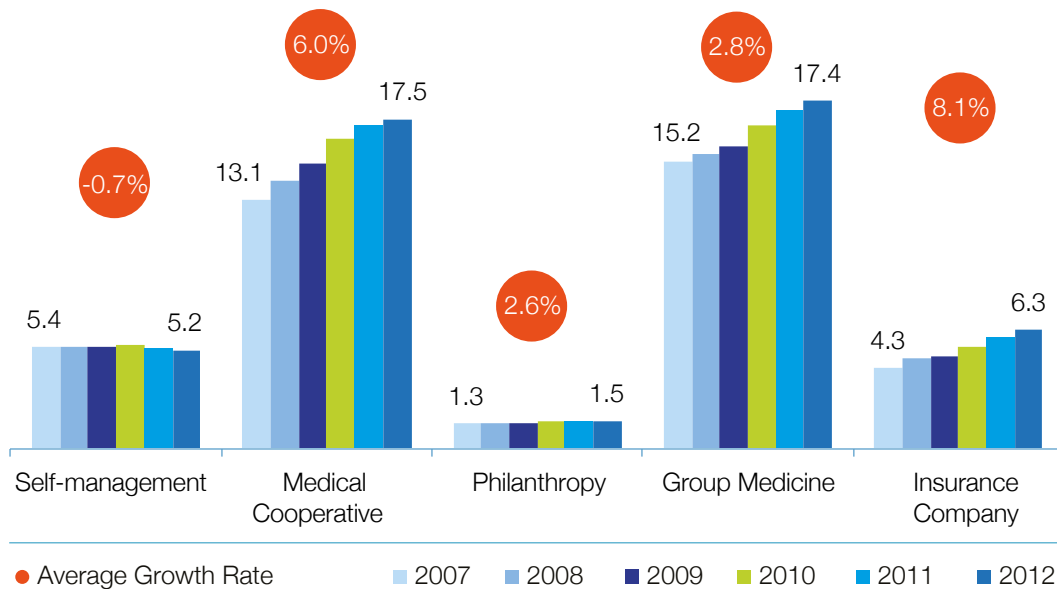
(By type of contract in %)



Source: Developed by Anahp based on the data from the ANS.

Number of Healthcare Plan Beneficiaries and Average Growth Rate

(By modality – in million)



Source: Developed by Anahp based on the data from the ANS.

The coverage of healthcare plans reached 24.7% of the population but it still shows large regional gap. In the Southeast, the coverage rate was 37.4% and in the South, which has the second highest rate, the coverage reached 23.4% of the

population, followed by the Midwest (18.3%), Northeast (12.1%) and North (10.8%). The medical cooperatives predominate in the South, Midwest and North and group medicines in the Southeast and Northeast.

Healthcare Plans Coverage Rate (December/2012, by modality and region – in %)

| Process | Self-management | Medical Cooperative | Group Medicine | Insurance Company | Philanthropy | Total |
|-----------|-----------------|---------------------|----------------|-------------------|--------------|-------|
| North | 1.5 | 5.5 | 2.3 | 1.3 | 0.2 | 10,8 |
| Midwest | 3.8 | 8.7 | 4.0 | 1.8 | 0.0 | 18.3 |
| Northeast | 1.7 | 3.7 | 5.0 | 1.6 | 0.0 | 12.1 |
| Southeast | 3.3 | 12.0 | 15.1 | 5.6 | 1.4 | 38.2 |
| South | 2.9 | 13.0 | 5.1 | 1.4 | 1.0 | 23.4 |
| Brazil | 2.7 | 9.0 | 9.0 | 3.2 | 0.8 | 24.7 |

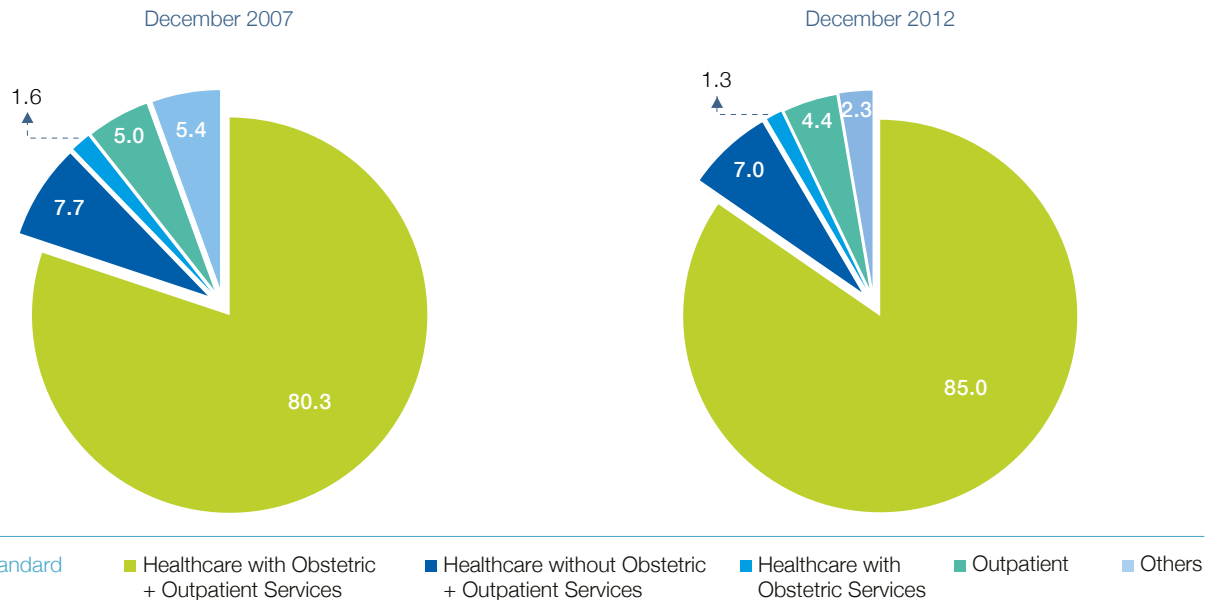
Source: Developed by Anahp based on the data from the ANS.

Most beneficiaries are on healthcare coverage contracts that provide obstetric and outpatient services, which representativeness increased from 80.3% of the total in 2007 to 85.0% in 2012. In the same period, the participation of

beneficiaries on modality contracts with healthcare coverage without obstetric services but with outpatient services, healthcare coverage with obstetric services but without outpatient services and healthcare coverage only with outpatient services decreased.

Healthcare Plans Beneficiaries

(By type of coverage – in %)



Source: Developed by Anahp based on the data from the ANS.

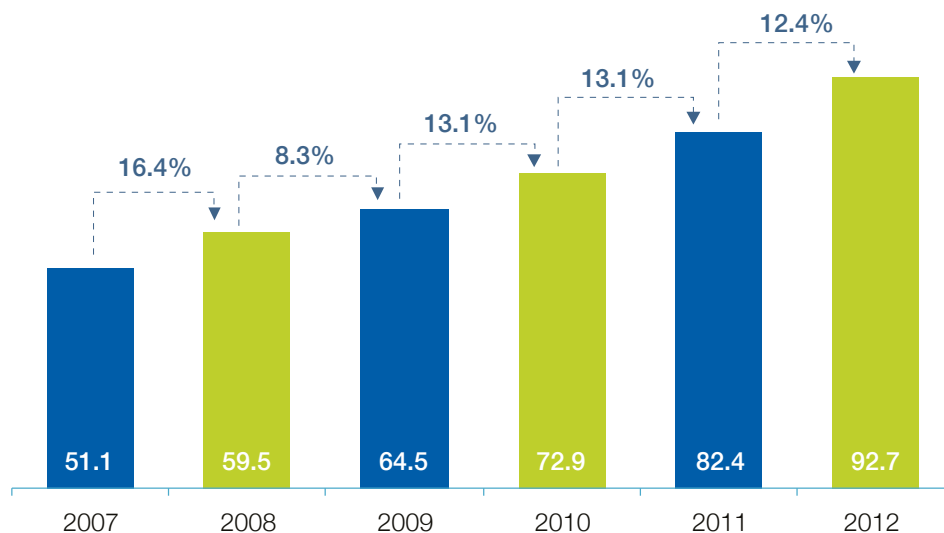
Revenue

The revenue increased 12.4% in 2012 if compared to 2011 – from R\$ 82.4 billion to R\$ 92.7 billion. The average monthly ticket of the sector increased in nominal terms from R\$ 146.27 to R\$ 161.14. However, if inflation is deducted based on the IPCA (Amplified Consumer Price Index), we can see that the

average monthly ticket with 2012 prices slightly increased – from R\$ 153.87 to R\$ 161.14. This may indicate that despite making readjustments in the client base, operators may have made smaller readjustments in the sales price of plans or even reduced it in the period.

Revenue

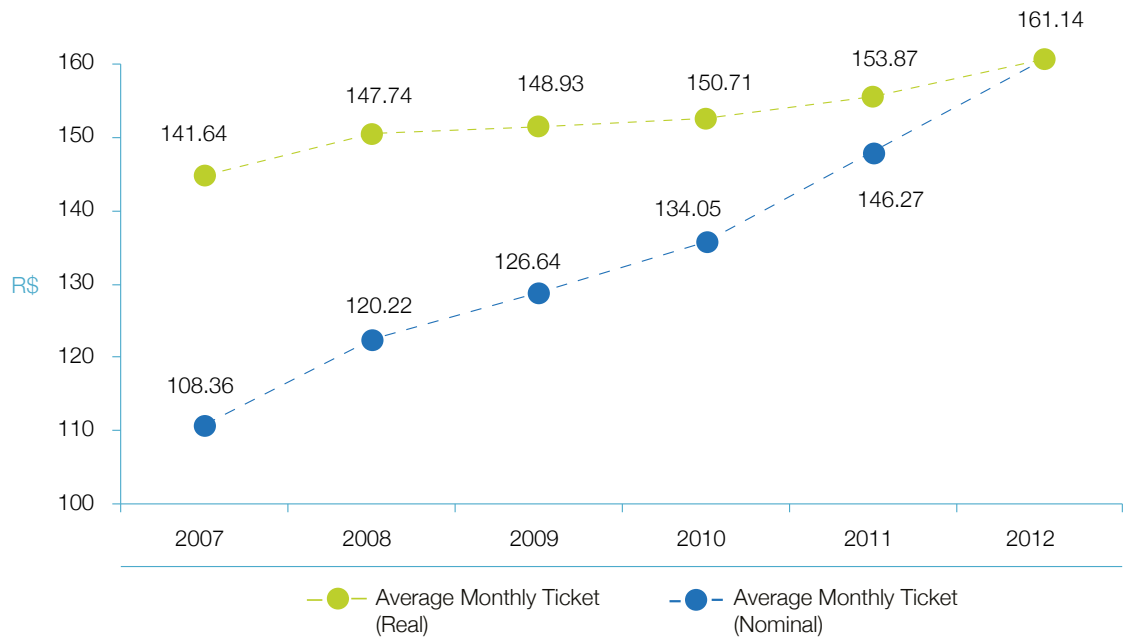
(in billion R\$)



Source: Developed by Anahp based on the data from the ANS.

Average Monthly Ticket

In nominal terms and in real terms with 2012 prices (inflation deducted based on the IPCA)



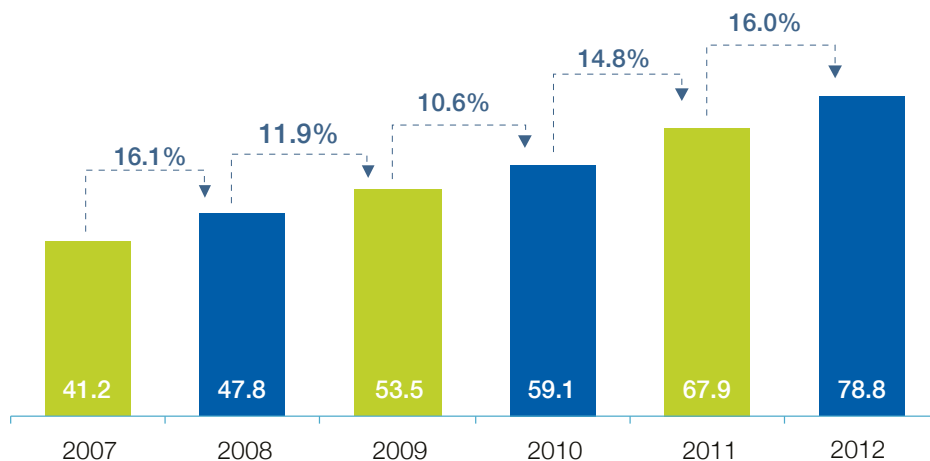
Source: Developed by Anahp based on the data from the ANS.

Benefits Payments

In 2012, the benefits payment reached about R\$ 78.8 billion - 16.0% higher than 2011. This growth rate was higher than the revenue growth (12.4%), increasing the claims ratio from 82.4% to 85.0%.

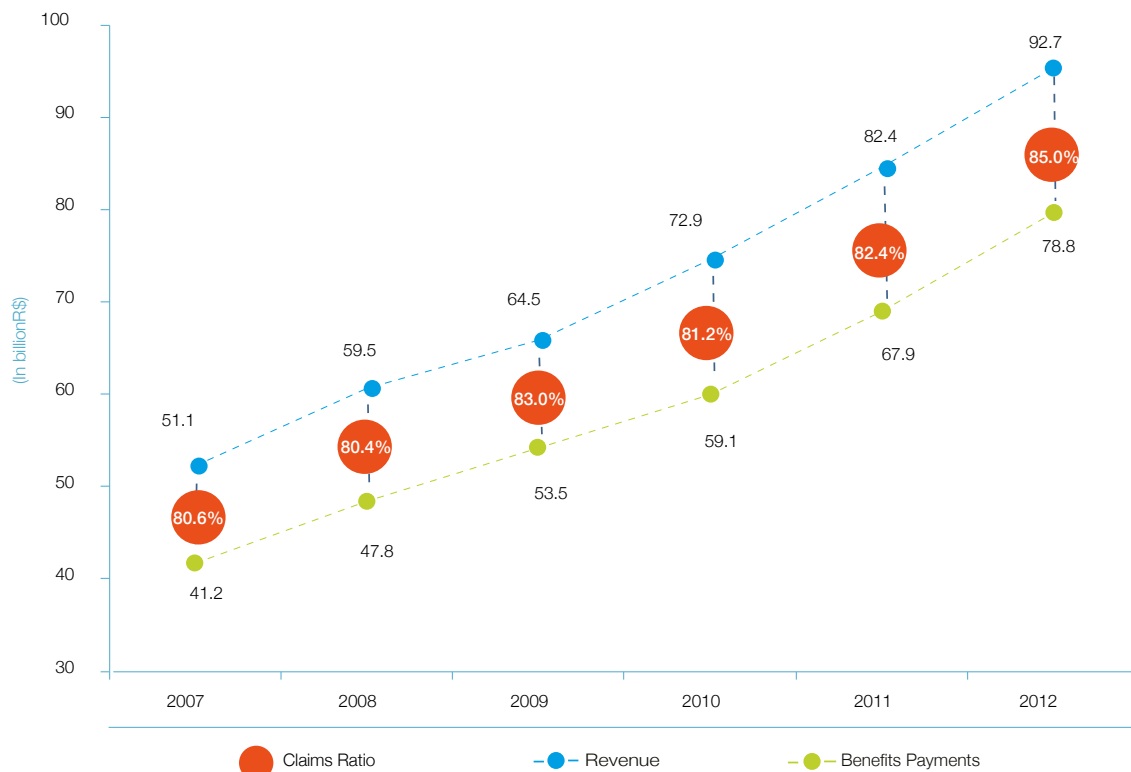
Benefits Payments

(in billion R\$)



Source: Developed by Anahp based on the data from the ANS.

Claims Ratio, Revenue from Revenue and Benefits Payments



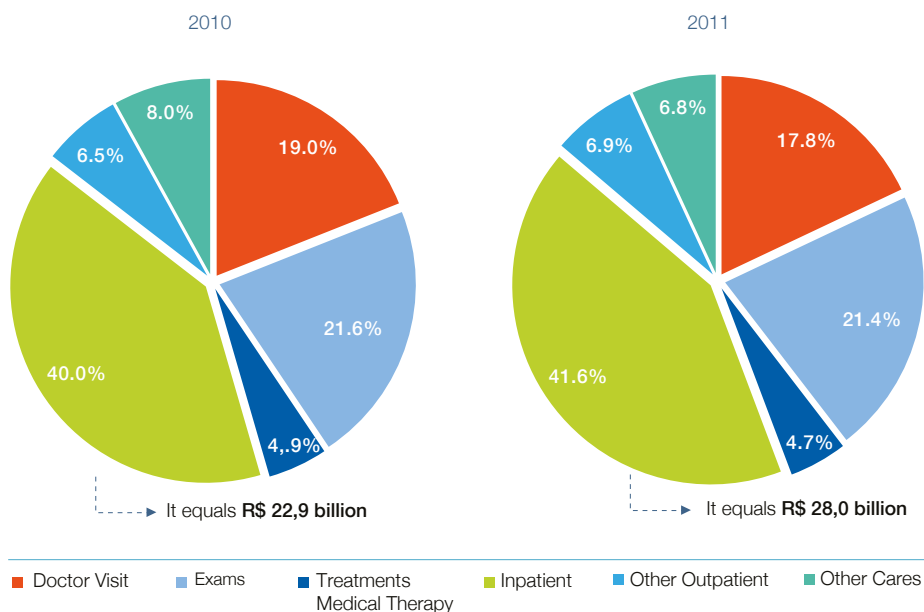
Source: Developed by Anahp based on the data from the ANS.

The main spending category of benefits payments in the supplementary healthcare market refers to hospital admissions, which representativeness increased from 40% in 2010 to 41.6% in 2011 – last year with information available. This percentage

represented an amount of R\$ 22.9 billion in 2010 and R\$ 28.0 billion in 2011. The second main spending category of benefits payments is whit exams: 21.6% of the total in 2010 and 21.4% in 2011; and the third one is with doctor visits, 19.0% in 2010 and 17.8% in 2011.

Benefits Payments by Spending Category

(By type – in %)



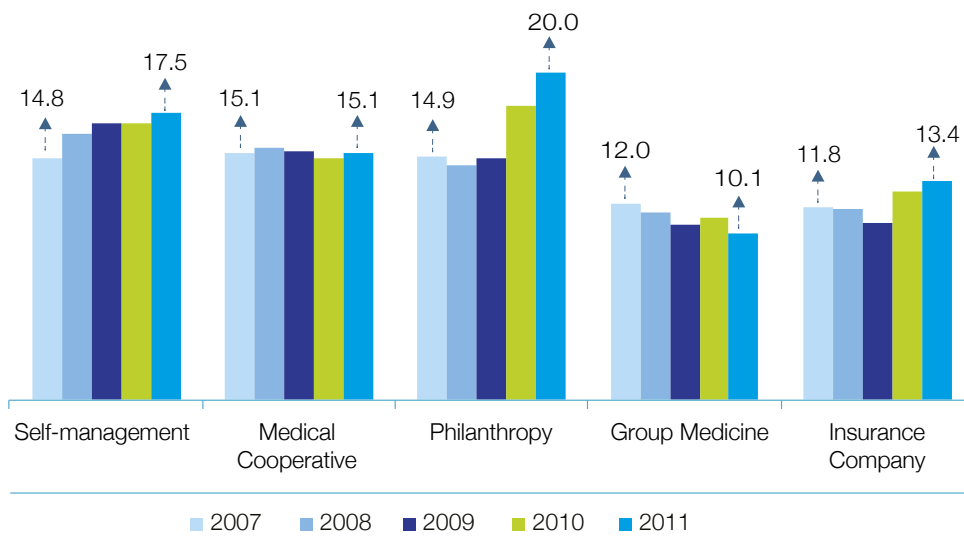
Source: Developed by Anahp based on the data from the ANS.

In 2011, the inpatient¹ increased in almost all modalities except for group medicine. The rate of philanthropy modality was 20%; self-management 17.5%; medical cooperatives 15.1%; insurance companies 13.4%; and group medicine 10.1%. The average inpatient expense is almost twice as much in insu-

rance companies (R\$ 9,608 in 2011) in relation to the one that ranked second; self-management (R\$ 5,153). The third highest average hospital admission expense is in group medicine (R\$ 4,547), followed by medical cooperatives (R\$ 3,865) and philanthropy (R\$ 2,347).

Beneficiary Inpatient Rate

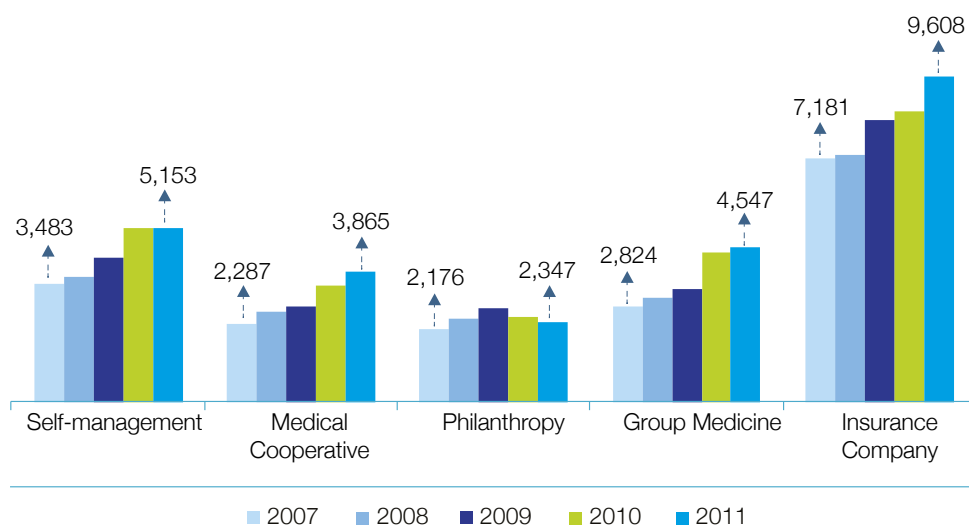
(By modality – in %)



¹The rate is calculated for each modality, dividing the total of inpatient by the average number of beneficiaries.
Source: Developed by Anahp based on the data from the ANS.

Average Inpatient Expense

(By modality – in R\$)



Source: Developed by Anahp based on the data from the ANS.

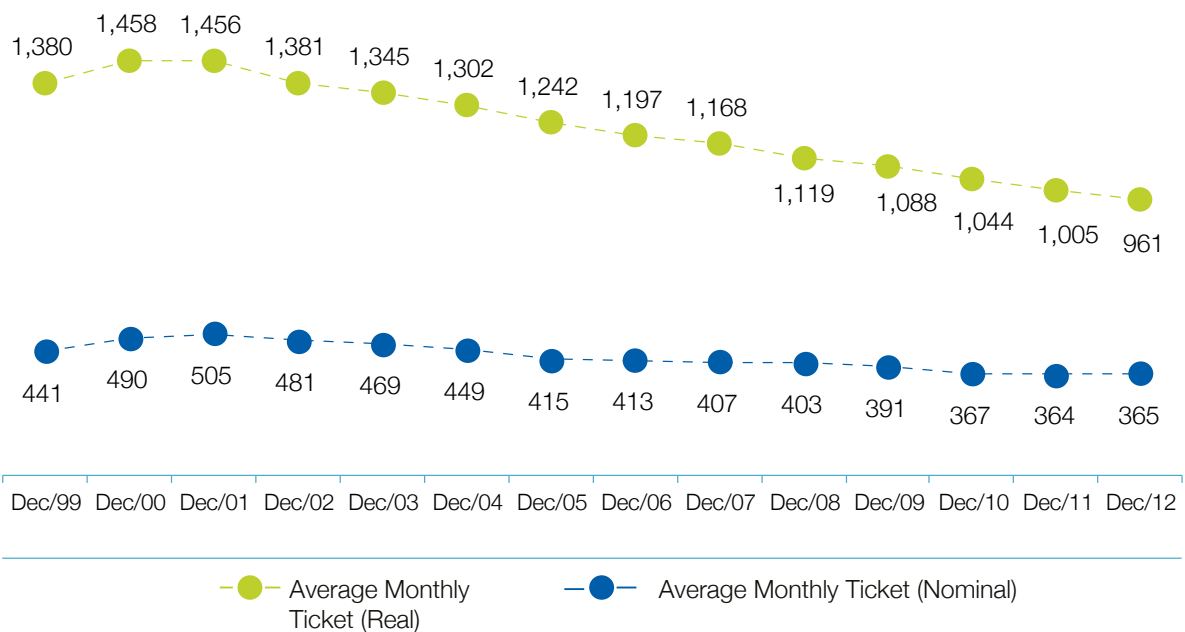
Market Concentration

The market is on the spot light with the number of healthcare plan operators continually decreasing. Between 2011 and 2012, 44 operators were closed down, leaving 961 operators in business.

In December 2012, the ten largest operators (classified by economic groups) had 37.7% of the market share, which equals 18.1 million beneficiaries.

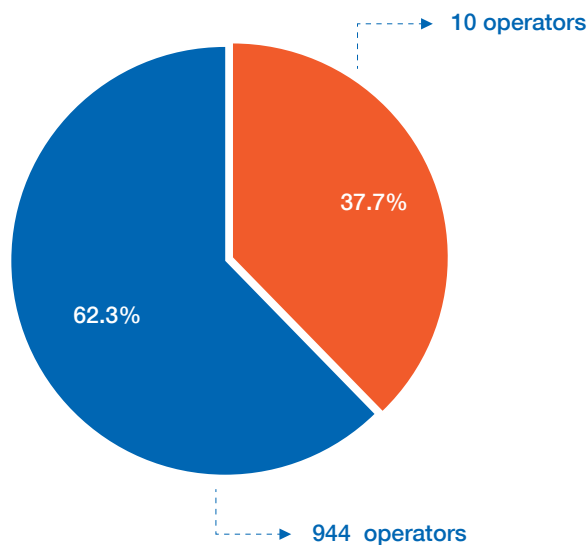
Number of Operators with Beneficiaries in Business

(Operators with beneficiaries)



Source: Developed by Anahp based on the data from the ANS.

Market Share of the Ten Largest Healthcare Plan Operators (in %)



Note: For the ten largest operators, companies that belong to the same group were classified together.

Source: Developed by Anahp based on the data from the ANS.



Economic and Financial Analysis

In 2012, Anahp's Hospitals posted an increase of 4% in Average Revenues, less than the inflation rate. Hospital supplies' share dropped by 3.6 percentage points

Average growth of labor costs, which accounts for 42.1% Anahp Hospitals' total expenses, increased 7.7%, a higher rate than the increase in revenue

Social indicators and favorable macroeconomic foundations, namely more job offers, expansion of the middle class and higher incomes for the lower-income brackets, provided the bases for a continued increase in medical and hospital healthcare plans, although the number of beneficiaries grew at one of the lowest rates (only 2%) in recent years. Additionally, demand for hospital services was also pushed up by changes in demographic and epidemiological patterns.

For Anahp Hospitals, the positive scenario was even more appreciable, as these organizations hold safety and quality care to be strategic management issues. These distinctive characteristics not only render Anahp Hospitals ever more dynamic, innovative and secure, but also place them among the highest-ranking institutions in demand and top-of-mind recall.

The growth in hospital services can be attributed to the small increase in the number of beds in 2012 compared to 2011 (1.4%). But above all, this increase is mostly due to efficiency gains (reduced length of stay, reduction in bed turnover Interval, higher occupancy rates, etc.), as it can be seen in the "Operational Analysis" chapter. A higher hospitalization rate among beneficiaries has also contributed to the increase in services rendered.

Efficiency gains also contributed to significantly reduce Anahp Hospitals of sales outstanding about six days. This drop led to a reduction in working capital needs, which translated into a positive results for the institutions.

Institutional Performance

Likewise, the metrics of rejection rates, which measures the share of disallowed accounts against total net hospital revenue, has also shown efficiency gains in 2012, with a fall of 0.2 percentage point in comparison to 2011.

The positive scenario ensuing from higher demand, more services rendered and higher efficiencies was not enough to avert a lower-than-inflation growth in Average Revenue for Anahp's Hospitals. And since costs increased at rates above inflation, there was a significant negative impact to the financial results of these organizations.

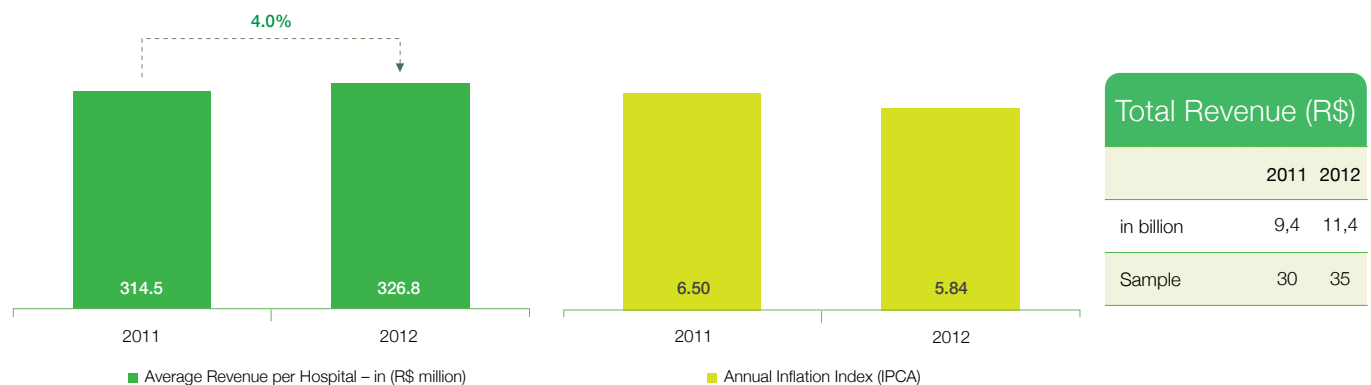
In this context, and aiming at reversing the situation, the adoption of price-realignment strategies, supported by quality and safety procedures, together with a more effective cost control seem to be the most cost-effective alternatives at hand. Considering the different variables involved in this economic-financial scenario one can see concrete evidence of the analysis conducted.

Total Revenue Anahp Hospitals

In 2012, total Revenue for Anahp Hospitals reached R\$ 11.4 billion, up of just over 21% compared to the figures reported in 2011. Part of this growth can be accounted by the fact that there were more hospitals (from 30 to 35) reporting results to the Integrated Hospital Indicator System (Sistema Integrado de Indicadores Hospitalares Anahp - SINHA). Average revenue per hospital grew from R\$314.5 million to R\$ 326.8 million, up 4% YOY.

One of the factors that may have contributed to the escalated demand for hospital services was the hike in beneficiaries' hospitalization rates. Average cost of per hospitalization also went up during this period, as shown in the "Supplementary Healthcare Market".

Average Revenue Per Hospital and Annual Inflation (IPCA)



| Total Revenue (R\$) | | |
|---------------------|------|------|
| | 2011 | 2012 |
| in billion | 9,4 | 11,4 |
| Sample | 30 | 35 |

Note: It must be said that revenue evolution depends on the sample, which may have varied during the year.

Source: SINHA / Anahp and IBGE.

Average prices evolution in Anahp Hospitals

Average Net Revenue per patient-day shows a 5.7% rise, from R\$ 2,858 in 2011 to R\$ 3,022 in 2012, whereas IPCA reported a 5.8% rise in inflation for the same period. In other words, revenue growth was not enough to offset inflation. Other cost increases, especially in payroll, which accounts for 42.1% of all hospitals' costs, also exceeded revenue growth.

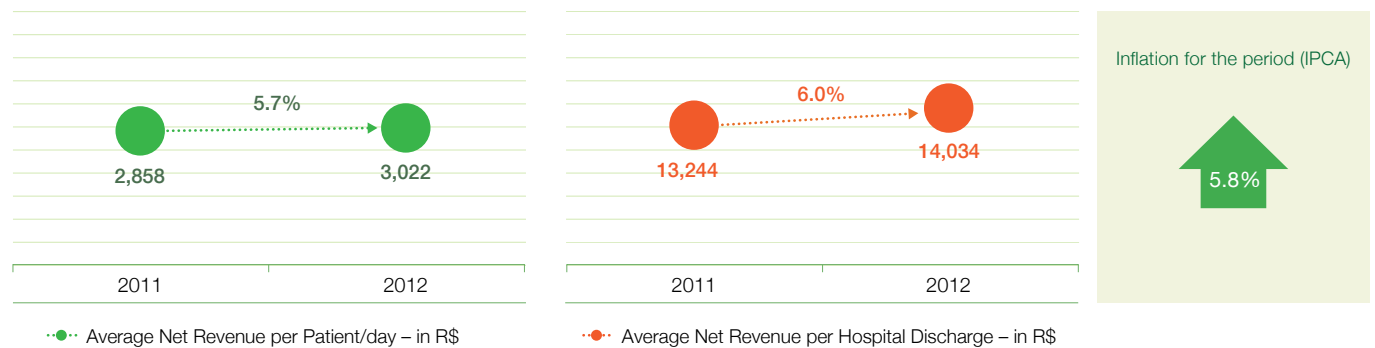
A considerable share of cost increases occurred under labor force expansion. During 2012, hospitals expanded their workforce by 8.1%. Investments were also made to train employees and to achieve higher safety levels in healthcare, attaining lower incidence of hospital infection, lower mortality rates, maintenance of certifications, among other benefits.

This data is broken down in the article about People Management

and Healthcare Performance section. It is important to highlight that abiding by quality assurance practices in National and International Accreditation Systems, although of the essence for hospitals, demands investments and pushes up costs.

Average Net Revenue per Hospital Discharge grew slightly more than the Average Net Revenue per patient/day. More precisely, while average net revenue per patient/day increased 5.7%, Average Net Revenue per Hospital Discharge grew by 6%, going from R\$ 13,244 to R\$ 14,034. A reduction from 4.7 to 4.6 days in average hospital stay stands out among the metrics, as shown in section "Operating Analysis", with impact on the revenue variables dynamics.

Net Average Revenue per Patient-Day and Hospital Discharge (in R\$)



Source: SINHA/Anahp.

Global Revenue Breakdown by Type of Payment

Daily Rates and Fees as well as Diagnostics and Therapy Unit (SADT) grew their share in total revenue, whereas revenue from hospital supplies dropped sharply. Daily Rates and Fees reached 25.1%, up 2.5% compared to 2011. Hospital supplies dropped from 51.5% to 47.9%, posting a reduction of 7% for the period. Diagnostics and Therapy Unit revenue's share increased from 14.1% to 16.4%.

The declining share of Hospital Supplies attests to the successful strategy by healthcare operators of focusing efforts on reducing material and medication costs. However, such drop was not translated into migration of margins to daily rates and fees, as revenue showed only a slight increase, not enough to offset losses with materials and medication.

| Revenue Breakdown by Type of Payment | | | | | | |
|--------------------------------------|------|------|------|------|------|------|
| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| Daily Rates and Fees | 33.1 | 30.3 | 29.4 | 28.0 | 24.5 | 25.1 |
| Hospital Supplies | 46.4 | 48.6 | 50.9 | 48.5 | 51.5 | 47.9 |
| Diagnostics and Therapy Unit | 11.1 | 12.6 | 11.6 | 11.2 | 14.1 | 16.4 |
| Other Services / Operational | 2.9 | 2.5 | 3.2 | 3.4 | 4.5 | 4.9 |
| Other Operational | 6.6 | 6.0 | 4.8 | 8.9 | 5.5 | 5.7 |

Note: It must be said that the evolution of the metric depends on the sample that may have varied from year to year.
Source: SINHA / Anahp.

Total Revenue by Source of Payment

The main sources of revenue are still private, enhancing the profile of Anahp Hospitals' Assistance. In 2012, 91% of total revenues were derived from services to beneficiaries of healthcare plans,

8.6% of private assistance (out of pocket), and only 0.5% of the total revenue was paid by Public Healthcare System (SUS).

Breakdown of Revenues by Nature of Payment Source

| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------------------------|------|------|------|------|------|------|
| Public Healthcare System | 1.9 | 1.7 | 1.8 | 0.8 | 0.7 | 0.5 |
| Private (Out of pocket) | 6.4 | 7.0 | 8.9 | 7.3 | 4.8 | 8.6 |
| Healthcare Plan | 91.7 | 91.4 | 89.3 | 91.9 | 94.4 | 90.8 |

Source: SINHA / Anahp.

Care provided to beneficiaries of healthcare operators under the category Insurance Companies remains the main source of revenue for hospitals participating in the survey, accounting for 37.8% of total revenue from healthcare plans. At the same time, there was significant increase in revenue coming from operators under the category Group Medicine and Medical

Cooperatives, while the share of self-management dropped, resulting in a scenario with greater diversification of sources. Note that the fall in the volume of revenues coming from self-management operators was caused by a reduction in the number of beneficiaries under this modality introduced in 2012, as shown in section "private healthcare market".

Revenue Breakdown by Payer

| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---------------------|------|------|------|------|------|------|
| Insurance Company | 46.7 | 46.0 | 44.7 | 52.6 | 38.5 | 37.8 |
| Self-management | 23.1 | 21.4 | 25.3 | 21.2 | 29.9 | 22.3 |
| Group Medicine | 20.7 | 20.2 | 18.5 | 15.1 | 15.5 | 20.7 |
| Medical Cooperative | 9.4 | 12.5 | 11.5 | 11.1 | 16.1 | 19.2 |

Source: SINHA / Anahp.

Global Revenue Breakdown by Nature

The largest expenses between Anahp Hospitals' are with payroll, which increase each year and accounted for a 42.1% share of total expenses in 2012. The second largest account is hospital supplies, representing a 25.2% share, and the third largest entry refers to technical operational contracts (8.3%), which are outsourced.

Labor contracts are usually adjusted according to union agreements. As a whole, wage adjustment rates have been

higher than inflation. Between 2011 and 2012, personnel costs increased 7.7% in Anahp Hospitals, exceeding increases in Average Revenue per Patient/Day and Hospital Discharges.

Part of the work is performed by subcontractors, whose adjustment clauses are pegged to inflation and are also ruled by union agreements.

Breakdown of Total Expenditures (by type of expenditure)

| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|-------------------------------------|------|------|------|------|------|------|
| Personnel costs | 37.5 | 36.8 | 37.3 | 38.3 | 40.0 | 42.1 |
| Hospital Supplies | 30.5 | 30.1 | 30.9 | 29.3 | 27.6 | 25.2 |
| Other Supplies | 3.9 | 3.6 | 3.7 | 3.8 | 4.4 | 3.1 |
| Technical and Operational Contracts | 8.3 | 8.3 | 7.1 | 7.8 | 8.3 | 8.3 |
| Support and Logistics Contracts | 3.7 | 4.2 | 4.2 | 4.8 | 4.9 | 5.0 |
| Utilities | 3.3 | 3.0 | 2.7 | 2.3 | 2.2 | 2.7 |
| Maintenance and Technical Support | 2.2 | 2.1 | 2.1 | 2.1 | 1.9 | 3.1 |
| Depreciation | 4.7 | 5.0 | 5.1 | 4.6 | 4.9 | 4.1 |
| Other Expenses | 5.9 | 6.9 | 6.8 | 6.9 | 5.7 | 6.4 |

Source: SINHA / Anahp.

Average of sale outstanding and Rejection Rate

The average period to receive amounts from sales (number of days of sales outstanding) is estimated based on the total accounts receivables held by hospitals in December 2012 and the revenue collected for the same year. In this case, the higher the share of accounts receivable, the higher the number of days of sales outstanding.

Historically, hospitals post high average collection periods,

especially regarding services provided to beneficiaries of healthcare plans, whose process for documentation analysis process is lengthy. This delay damages hospitals financial management, as the average collection period is well above the average period for payment of wages and suppliers. In this case, service providers need to have more injections of capital. In 2012, the outstanding was reduced by about six days, from 72 to 66 days, a decrease of 8%.

Average Collection Period

| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------|------|------|------|------|------|------|
| Anahp | 71.8 | 69.2 | 70.7 | 81.8 | 72.4 | 66.4 |

Source: SINHA / Anahp.

The rejection indicator measures the share of total accounts rejected (disallowed) in comparison to total net revenue posted by the hospitals. In 2012, this indicator suffered a slight decline

of 0.2 percentage point compared to 2011, from 3.2% to 3.0% of revenue.

Progression of Average Rejection Rate

| Nature | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------|------|------|------|------|------|------|
| Anahp | 3.4 | 3.3 | 2.8 | 2.6 | 3.2 | 3.0 |

Source: SINHA / Anahp.



People Management Analysis

Number of employees increased by 8.1% in Anahp Hospitals

In 2012 the group of hospitals created almost 81,000 direct jobs in Brazil

In 2012, the indicators which are part AHAHP Hospitals SINHA (People Management Indicators within the Integrated Hospital Indicator System) were redesigned. This entailed a process developed in the context of a broader Anahp project, supported by expert advice and intense dedication on the part of our People Management Work Group. The review was concluded with the creation of 26 metrics, which will be collected as of 2013. 14 of these metrics were retrospectively collected for 2012.

The project aimed at modernizing People Management indicators, making them more accurate and in line with best practice standards (1). Indicators of Nursing Teams, for example, began to consider the number of professionals per critical (ICU) / semi-critical and non-critical beds, as well as the workload of these professionals, according to the concept of Full-Time Employee (FTE), derived from the standard American FTE (Full-time Employee).

Turnover indicators detailing voluntary and involuntary terminations were collected, checking whether admissions were to replace existing vacancies or to expand the workforce. The number of hours in training were also recorded in more detail and more comprehensively, to include all programs - whether formal education programs, such as undergraduate scholarships, graduate courses and English language, or short-term courses, and technical training, as well as in-company sessions, conferences, symposia, among other modalities of training, in person or by distance learning, provided they had received grant institution.

Next, Anahp presents the results of this extensive project, which gains greater comparability, intra and inter-industries. With the changes accomplished, the historical series published until 2011 ceases to be published for most indicators, avoiding comparison of data gathered under different concepts, calculation procedures and collection.

Employee Profile

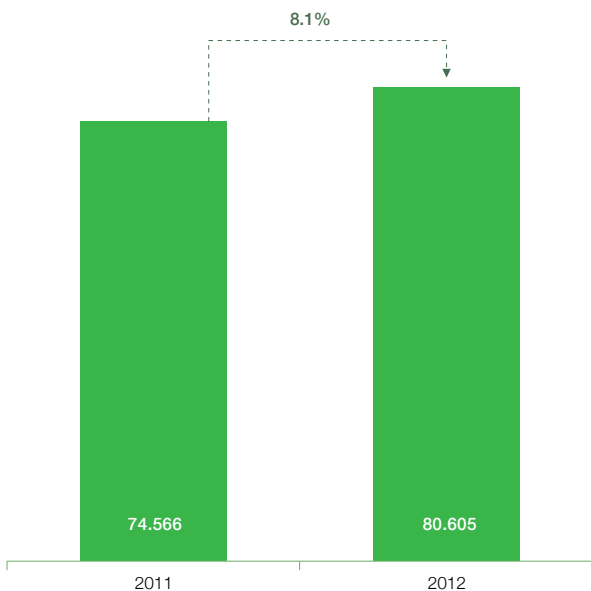
In 2012, the staff of 46 Anahp Hospitals totaled 80,605 employees. This total is 8.1% higher than the amount recorded in 2011 (Graph 1).

The 32 institutions that answered the survey account for 73.3% of the total number of employees in Anahp's Hospitals. These

hospitals increased staffing by 8.1% in 2012, a rate that far exceeds overall job creation in Brazil for the same period, i.e. 2.9% (Graph 2). This attests to the capacity of Anahp Hospitals to grow creating jobs.

Graph 1 – Jobs Created

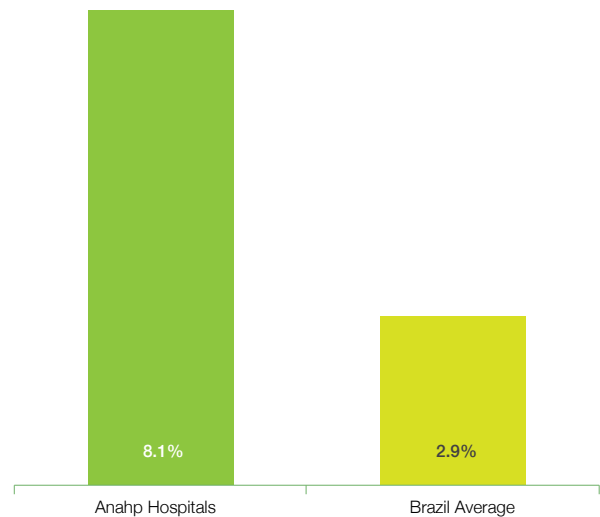
Anahp Hospitals



Source: SINHA/Anahp.

Graph 2 - Jobs Growth in 2012

Anahp Hospitals and Brazil Average²



Source: SINHA / Anahp, CAGED and RAIS.

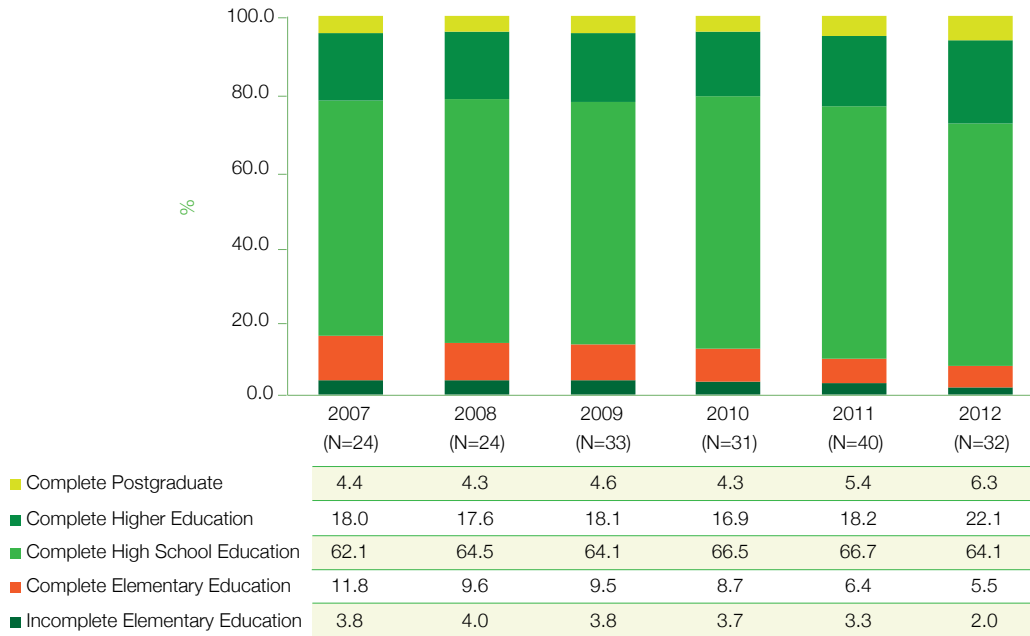
Most of the employees (64.1%) are high school education, and 22.1% have higher education degrees; 6.3% have post-graduate degrees and the remainder have finished primary school (7.5%) (Graph 3). It is important to highlight that 14% of the nurses have completed graduate courses and have postgraduate degrees.

Comparing the survey's data with previous research, we see that the share of employees with higher education levels is increasing continuously. For this specific set of data we present the historic time series, since there was no significant change in the metrics' definition.

¹ The theoretical references on the subject that guided the definitions of the indicators were: Jac Fitz-enz and Barbara Davison. How to Measure Human Resource Management, 2001 Ed McGraw Hill. Jac Fitz-enz. The ROI of Human Capital: Measuring the Economic Value of Employee Performance – second edition, 2009. Rugenia Maria Pomi. Reporting in Human Resource Management and Business for Sustainability, 2012 Sextant Brazil.

² Brazil Average was calculated comparing the total number of jobs created in 2012, as per data by the General Register of Employed and Unemployed (1.3 million), to total number of employees in the formal market in December 2011 (46.3 million – data from the Annual Social Information – RAIS).

Graph 3 – Employees’ Education Level



Source: SINHA/Anahp.

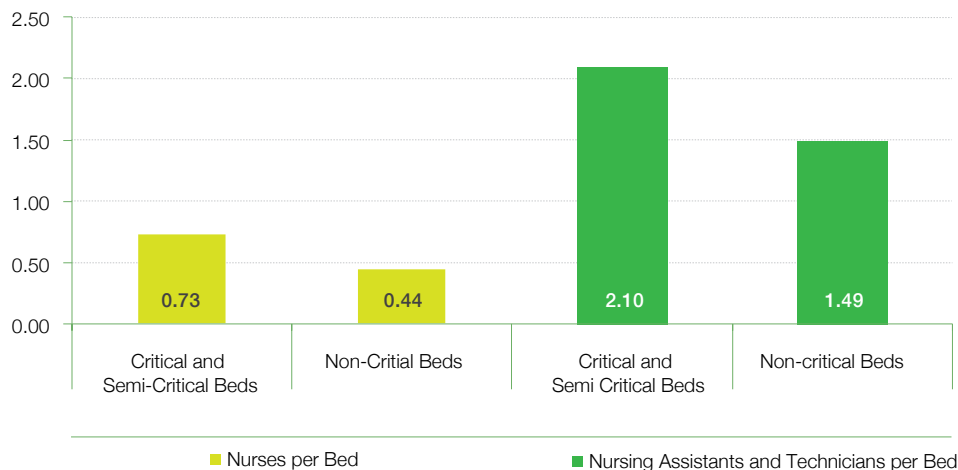
Personnel Productivity: nursing structure

Productivity indicators were collected for nursing professionals only. The data considers the total number of hours worked by nurses and nursing assistants/technicians assigned to healthcare functions. In order to render the different work shifts uniform, the hours for each day were totaled and divided by the adopted standard of 180 hours per month, resulting in FTEs (Full Time Employees). The staff was also broken down by types of bed, in that the infrastructure that caters to critical

(ICU) and semi-critical was separated from those who provide care to noncritical beds. The staff per critical / semi-critical bed was equivalent to 0.73 nurse with a standard 180 hour monthly journey and 2.10 nursing assistants and technicians with standard monthly journeys of 180 hours for each operational bed. As to non-critical beds, the ratio is 0.44 nurse and 1.49 auxiliary nurse per operating bed under the same monthly journey standard (Graph 4).

Graph 4 - Number of Nurses and nursing assistants / technicians (default 180h)

(Per Critical / Semi-Critical and Non-Critical Bed)



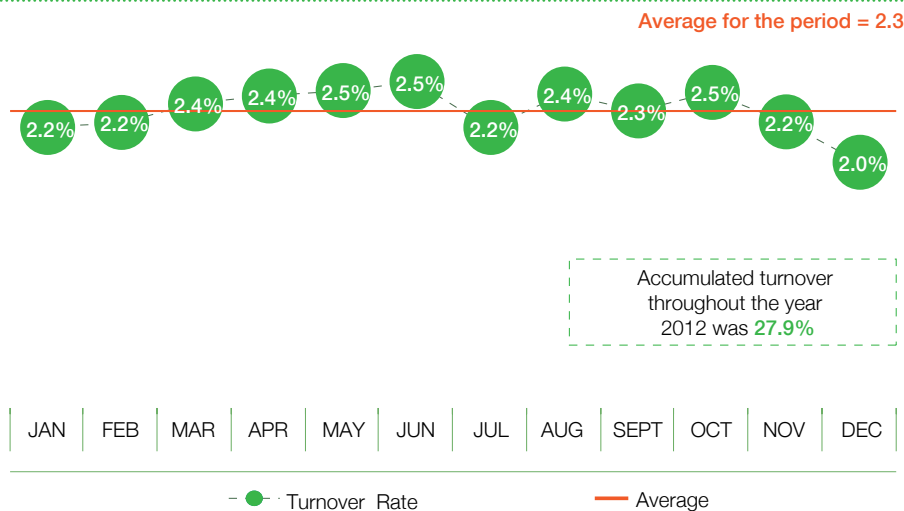
Source: SINHA/Anahp.

Turnover and Absenteeism Index Less than 15 days

The Staff turnover rate is calculated considering the total number of admissions (due to workforce increase or replacement) added to Terminations (voluntarily or involuntarily) and the total workforce (active personnel list) for a given period. In Anahp

Hospitals, monthly turnover rates ranged from 2% (lowest rate, recorded in December) to 2.5% (highest rate, recorded in May, June and October), in that the average rate for 2012 was 2.3%. The accumulated rate for 2012 was 27.9% (Graph 5).

Graph 5 - Monthly Turnover Rate for 2012 (in %)



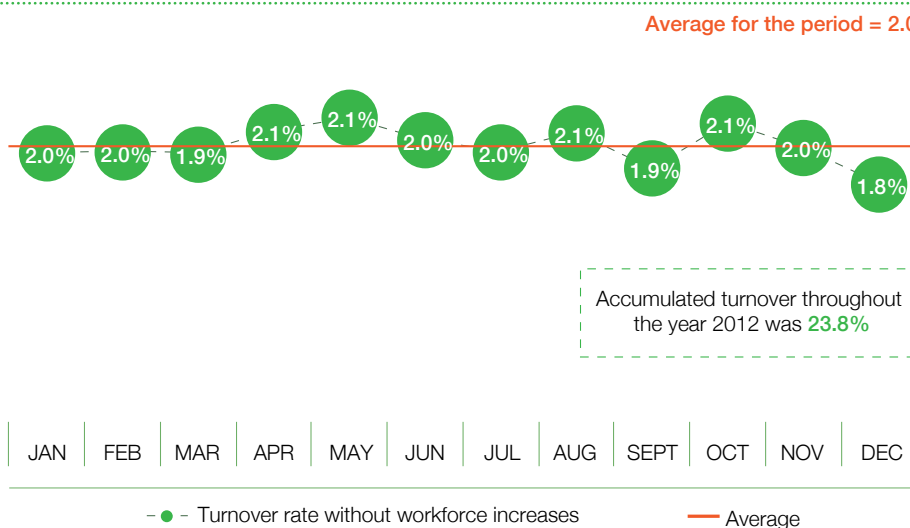
Source: SINHA/Anahp.

Turnover Rate Excluding Increase in Workforce

Staff turnover is a classic metric showing the rate at which employees enter and leave organizations. However, one derivation of this indicator suggests increases in workforce should be excluded from the calculation. The purpose of this adapted indicator, called "Turnover excluding workforce increase" is to show only unwanted staff turnover and terminations. If we exclude the data regarding admissions for

workforce increase purposes, higher rates are probably an indication of a deterioration in staff retention patterns, whereas the classical metric Graphs may only reflect a staff increase due to planned expansion plans. Excluding admissions aimed at workforce increase, Turnover Rates varied from 1.8% to 2.1% with an average equivalent of 2.0% and an accumulated index for the year 2012 of 23.8% (Graph 6).

Graph 6 - Turnover Rate Excluding Workforce Increase 2012 (in %)



Source: SINHA/Anahp.

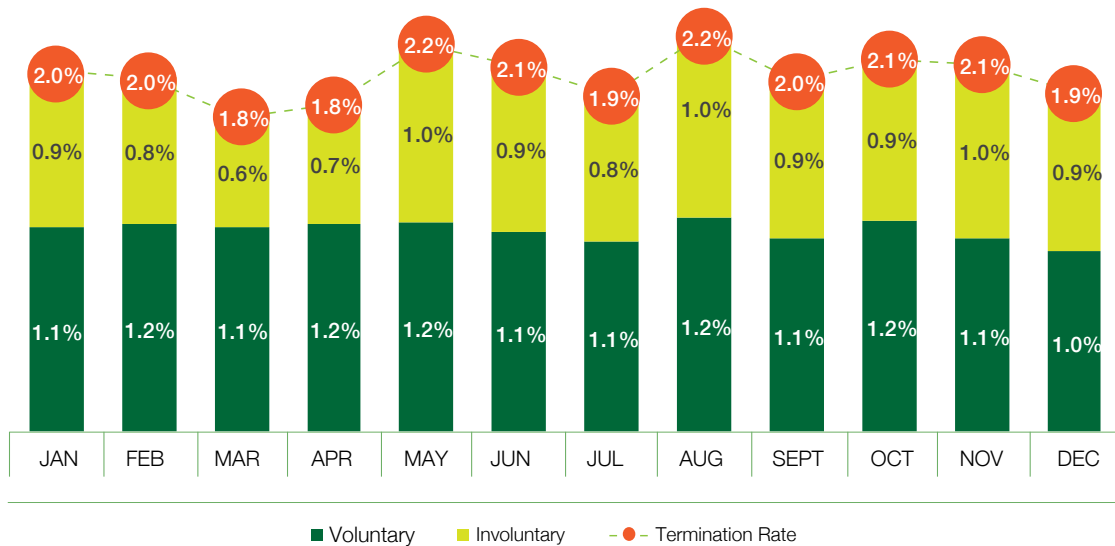
Termination Rates

Termination Rate provides the ratio between total terminations, both voluntarily (dismissal at the request of the employee) and involuntary (dismissal by the company), to total staff.

Monthly Termination Rates ranged from 1.8% to 2.2% in 2012, in that the average for the whole year was 2.0% (Graph 7). The rate of voluntary termination for the year was 13.4% and for involuntary terminations 10.6%. In a booming labor market, there was a record number of Brazilians resigning from their positions³. According to data from the General Register

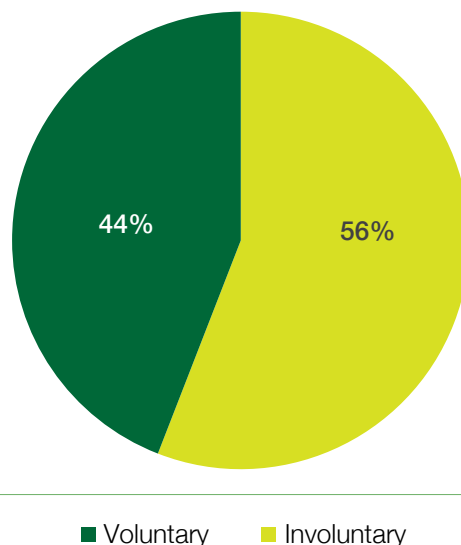
of Employed and Unemployed (CAGED - Cadastro Geral de Empregados e Desempregados), 34.4% of terminations in 2012 were initiated by the workers. In 2007, the situation was different – during that year, voluntary terminations were at 25.8% of the total. In Anahp Hospitals, this situation is even more evident. The number of voluntary terminations is greater than the number of involuntary layoffs: 56% voluntary and 44% involuntary (Graph 8).

Graph 7 – Monthly Termination Rate 2012 (in %)



Source: SINHA/Anahp.

Graph 8 - Voluntary / Involuntary Terminations in 2012 (in %)



Source: SINHA/Anahp.

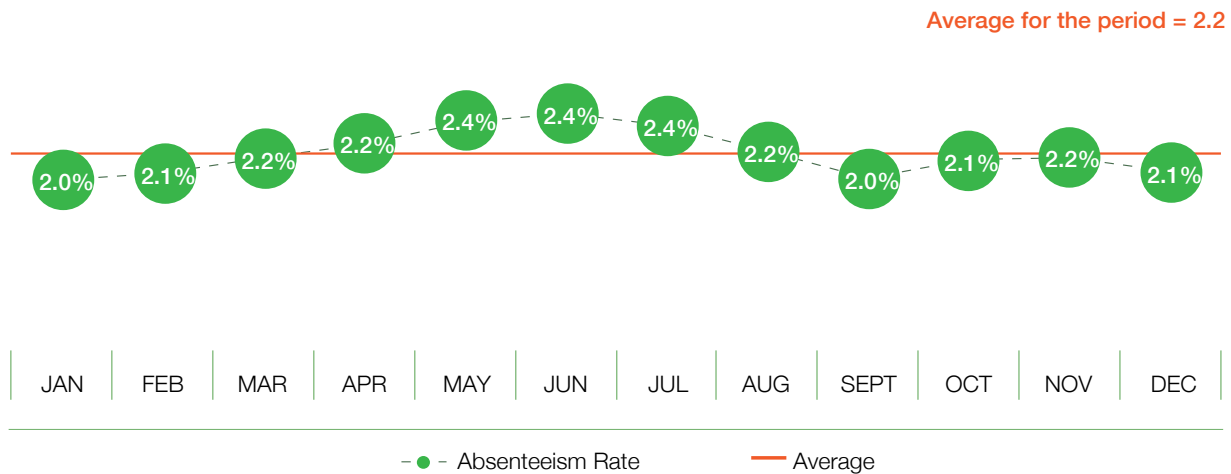
³Article published by O Estado de São Paulo newspaper, on April 8, 2012. Headline: Com sobra de emprego, mais brasileiros deixam a empresa para trocar de patrão.

Absenteeism shorter than 15 days

Absenteeism shorter than 15 days is the ratio between the total number of hours absent from work due to delays or work leaves lasting less than 15 days, in comparison to the total number of work hours projected. This rate may be higher in hospitals mainly due to the fact that employees tend to have multiple jobs, suffering from work overload, and are more susceptible to diseases, absences

or delays, stress due to workload or changes in processes, among other reasons. The Monthly absenteeism rate in 2012 ranged from 2.0% to 2.4% with an average equivalent to 2.2% (Graph 9). Rates are higher in the months of May, June and July, possibly due to the increase in respiratory diseases due to lower temperatures and humidity.

Graph 9 - Monthly Absenteeism Rate 2012 (in %)



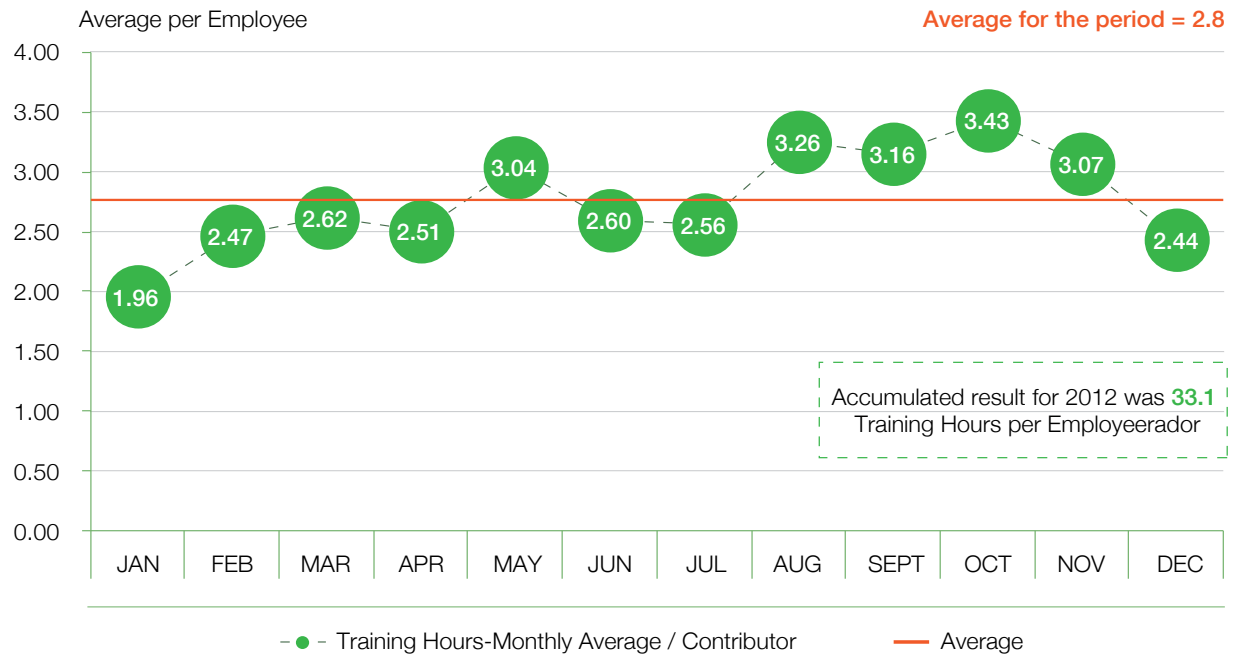
Source: SINHA/Anahp.

Development: Training Hours per Employee

Training Hours per Employee is the metric that indicates the average number of hours each employee dedicates to training during a one-month period. Both short courses and subsidized traditional institutional development courses are included. In 2012, each employee averaged 33.1 training hours, i.e. 2.8 hours per month. Over the months, there is a higher concentration of training during the second half of the year (Graph 10).

According to Sextant Brazil research, the consolidated figure for companies within the service sector is 39 hours / employee year. Even taking into consideration the differences between hospitals and other branches of the service industry and accounting for the limitations of purely quantitative indicator the gap indicates that there is still room for further investments in this area.

Graph 10 - Man-Hours Training
(Average per Employee)



Source: SINHA/Anahp.



Operational Analysis

Anahp Hospitals consolidate investments and continue putting safety and quality of care first

Anahp hospitals grew total number of operational beds by 1.4% in 2012, to 9,200, compared to 9,071 beds in 2011

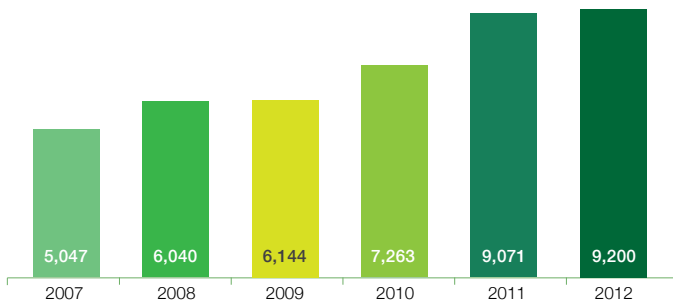
Anahp Hospitals promoted extensive expansion of their service infrastructure, making significant investments to enhance the quality and safety of services provided. These investments are designed to meet the rising demand for healthcare services. An increase in the Total Number of Beds and in their complexity (increase of beds in ICU and Step-down Units) as well as in the rise in operating rooms and diagnostic equipment resulted from these efforts.

Total Number of Beds among Anahp Hospital members grew by 1.4% in 2012 compared to 2011, from 9,071 to 9,200 operating beds (Graph 1). Of this total, 1,383 are adult ICU beds, 442 neonatal ICU and 321 are Step-down Units (Graph 3).

Total Number of Surgeries and Hospitalizations increased and the number of Step-down Units was expanded, pushing down ICU beds occupancy rates. General occupancy rate in hospitals increased from 76.9% to 78.8% (Graph 2), while adult ICU beds occupancy rate dropped from 79.9% to 72.8% and semi-intensive care beds rose from 82.4% to 87.3% (Graph 4).

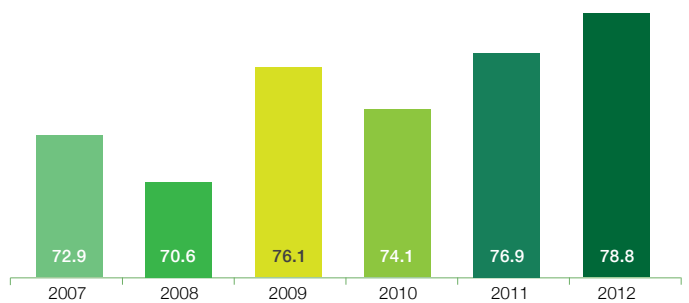
Institutional Performance

Graph 1 - Total Number of Beds



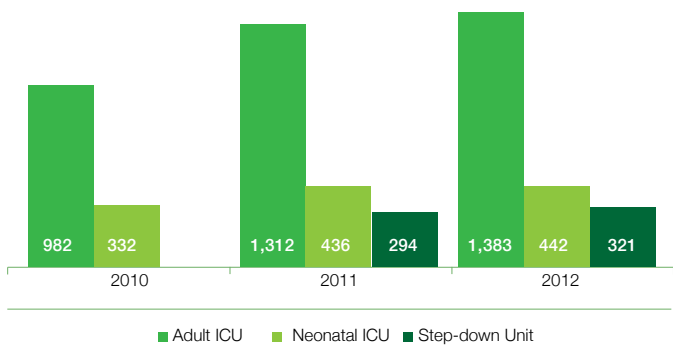
Source: SINHA/Anahp e PMPA/Anahp.

Graph 2 - Bed Occupancy Rate (in %)



Source: SINHA/Anahp e PMPA/Anahp.

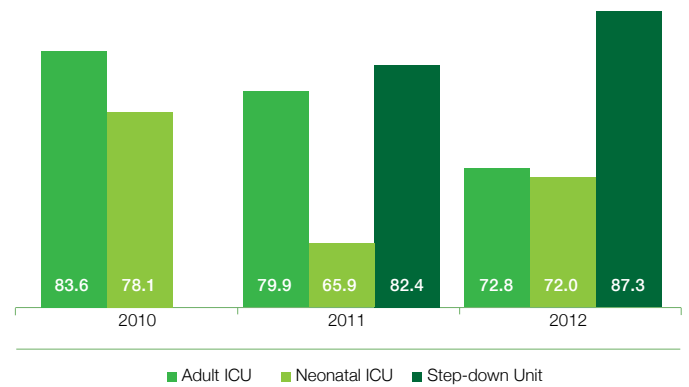
Graph 3 - Number of ICU and Step-down Units



Fonte: PMPA/Anahp.

1 ICU and Step-down Units started being reported in "Best Practices Assistance Project" indicators in 2010 and 2011, respectively.

Graph 4 - Occupancy Rate of UTIs and Step-down Units (in %)

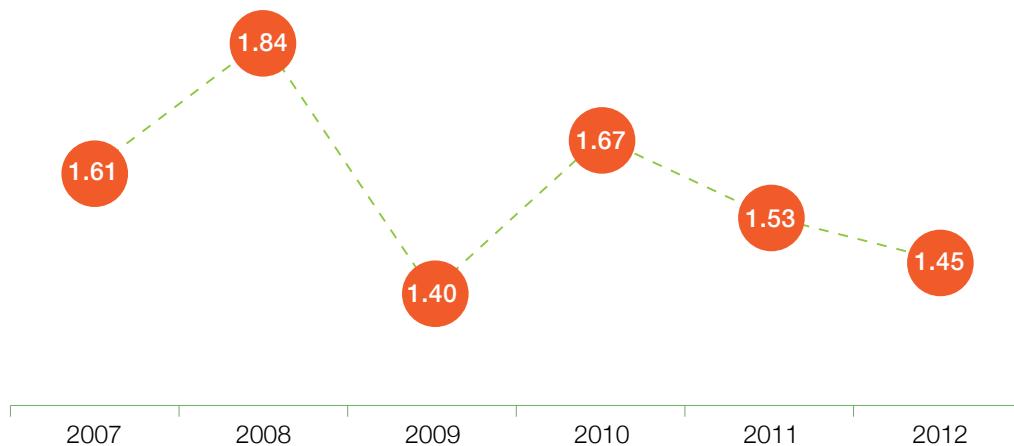


Fonte: PMPA/Anahp.

With the increase in Occupancy Rate, the Bed Turnover Interval, i.e., the average interval between patients was reduced from 1.53 to 1.45 days (Graph 5). Thus, after each hospital

discharge, beds remained empty for a shorter time, increasing the efficiency hospital resources used.

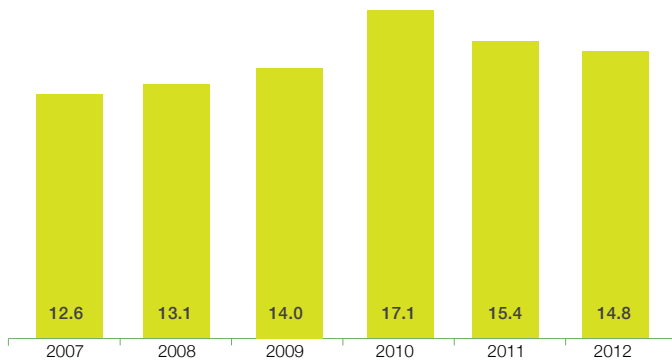
Graph 5 - Bed Turnover Interval (in days)



Source: SINHA/Anahp.

ICU admission rates showed a slight decrease, from 15.4% to 14.8% (Graph 6), continuing the downward trend that began in 2010. Better indications for bed use contribute to reduce health system costs. Hospital admission through emergency rates

Graph 6 - ICU Admission Rate (in %)

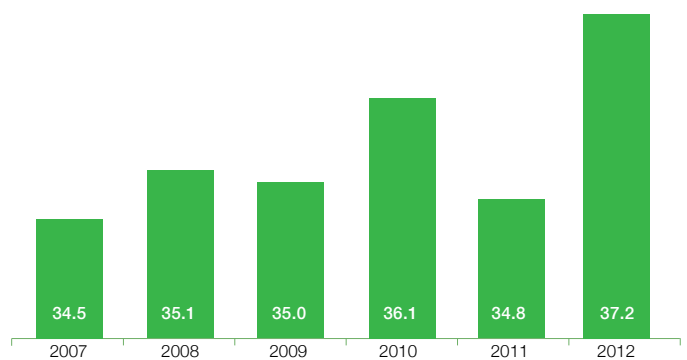


Source: SINHA/Anahp.

With the expansion of infrastructure and technological facilities, hospitals expanded their services offer, as we can see from the rise in number of surgical procedures, hospitalizations, consultations and tests. Total Number of Hospital Discharges was up by 2.6%, from

increased from 34.8% to 37.2% (Graph 7), indicating that 37.2% of total admissions came from the emergency department. This is an important trend, demonstrating emergency contribution to hospital general turnover.

Graph 7 - Hospital Admission Through Emergency Rate (in %)



Source: SINHA/Anahp.

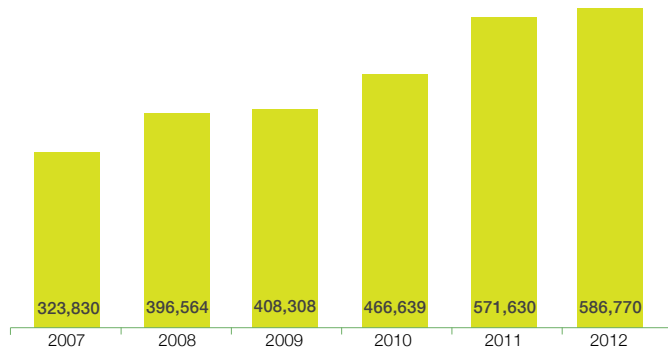
571,630 to 586,770 discharges (Graph 8). This rise was driven by the fact that there were more beds available and also due to higher efficiency in the use of this infrastructure, leading to lower Average Length of Stay: a drop from 4.76 days to 4.64 days (Graph 9 and Table 1).

Table 1 - Indicators

| | | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------------------------------------|---------|------|------|------|-------|-------|-------|
| ICU Admission Rate (%) | Average | 12.6 | 13.1 | 14.0 | 17.1 | 15.4 | 14.8 |
| | Median | 10.1 | 9.8 | 9.6 | 9.8 | 10.5 | 12.0 |
| Admission Through Emergency Rate (%) | Average | 34.5 | 35.1 | 35.0 | 36.1 | 34.8 | 37.2 |
| | Median | 31.9 | 32.8 | 34.9 | 36.5 | 37.3 | 37.6 |
| Surgeries per room | Average | 856 | 953 | 931 | 1,045 | 1,081 | 977 |
| | Median | 784 | 897 | 896 | 893 | 1,000 | 1,023 |
| Delivery per room | Average | 529 | 523 | 545 | 624 | 648 | 664 |
| | Median | 478 | 517 | 456 | 572 | 643 | 673 |
| Occupancy Rate (%) | Average | 72.9 | 70.6 | 76.1 | 74.1 | 76.9 | 78.8 |
| | Median | 75.0 | 73.7 | 74.5 | 73.3 | 78.5 | 78.9 |
| Average Length of Stay (days) | Average | 4.24 | 4.51 | 4.40 | 4.51 | 4.76 | 4.64 |
| | Median | 4.26 | 4.28 | 4.18 | 4.32 | 4.54 | 4.54 |
| Turnover Interval (days) | Average | 1.6 | 1.8 | 1.4 | 1.7 | 1.5 | 1.5 |
| | Median | 1.6 | 1.6 | 1.4 | 1.6 | 1.4 | 1.3 |

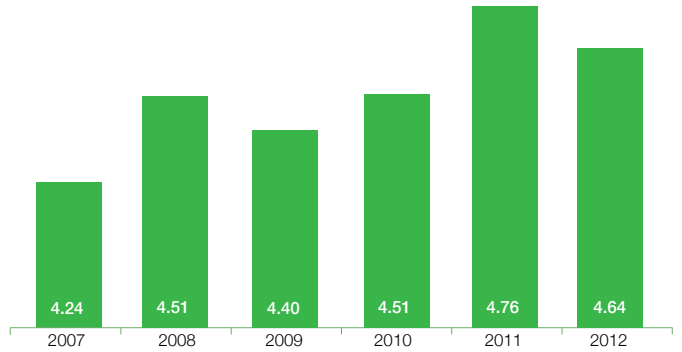
Source: SINHA/Anahp.

Graph 8 - Total Hospital Discharges



Source: PMPA/Anahp.

Graph 9 – Average Length of Stay (in days)

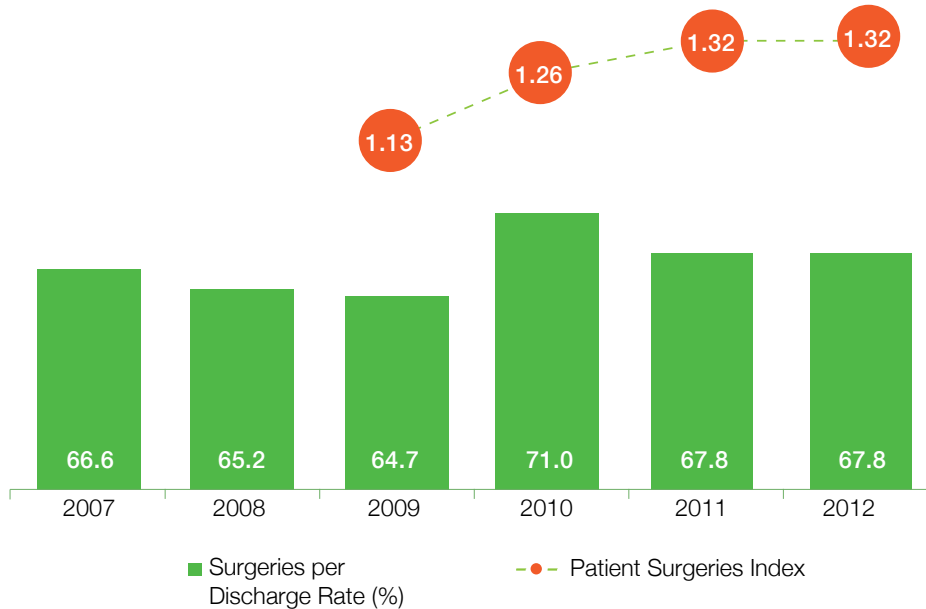


Source: PMPA/Anahp.

The share of patients undergoing surgical procedures in relation to the total of all hospital discharges, measured by Surgery per Discharges Rate remained constant compared to 2011, i.e.

around 67.8%. The rate of Surgeries per Patient has been rising since 2009, from 1.13 to 1.32, indicating increased complexity of surgical patients (Graph 10).

Graph 10 – Surgery per Discharges Rate (em %) and Patient Surgery Index

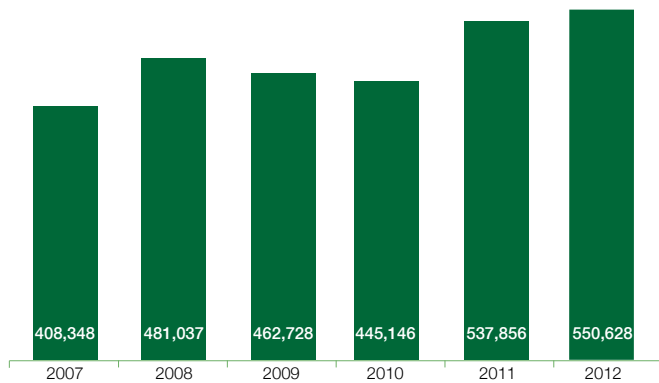


Source: PMPA/Anahp.

The Total Number of Surgeries increased 2.4%, in line with the expansion in the number of operating rooms, reaching 550,600 surgeries in 2012 (Graph 11). The number of surgeries is more concentrated in the Southeast, with 76.7% of total

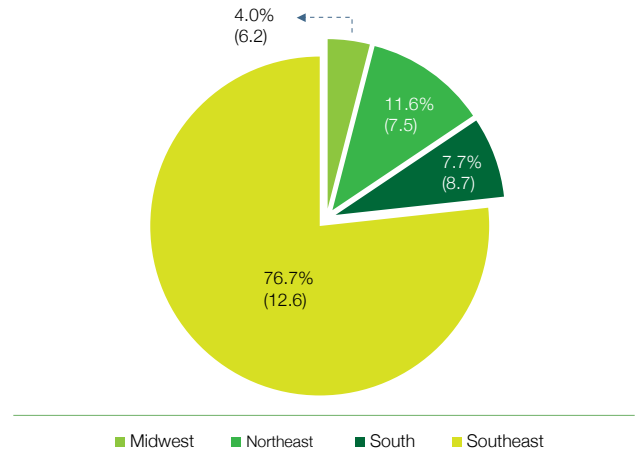
surgeries, followed by the Northeast (11.6%), South (7.7%) and Midwest (4.0%) (Graph 12 and Table 2). The Average Number of Operating Rooms per Hospital is around 12.6 in the Southeast, 8.7 in the South, 7.5 and 6.2 in the Northeast in the Midwest.

Graph 11 - Total Number of Surgeries



Source: SINHA/Anahp.

Graph 12 – Regional Breakdown Number of Surgeries and Average Number of Operating Rooms per Hospital - 2012



Source: SINHA/Anahp.

Table 2 – Clinical Production - Surgery

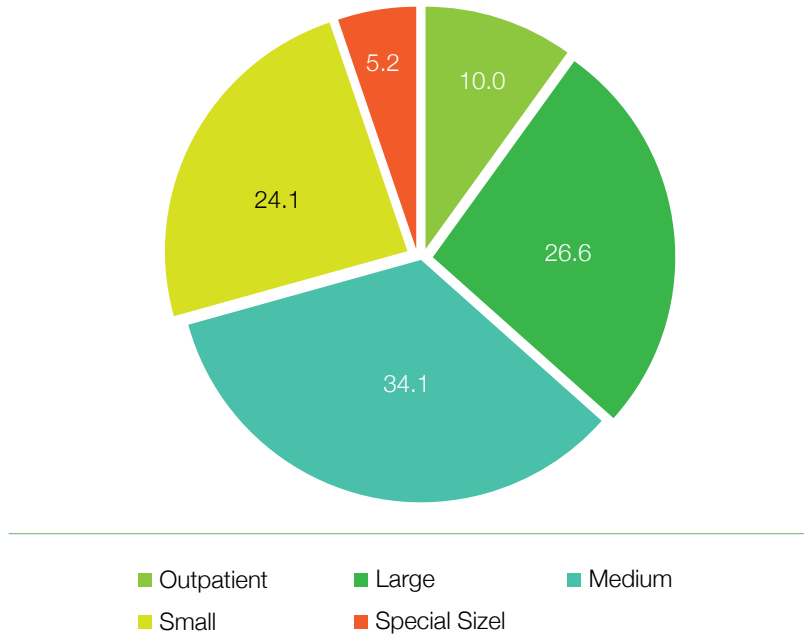
| | | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---------------------|---------|---------|---------|---------|---------|---------|
| Total Number of Surgeries | Total | 408,348 | 481,037 | 462,728 | 445,146 | 537,856 | 550,628 |
| | Outpatient | 12.3 | 11.4 | 12.2 | 9.5 | 10.1 | 10.0 |
| Surgeries Breakdown by Complexity (in%) | Major | 27.4 | 26.2 | 25.6 | 24.2 | 26.5 | 26.6 |
| | Medium | 33.2 | 36.7 | 33.8 | 38.0 | 34.5 | 34.1 |
| | Minor | 21.4 | 20.3 | 22.9 | 21.1 | 22.9 | 24.1 |
| | Special | 5.6 | 5.4 | 5.5 | 7.2 | 6.0 | 5.2 |
| | Number of Hospitals | 33 | 36 | 34 | 32 | 39 | 40 |

Source: SINHA/Anahp.

Surgeries' complexity were similar to last year's, in that 31.8% were special and major and 34.1% medium, totaling 65.9% of all surgeries of mid or high complexity (Table 2 and Graph 13).

It is important to highlight that organ transplants are included under special procedures, considered to be the most complex procedures in surgical area.

Graph 13 - Surgeries Breakdown by complexity (in %)

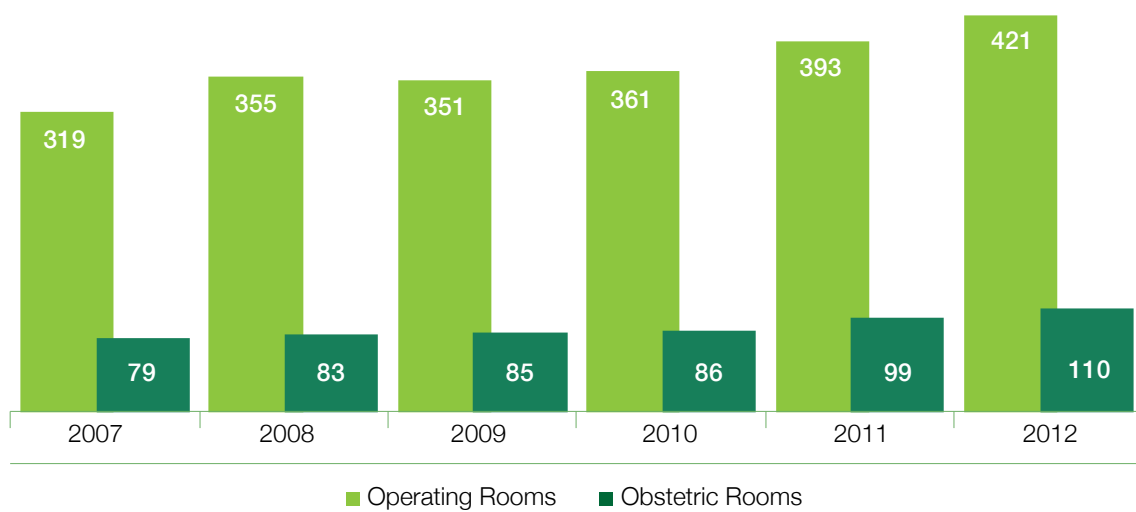


Source: SINHA/Anahp.

The number of operating rooms and obstetrical rooms expanded by 7.2% and 11.1% respectively compared to 2011. The number of operating rooms rose to 421 and the obstetric

rooms from 99 to 110 (Graph 14) in line with the growth of hospital beds, adult and neonatal ICUs.

Graph 14 - Total Obstetric and Operating Rooms

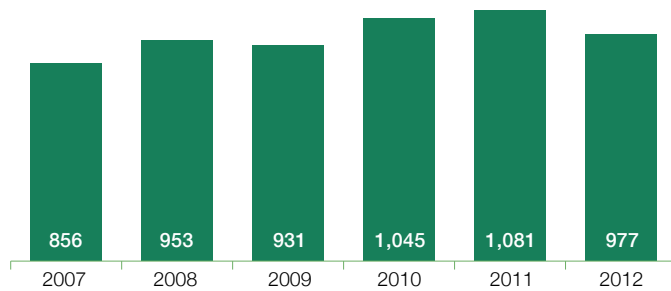


Source: SINHA/Anahp.

Infrastructure expansion and the availability of new operating rooms led to a 9.6% drop in the Average Number of Surgeries per room, from 1,081 to 977 surgeries / room for the year (Graph 15). This result, together with the number of surgeries per patient, highlights the increasing complexity of surgical procedures performed.

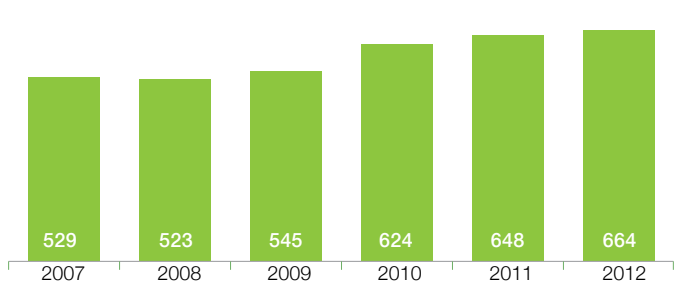
Growth in Total Number of Deliveries is associated with the expansion of obstetric rooms and higher number of deliveries per room: from 648 in 2011 to 664 in 2012 (Graph 16). This change results from an increase in demand, mostly for those hospitals that have invested in maternity units.

Graph 15 - Number of Surgeries per Room



Source: SINHA/Anahp.

Graph 16 - Number of Deliveries per Room

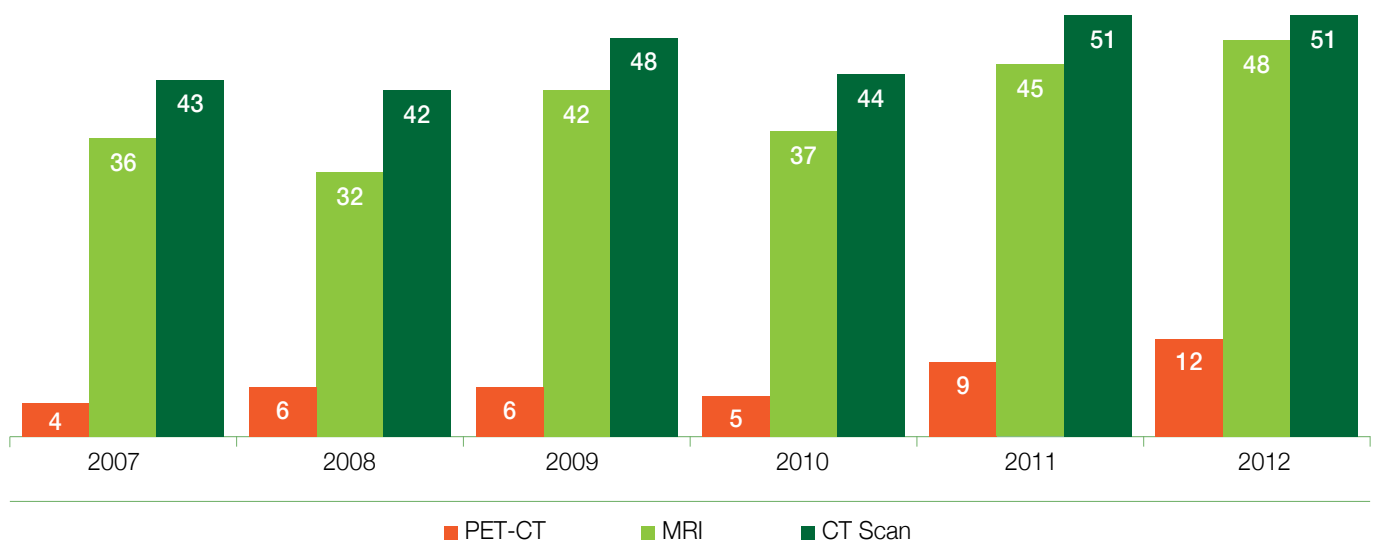


Source: SINHA/Anahp.

The total number of tests increased, following the expansion of diagnostic equipment infrastructure (Graph 17). The number of tests escalated from 29.4 million in 2011 (40 hospitals) to 35.5 million in 2012 (43 hospitals) (Graph 18). This result represents an average variation of 12% in the number of tests per hospital

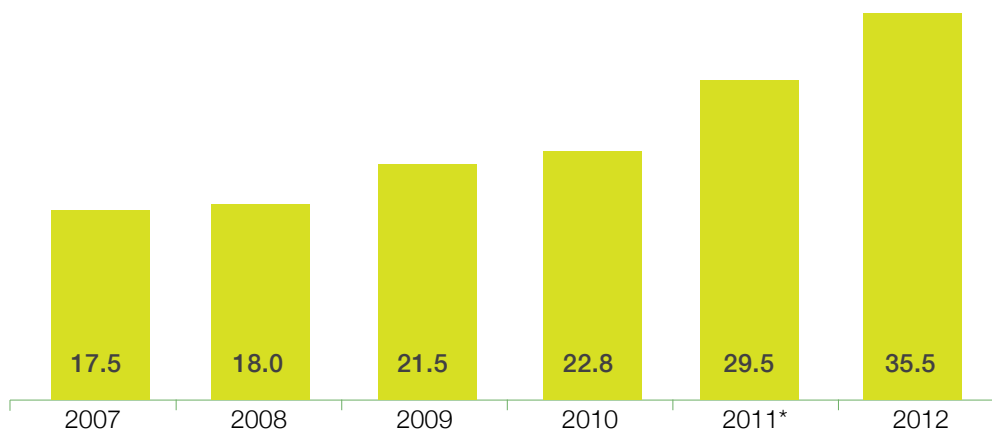
in 2012. Laboratory tests account for the largest share of total tests conducted in hospitals, but the expanded offer of imaging tests also contributed to the overall growth on the Total Number of Tests.

Graph 17 - Number of Selected Equipment (image)



Source: SINHA/Anahp.

Graph 18 - Total Tests (in millions)



Source: SINHA/Anahp.

*Information for 2011 has been adjusted in this issue of the Observatory.

Note: Totals include tests performed on both inpatients (internal) and outpatient (external).

The largest share of outsourced services in Anahp Hospitals corresponds to Laundry and Security. These services are contracted by 78.8% and 74.2% of hospitals, respectively. Accounting (96.9%), Maintenance (93.8%), Information Technology (90.3%), Reception / Entrance (78.1%), Technical

Housekeeping (69.7%) and Dietetics Nutrition / Kitchen (67.7%) are predominantly developed by in-house teams. Finally, Building Cleaning services are almost equally divided between contractors and in-house teams (Table 4).

Table 4 - Participation of Own and Outsourced Services by Type of Service

| | Contracted (%) | In-house Teams (%) |
|------------------------------|----------------|--------------------|
| Laundry | 78.8% | 21.2% |
| Security | 74.2% | 25.8% |
| Technical Housekeeping | 30.3% | 69.7% |
| Building Cleaning | 48.5% | 51.5% |
| Reception/ Entrance | 21.9% | 78.1% |
| IT | 9.7% | 90.3% |
| Maintenance | 6.3% | 93.8% |
| Contabilidade | 3.1% | 96.9% |
| Nutrição Dietética / Cozinha | 32.3% | 67.7% |

Source: SINHA/Anahp.

The analysis of operational data therefore shows that the Anahp Hospitals keep pace with the growth in demand for healthcare services arising from higher income and employment, expanding

their service capacity, maintaining and expanding investments in quality and safety in healthcare environment.



Healthcare Services Management

The work of the group involved in the healthcare best practices shows the dedication of technical teams of Anahp hospitals towards achieving excellence in healthcare services

The efficacy of this work model is proven by its results, given that each hospital is directly associated with achieving the best established practices

The Best Healthcare Practices Project (PMPA) started in 2003 and is based on three pillars. The first one is focused on routine discussions of key topics for safety, quality and best practices based on literature and experience exchange among institutions. The other pillar is based on the continuous improvement of data consistency and reliability of clinical and management information. Finally, quality criteria and standards to be met by hospitals for selected pathologies are defined through monitoring of updated clinical protocols with the latest in national and international literature.

The project gathers technical directors and representatives of technical healthcare teams every two months. The involvement and contribution of the associated hospitals' technical teams are central aspects to differentiate and qualify work on the Best Healthcare Practices Project PMPA. The efficacy of this work model is proven by its results, given that each hospital is directly associated with achieving the best established practices. This type of involvement plays an essential role in building the monitoring system and implementing improvements resulting from such work.

Under the project, monthly indicators are collected and data are shared with associates on a quarterly basis, along with the definition of targets for the group of hospitals. The hospitals are also required to submit information on annual hospital discharges, which serve to audit monthly data and to complement the analysis of the hospitals' morbidity and mortality profile.

Most of the associated hospitals' structure is large (between 150 and 500 beds) or even larger (above 500 beds) concerning installed available bed capacity. Based on the classification ranking established by the Ministry of Health Ordinance 2224 (Brazil, 2002), which sets healthcare complexity standards – type and number of beds in general; ICU beds; number of surgery rooms; and attention to high risk pregnancies – 86% of the hospitals fall into category four (more complex healthcare structure), whereas the other 14% fall into category three. This means there are no low complexity hospitals among the associates.

Hospitals with such structure should only be compared to hospitals of similar size (category three and four), given that, upon analyzing the results, we can see that the more complex the organization is, the greater is its capacity to service patients with severe conditions and higher risk of complications.

All the hospitals have high volume Emergency Departments. In most cases, they are general hospitals – only two are specialized; 54% of them have maternity wards and they are all intended for acute cases.

Healthcare Services Management

In 2012, we analyzed data on 37 hospitals among the 46 associates. Such information is used to audit and consolidate information sent for the Best Healthcare Practices Project, showing strategic and detailed data on the clinical, epidemiological and commercial profile of the hospitals' treated population, while also assisting in planning and defining initiatives and goals related to healthcare services management of each of the hospitals and the group as a whole.

Hospitals have invested in the improvement of systems of information, clinical diagnosis record and procedures. However, the rate remained at 5% to 7% on diagnoses included in the chapter III-Defined Symptoms and Affections in the past years. If compared to 2011, the number of ignored ones increased, which mirrors changes in the system of some hospitals and establishment of new hospitals.

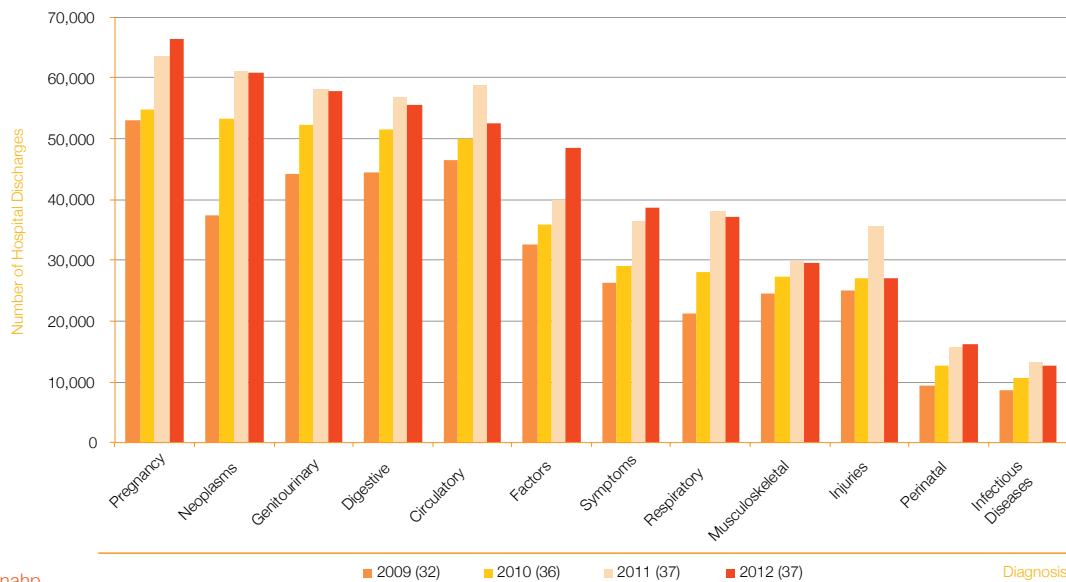
The recovery and accuracy of records in the systems qualify analyses, enabling to understand variations of patient profiles in relation to complexity (type of procedure), severity (comorbidities) and use of resources, thus subsidizing care schedule and planning in the hospital and ensuring care continuity.

Investments in the qualification of personnel to work in Medical Registry Services, the exclusion of physicians from the process of codifying, and expanding the use of clinical data in management have contributed to transform these outcomes. This change pays greater respect to patients' right, provides greater safety in processes and maximizes the organizations' clinical assets in the teaching and research areas.

In 2012, the list of the main diagnosis included according to the chapter of the International Classification of Diseases (ICD-10) that caused hospital admissions did not change. The main diagnoses causing hospital admission were: Pregnancy, Childbirth and Puerperium, Neoplasm (cancer), Genitourinary Diseases, Digestive Tract Diseases, Circulatory System Diseases, other Factors (reasons for seeking help unrelated to diseases, such as specific procedures – adjustment or removal of orthoses or prostheses and chemotherapy), Respiratory System Diseases, Injuries and Poisoning (fractures and injuries resulting from accidents and external causes), Musculoskeletal System Diseases, Perinatal Diseases and Infectious Diseases. The group represented 85% of the treated population. We can estimate an increase in healthcare activities related to maternity (pregnancy), including other factors and perinatal. There is also a slight reduction in neoplasm and genitourinary diseases and a significant decrease in injuries and circulatory system diseases. Part of this reduction is due to failure of records in information systems, which showed a greater number of diagnoses classified under Symptoms and in the chapter Factors (Graph 1 / Table 1).

In order to overcome this limitation, various hospitals are investing in Medical Registry Services, training teams to codify diagnoses and procedures and improving data entry consistency in computerized systems.

Graph 1 – Distribution of Hospital Discharges according to Main Diagnoses (ranked by ICD chapter – 10th Review)



Source: PMPA/Anahp.

Table 1 – Annual Distribution of Hospital Discharges According to Main Diagnoses (Ranked by ICD chapter)

| ICD Chapter | Year | | | | | | | | |
|----------------------|----------------|--------------|----------------|--------------|----------------|--------------|----------------|--------------|-----------------|
| | 2009 (32) | | 2010 (36) | | 2011 (37) | | 2012 (37) | | Variation 12/11 |
| | Total | % | Total | % | Total | % | Total | % | |
| Pregnancy | 53,125 | 12.1 | 54,771 | 11.1 | 63,712 | 11.3 | 66,473 | 11.4 | 4.3 |
| Neoplasm | 37,361 | 8.5 | 53,256 | 10.8 | 61,071 | 10.8 | 60,905 | 10.4 | -0.3 |
| Genitourinary | 46,561 | 10.6 | 49,989 | 10.1 | 58,043 | 10.3 | 57,946 | 9.9 | -0.2 |
| Digestive | 44,317 | 10.1 | 52,336 | 10.6 | 56,778 | 10.1 | 55,614 | 9.5 | -2.1 |
| Circulatory | 44,525 | 10.2 | 51,534 | 10.4 | 58,853 | 10.4 | 52,573 | 9.0 | -10.7 |
| Factors | 21,261 | 4.9 | 28,073 | 5.7 | 39,960 | 7.1 | 48,393 | 8.3 | 21.1 |
| Symptoms | 26,240 | 6.0 | 29,155 | 5.9 | 36,442 | 6.5 | 38,765 | 6.6 | 6.4 |
| Respiratory | 32,687 | 7.5 | 35,803 | 7.2 | 38,112 | 6.7 | 37,124 | 6.4 | -2.6 |
| Musculoskeletal | 24,450 | 5.6 | 27,315 | 5.5 | 29,910 | 5.3 | 29,539 | 5.1 | -1.2 |
| Injuries | 25,121 | 5.7 | 27,125 | 5.5 | 35,612 | 6.3 | 27,014 | 4.6 | -24.1 |
| Perinatal | 8,549 | 2.0 | 10,676 | 2.2 | 15,815 | 2.8 | 16,105 | 2.8 | 1.8 |
| Infectious Diseases | 9,471 | 2.2 | 12,627 | 2.6 | 13,141 | 2.3 | 12,616 | 2.2 | -4.0 |
| Endocrine | 8,264 | 1.9 | 10,470 | 2.1 | 12,011 | 2.1 | 12,056 | 2.1 | 0.4 |
| Nervous System | 8,373 | 1.9 | 9,909 | 2.0 | 10,460 | 1.9 | 10,152 | 1.7 | -2.9 |
| Skin | 4,766 | 1.1 | 5,109 | 1.0 | 6,327 | 1.1 | 6,200 | 1.1 | -2.0 |
| Congenital | 3,458 | 0.8 | 3,907 | 0.8 | 4,185 | 0.7 | 3,862 | 0.7 | -7.7 |
| Eyes and Eye-related | 2,943 | 0.7 | 2,689 | 0.5 | 3,490 | 0.6 | 3,362 | 0.6 | -3.7 |
| Blood | 2,005 | 0.5 | 2,217 | 0.4 | 2,299 | 0.4 | 2,498 | 0.4 | 8.7 |
| Hearing | 1,665 | 0.4 | 2,096 | 0.4 | 2,147 | 0.4 | 1,817 | 0.3 | -15.4 |
| Mental | 1,145 | 0.3 | 1,307 | 0.3 | 1,431 | 0.3 | 1,485 | 0.3 | 3.8 |
| No information | 31,189 | 7.1 | 24,380 | 4.9 | 15,108 | 2.7 | 39,514 | 6.8 | 161.5 |
| Total | 437,476 | 100.0 | 494,744 | 100.0 | 564,907 | 100.0 | 584,013 | 100.0 | 3.4 |

Note: Numbers in parentheses represent the number of hospitals that submitted databases.

Source: PMPA/Anahp.

Assistance Performance

Between 2011 and 2012, we can see 3.4% increase in the number of hospital admissions. However, this increase is not related to the inclusion of data from new associated hospitals. In this same period, 83% of 35 hospitals that submitted data in the two analyzed years showed an increase in the number of hospital admissions. Among these institutions, ten hospitals increased their number of hospital admissions by more than 10%. The average increase was 5.4% of 37 institutions in the year.

Considering the hospital admission rate has been 14% in the supplementary healthcare market, the number of patients

treated in these hospitals is approximately 4,171,522, which equals 9% of the healthcare plan beneficiaries.

By analyzing the profile of hospital admissions according to gender and age range, we can see that women show a higher rate of hospital admission in the reproductive phase (between 15 and 49 years old). The age group that has been admitted to hospitals the most is of patients aged above 90 years old, although they still represent only 1.5% of the hospital discharges. The number of patients aged above 60 years old increased 2% in 2012 if compared to 2011. These numbers evidenced the aging of the treated population. (Table 2, Graphs 2 and 3)

Table 2 – Distribution of Hospital Discharges According to Gender and Age Range

| Age Range | 2011 (37) | | | | | | Total 2011 | | 2012 (37) | | | | | | Total 2012 | | Variation 12/11 |
|--------------|----------------|--------------|----------------|--------------|------------|--------------|----------------|--------------|----------------|--------------|----------------|--------------|-----------|--------------|----------------|--------------|-----------------|
| | Female | | Male | | Ign | | | | Female | | Male | | Ign | | | | |
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | | | |
| < 15 | 37,170 | 11.1 | 46,030 | 20.0 | 20 | 18.2 | 83,220 | 14.7 | 41,038 | 11.8 | 49,850 | 21.0 | 17 | 18.7 | 90,905 | 15.6 | 9.2 |
| 15 a 29 | 53,851 | 16.1 | 25,544 | 11.1 | 16 | 14.5 | 79,411 | 14.1 | 52,080 | 15.0 | 24,570 | 10.4 | 13 | 14.3 | 76,665 | 13.1 | -3.5 |
| 30 a 44 | 104,580 | 31.2 | 39,722 | 17.3 | 25 | 22.7 | 144,327 | 25.5 | 112,255 | 32.3 | 41,259 | 17.4 | 20 | 22.0 | 153,536 | 26.3 | 6.4 |
| 45 a 59 | 59,335 | 17.7 | 47,264 | 20.6 | 21 | 19.1 | 106,620 | 18.9 | 59,792 | 17.2 | 47,994 | 20.3 | 15 | 16.5 | 107,801 | 18.5 | 1.1 |
| 60 a 74 | 43,279 | 12.9 | 43,350 | 18.9 | 18 | 16.4 | 86,647 | 15.3 | 43,344 | 12.5 | 43,767 | 18.5 | 16 | 17.6 | 87,127 | 14.9 | 0.6 |
| 75 a 89 | 31,557 | 9.4 | 25,359 | 11.0 | 10 | 9.1 | 56,926 | 10.1 | 32,269 | 9.3 | 26,101 | 11.0 | 6 | 6.6 | 58,376 | 10.0 | 2.5 |
| > ou = 90 | 5,112 | 1.5 | 2,473 | 1.1 | - | - | 7,585 | 1.3 | 5,762 | 1.7 | 2,867 | 1.2 | 2 | 2.2 | 8,631 | 1.5 | 13.8 |
| Ign | 93 | 100 | 78 | 0.0 | - | - | 171 | 0.0 | 544 | 0.2 | 426 | 0.2 | 2 | 2.2 | 972 | 0.2 | 468.4 |
| Total | 334,977 | 100.0 | 229,820 | 100.0 | 110 | 100.0 | 564,907 | 100.0 | 347,084 | 100.0 | 236,834 | 100.0 | 91 | 100.0 | 584,013 | 100.0 | 3.4 |

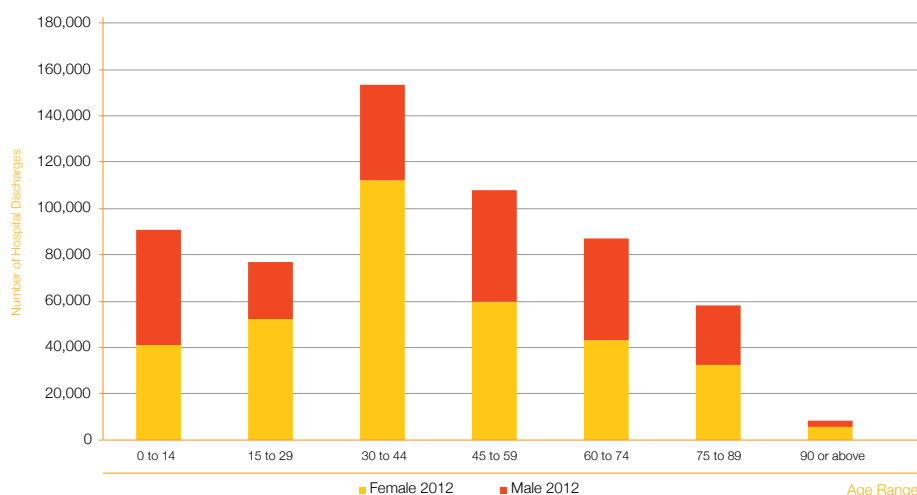
Note: Numbers in parentheses represent the number of hospitals that submitted databases.

Source: PMPA/Anahp.

The number of cases among women increased 3.6%, whereas among men 3.1%. However, it is important to highlight there was a significant increase in the number of cases specifically

among men aged above 60 years old, even though the majority of cases is still of women, particularly aged above 75 years old.

Graph 2 – Distribution of Hospital Discharges According to Gender and Age Range



Source: PMPA/Anahp.

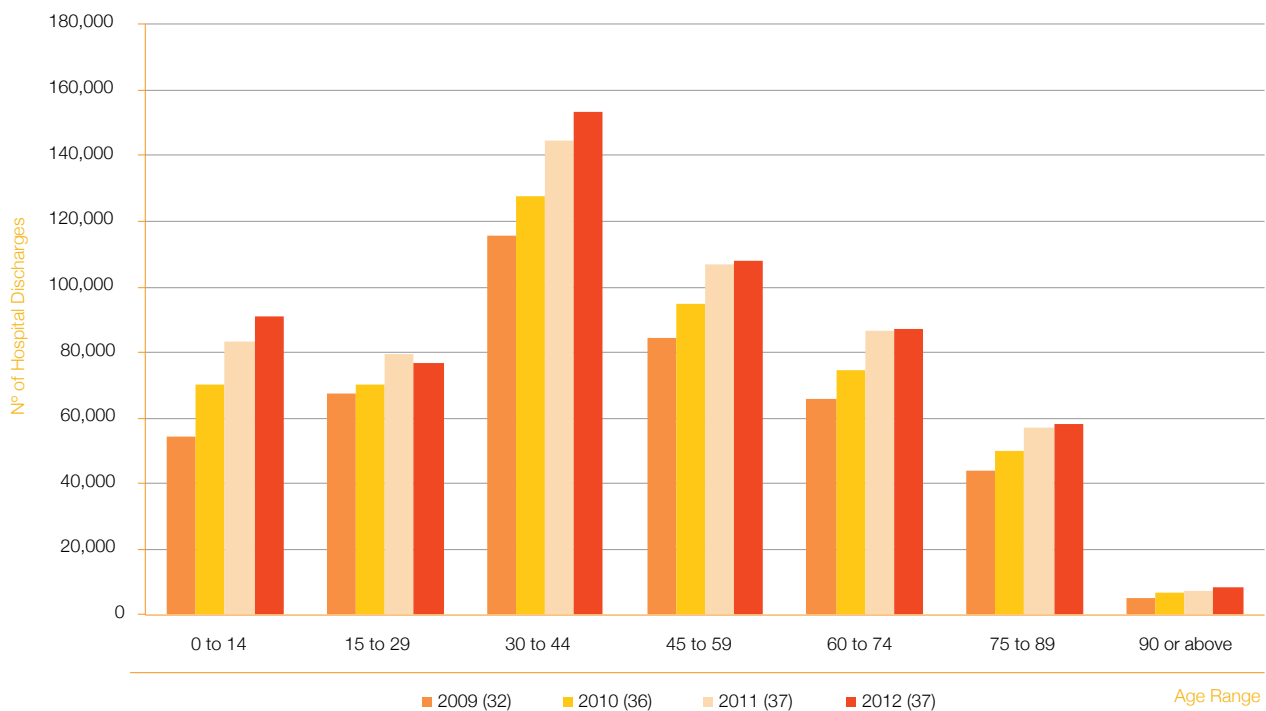
Variation 2012 / 2011

| Age Range | Gender | |
|--------------|------------|------------|
| | Female | Male |
| < 15 | 10.41 | 8.30 |
| 15 a 29 | -3.29 | -3.81 |
| 30 a 44 | 7.34 | 3.87 |
| 45 a 59 | 0.77 | 1.54 |
| 60 a 74 | 0.15 | 0.96 |
| 75 a 89 | 2.26 | 2.93 |
| > ou = 90 | 12.72 | 15.93 |
| TOTAL | 3.6 | 3.1 |

It is also important to highlight the increase in the number of cases among women aged between 30 and 44 years old. One of the aspects that has created great impact on the use of healthcare services within this age range is the increase of first pregnancy aged above 30 years old and pregnant women aged between 40 and 44 years old. This phenomenon is universal and related to cultural changes and the intensive inclusion of women in the labor market. In Brazil, particularly in the Southeast, there was a significant decrease in the birth rate, as well as change in the age range of mothers. If we compare the years 2005 and 2010, we can see a substantial increase of 17% in the number of babies born alive of mothers aged between 35 and 44 years old (DATASUS).

This scenario requires more complex standards in prenatal, childbirth and newborn care with differentiated risks both for mothers and babies. From the healthcare perspective, maternity care involves medium and high complex procedures, requiring highly qualified medical teams and frequent intensive care. In the historical series, we can see an increase in all age ranges. In the age group between 15 and 29 years old, there was a slight decrease between 2011 and 2012. Between 2009 and 2012, the age range of the patients treated in hospitals changed in groups aged above 60 years old who drew attention to importance, corresponding to 26% of the number of hospital discharges in 2012 (Graph 3).

Graph 3 – Annual Distribution of Hospital Discharges According to Age Range



Source: PMPA/Anahp.

The aging of the treated population means high impact on length of stay and on pressure for backup beds. The main diagnoses causing hospital admission among female population aged between 15 and 29 years old to associated hospitals of Anahp were pregnancy, childbirth and puerperium, whereas women aged between 30 and 44 years old were admitted to treat genitourinary affections. As for women aged below 15 years old, they were admitted to associated hospitals for neonatal care, in addition to treating respiratory problems, mainly including asthma and pneumonia, whereas women aged above 45 years old, they were mainly treated for neoplasm, as well as circulatory system diseases (Table 3). The main diagnoses causing hospital admission among male population, excluding ill-defined affections, in decreasing order,

were digestive tract diseases, circulatory system diseases, neoplasm and genitourinary diseases. As for men aged below 15 years old, they were admitted to associated hospitals showing the same health problems as women their age. Neonatal care, included in the chapter Factors, and respiratory system diseases were the health problems that most required care.

Injuries resulting from traffic accidents, urban violence and other external causes were the main reasons for hospital admission in the age range between 15 and 29 years old, whereas within the age range between 30 and 59 years old, they were digestive tract diseases, circulatory system diseases and genitourinary diseases.

Table 3 – Distribution of Hospital Discharges According to Age Range (Female) - 2012

| Chapter | Age Range | | | | | | | | Overall Total | |
|-----------------|------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-----------------------|------------|----------------|--------------|
| | 0 a 14 years old | 15 a 29 years old | 30 a 44 years old | 45 a 59 years old | 60 a 74 years old | 75 a 89 years old | 90 years old or above | Ignored | n° | % |
| Pregnancy | 12 | 20,393 | 45,735 | 333 | - | - | - | - | 66,473 | 19.2 |
| Neoplasm | 804 | 2,453 | 9,429 | 12,369 | 7,804 | 3,376 | 280 | 40 | 36,555 | 10.5 |
| Genitourinary | 882 | 5,866 | 13,782 | 8,270 | 3,645 | 2,560 | 580 | 38 | 35,623 | 10.3 |
| Digestive | 1,405 | 4,243 | 8,521 | 6,695 | 4,550 | 2,722 | 310 | 65 | 28,511 | 8.2 |
| Circulatory | 194 | 2,004 | 6,788 | 6,757 | 5,810 | 5,446 | 1,014 | 67 | 28,080 | 8.1 |
| Factors | 15,639 | 1,629 | 3,163 | 2,660 | 1,918 | 1,056 | 134 | 49 | 26,248 | 7.6 |
| Symptoms | 1,832 | 3,751 | 5,436 | 4,066 | 3,495 | 3,349 | 647 | 78 | 22,654 | 6.5 |
| Respiratory | 5,394 | 2,501 | 2,290 | 1,627 | 1,904 | 2,980 | 1,003 | 86 | 17,785 | 5.1 |
| Musculoskeletal | 318 | 1,272 | 3,226 | 4,612 | 3,856 | 1,737 | 119 | 23 | 15,163 | 4.4 |
| Injuries | 967 | 1,341 | 2,129 | 2,247 | 2,017 | 2,101 | 390 | 34 | 11,226 | 3.2 |
| Endocrine | 212 | 1,415 | 3,302 | 1,891 | 878 | 544 | 100 | 13 | 8,355 | 2.4 |
| Others | 11,478 | 3,019 | 4,063 | 3,885 | 3,398 | 3,288 | 659 | 47 | 29,837 | 8.6 |
| Ignored | 1,901 | 2,193 | 4,391 | 4,380 | 4,069 | 3,110 | 526 | 4 | 20,574 | 5.9 |
| Total | 41,038 | 52,080 | 112,255 | 59,792 | 43,344 | 32,269 | 5,762 | 544 | 347,084 | 100.0 |

Source: PMPA/Anahp.

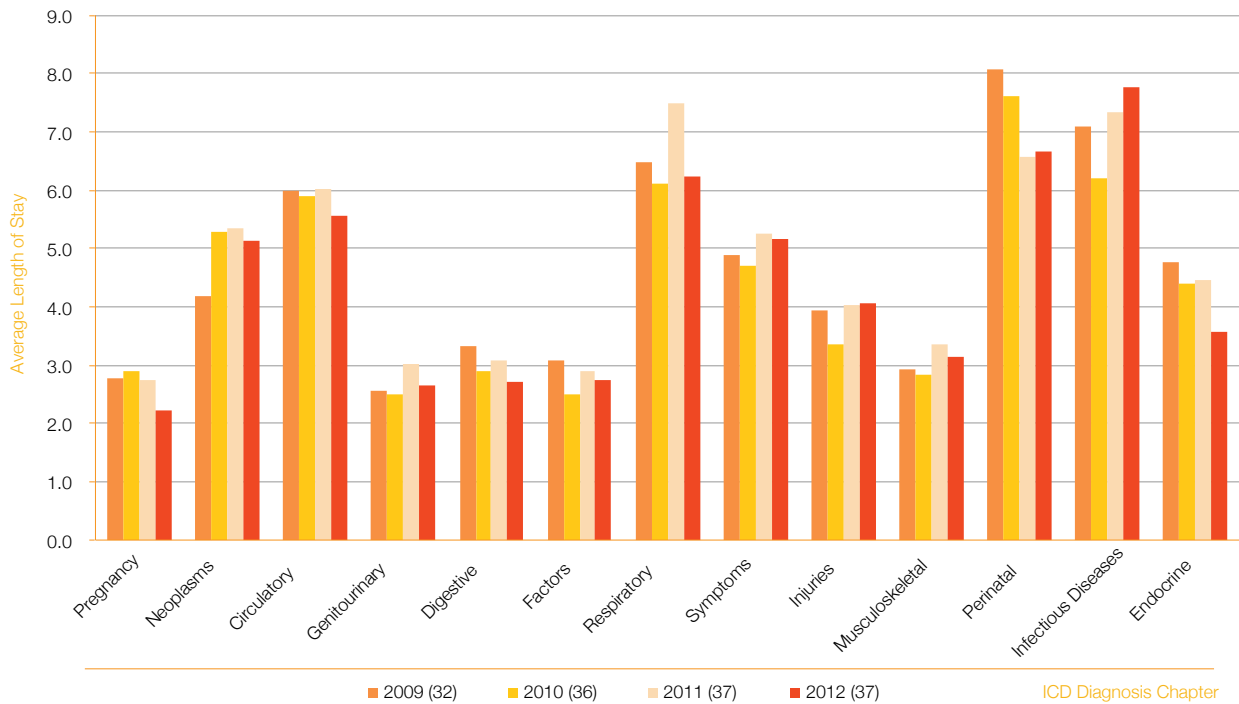
In the age range between 60 and 74 years old, the main diagnosis causing hospital admission was neoplasm, followed by circulatory system diseases and digestive tract diseases. In the age group above 75 years old, circulatory system diseases, in addition to respiratory system diseases and injuries resulting from external causes were also causing hospital admission (Table 4).

In Graph 4, we can see the Average Length of Stay according to the main diagnoses (ICD chapter, 10th review) concerning the last four years of the series. There was a slight reduction in the Length of Stay regarding most diagnoses. As for infectious diseases, we can see an increase in the Length of Stay. For the set of diagnoses, the average length of stay remained at 4.5 days in 2012.

Table 4 – Distribution of Hospital Discharges According to Age Range (Male) – 2012

| Chapter | Age Range | | | | | | | | Overall Total | |
|---------------------|------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-----------------------|------------|----------------|--------------|
| | 0 a 14 years old | 15 a 29 years old | 30 a 44 years old | 45 a 59 years old | 60 a 74 years old | 75 a 89 years old | 90 years old or above | Ignored | n° | % |
| Digestive | 2,409 | 3,063 | 6,519 | 7,405 | 5,223 | 2,272 | 157 | 49 | 27,097 | 11.4 |
| Circulatory | 240 | 1,024 | 3,169 | 6,747 | 7,796 | 5,023 | 430 | 47 | 24,476 | 10.3 |
| Neoplasm | 1,149 | 1,383 | 2,968 | 6,481 | 8,385 | 3,728 | 210 | 37 | 24,341 | 10.3 |
| Genitourinary | 2,624 | 2,594 | 5,303 | 4,986 | 4,135 | 2,351 | 270 | 51 | 22,314 | 9.4 |
| Factors | 16,287 | 634 | 1,298 | 1,584 | 1,454 | 799 | 55 | 29 | 22,140 | 9.3 |
| Respiratory | 6,816 | 2,705 | 2,680 | 1,805 | 2,104 | 2,620 | 551 | 49 | 19,330 | 8.2 |
| Symptoms | 2,193 | 1,975 | 2,696 | 3,140 | 3,145 | 2,560 | 329 | 64 | 16,102 | 6.8 |
| Injuries | 1,616 | 3,963 | 4,658 | 2,969 | 1,523 | 889 | 145 | 23 | 15,786 | 6.7 |
| Musculoskeletal | 331 | 2,135 | 4,383 | 4,274 | 2,401 | 799 | 30 | 17 | 14,370 | 6.1 |
| Perinatal | 8,329 | 8 | 11 | 8 | 10 | 10 | - | 2 | 8,378 | 3.5 |
| Infectious Diseases | 1,447 | 822 | 1,000 | 953 | 915 | 886 | 164 | 10 | 6,197 | 2.6 |
| Nervous System | 717 | 510 | 866 | 950 | 796 | 553 | 55 | 11 | 4,458 | 1.9 |
| Endocrine | 211 | 436 | 1,133 | 964 | 590 | 308 | 46 | 12 | 3,700 | 1.6 |
| Others | 2,913 | 1,308 | 1,292 | 1,341 | 1,265 | 938 | 143 | 17 | 9,217 | 3.9 |
| Ignored | 2,568 | 2,010 | 3,283 | 4,387 | 4,025 | 2,365 | 282 | 8 | 18,928 | 8.0 |
| Total | 49,850 | 24,570 | 41,259 | 47,994 | 43,767 | 26,101 | 2,867 | 426 | 236,834 | 100.0 |

Graph 4 – Annual Distribution of Average Length of Stay According to ICD Main Chapters – 10th Review

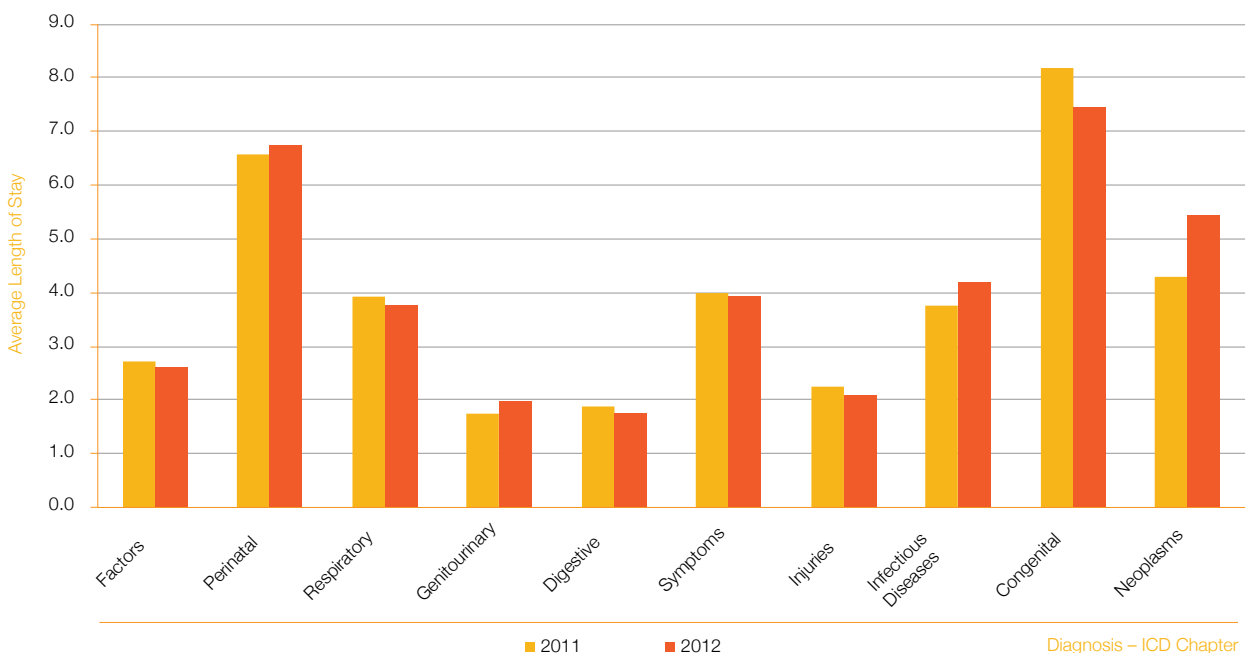


Source: PMPA/Anahp.

If we compare the years 2011 and 2012, the analysis according to age group shows an increase in the Length of Stay among patients aged below 15 years old with perinatal diseases,

genitourinary system diseases, infectious diseases and neoplasm. (Graph 5).

Graph 5 – Annual Distribution of Average Length of Stay According to Main Diagnoses Patients Aged Below 15 years old (ranked by ICD chapter – 10th Review)



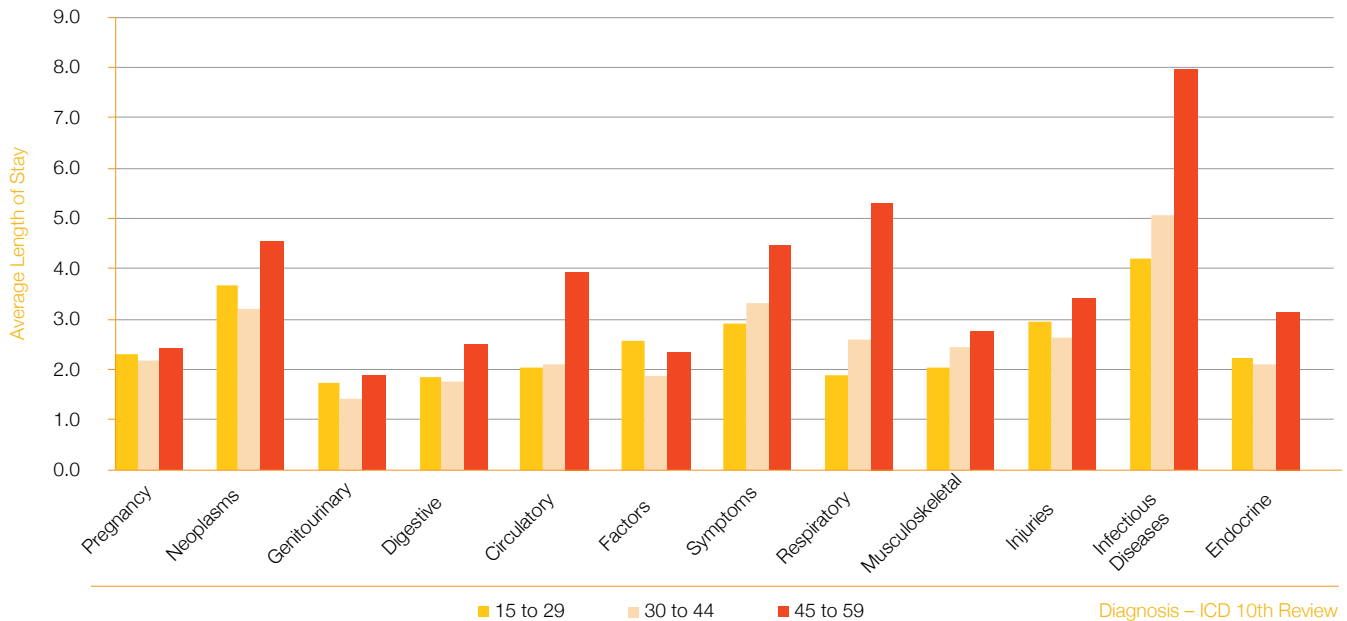
Source: PMPA/Anahp.

Assistance Performance

In Graph 6, we can see the Average Length of Stay for age groups between 15 and 29, 39 and 44 and 45 and 59 years old. The Average Length of Stay increases with age. For these age

groups, the longest Average Length of Stay was for infectious diseases, respiratory system diseases and neoplasm among the age group between 45 and 59 years old in 2012.

Graph 6 - Distribution of Average Length of Stay According to Main Diagnoses and Selected Age Ranges (2012)



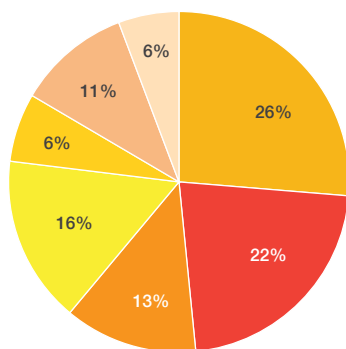
Source: PMPA/Anahp.

The higher the Average Length of Stay is, the lower the bed turnover and the higher the cost of the health system will be. Thus, investing in time management as suggested by the best scientific evidence is one of the most effective strategies to expand hospitals' operational capacity without opening new beds.

In graphs 7, 8 and 9, we can see the distribution of cases according to age range above 60 years old. Neoplasm, Circulatory System Diseases, Digestive System Diseases and Genitourinary System Diseases are predominant in patients

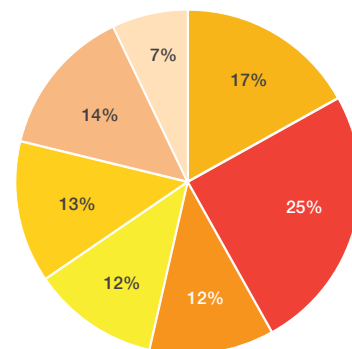
in 60 to 74 age ranges (Graph 7). Above the latter group, the incidence of Circulatory System Diseases and Respiratory System Diseases increase. Diseases of the Circulatory System are the main reason for hospital admission in the age range 75 to 89 years old (Graph 8), followed by Ischemic Heart Diseases, Congestive Heart Failure and Cerebrovascular Diseases being the main pathologies affecting this group. In the age group above 90 years old, respiratory system diseases and circulatory system diseases represent approximately 50% of the main reasons for hospital admission (Graph 9).

Graph 7 – Distribution of Hospital Discharges in the Age Range Between 60 and 74 years old According to Main Diagnoses (2012)



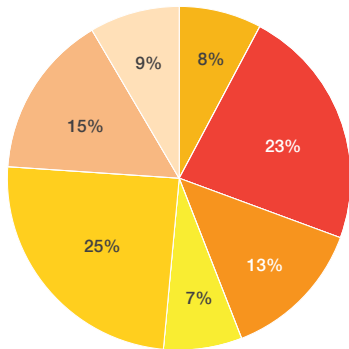
Source: PMPA/Anahp.

Graph 8 – Distribution of Hospital Discharges in the Age Range Between 75 and 89 years old According to Main Diagnoses (2012)



Source: PMPA/Anahp.

Graph 9 – Distribution of Hospital Discharges According to Age Range Above 90 years old and Main Diagnoses (2012)

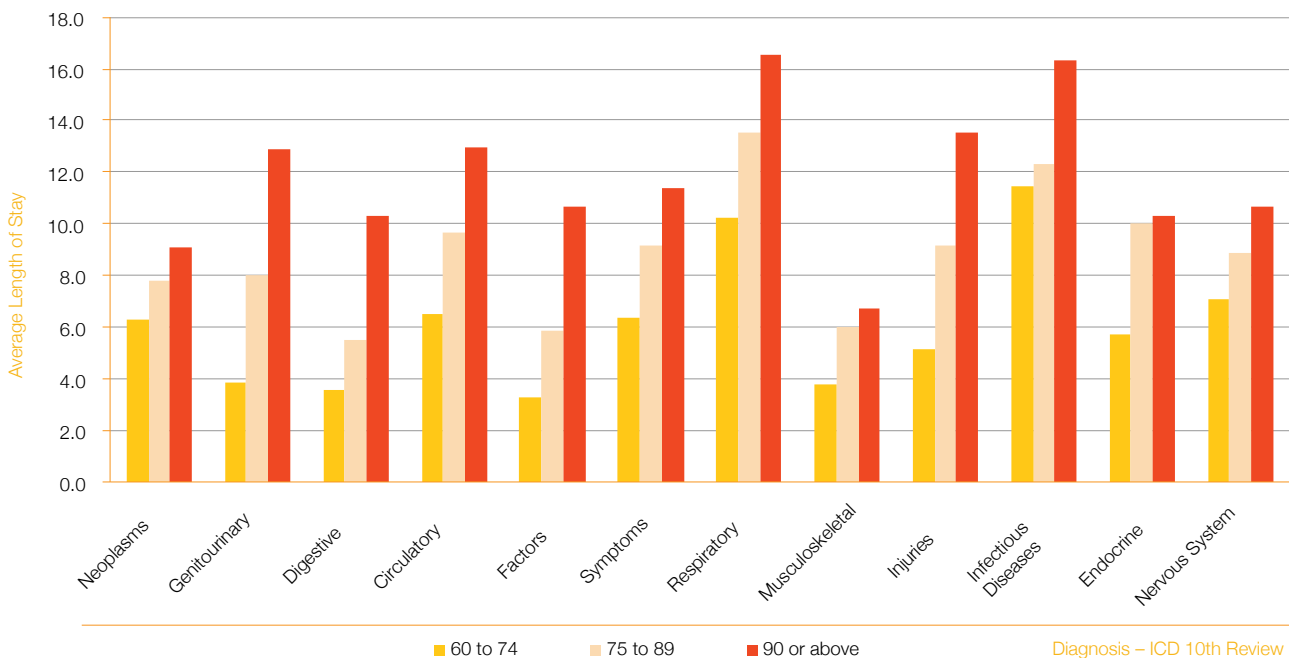


■ Neoplasms ■ Circulatory ■ Circulatory ■ Digestive
 ■ Respiratory ■ Symptoms ■ Injuries

Source: PMPA/Anahp.

As you can see in graph 10, the hospital length of stay increases with age. In the age range between 60 and 74 years old, infectious diseases, respiratory systems diseases and nervous system diseases, in this order, increased hospital length of stay if compared to other diagnoses. As for the above-mentioned age range, the hospital length of stay is from 5 to 7 days, whereas in the age range between 75 and 89 years old is 9 days. The diagnoses that caused the longest hospital length of stay were respiratory system diseases, infectious diseases and endocrine diseases. For patients above 90 years old, the average length of stay in general is 13 days. In relation to diagnoses, hospital length of stay is more than 10 days for the main cases except for neoplasm and musculoskeletal diseases. Monitoring cases of patients aged above 60 years old is essential for care management. Introducing palliative care when indicated, monitoring hospital discharge to ensure continuity of care, avoiding hospital non-scheduled readmission, backing up support for home care and building capacity of caregivers, among other initiatives, have improved patients' care and the use of beds for acute cases of decompensation.

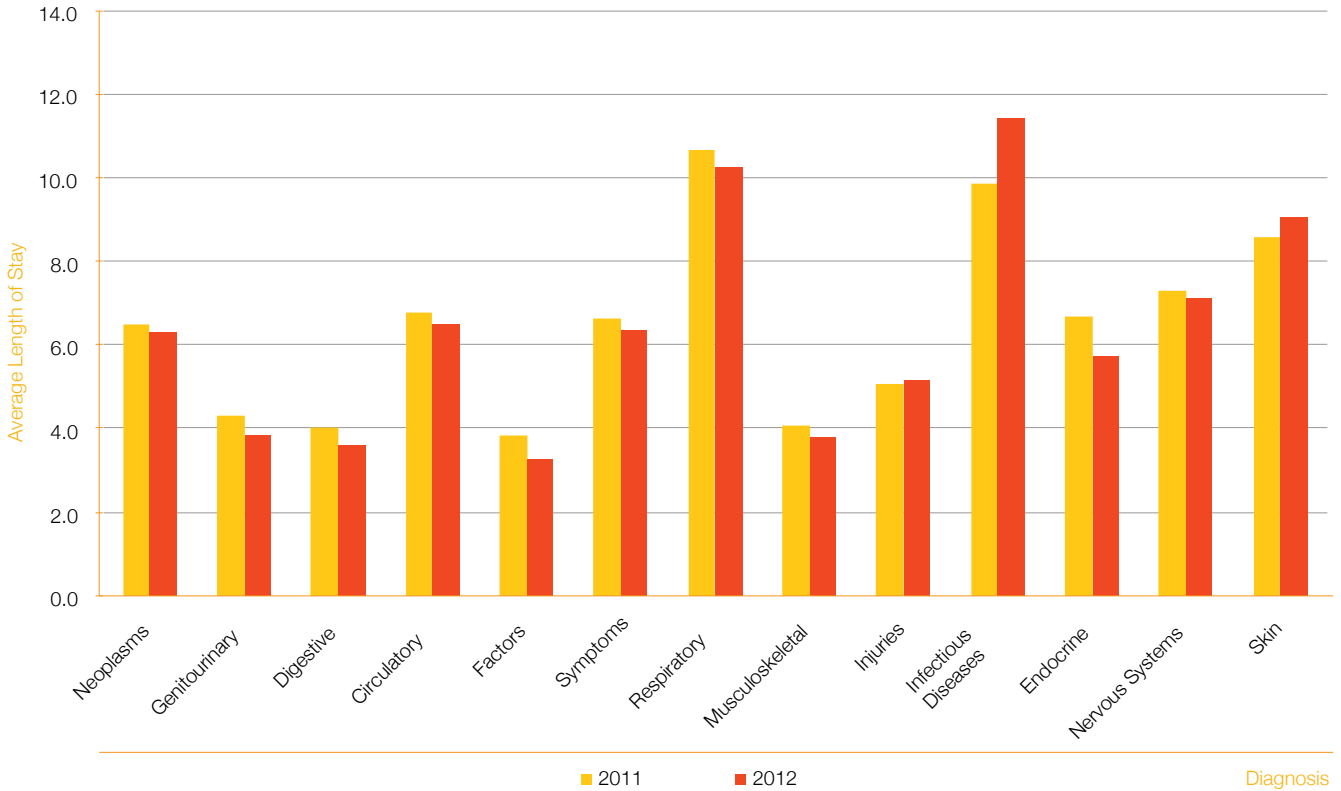
Graph 10 – Distribution of Average Length of Stay According to Main Diagnoses and Selected Age Ranges (2012)



Source: PMPA/Anahp.

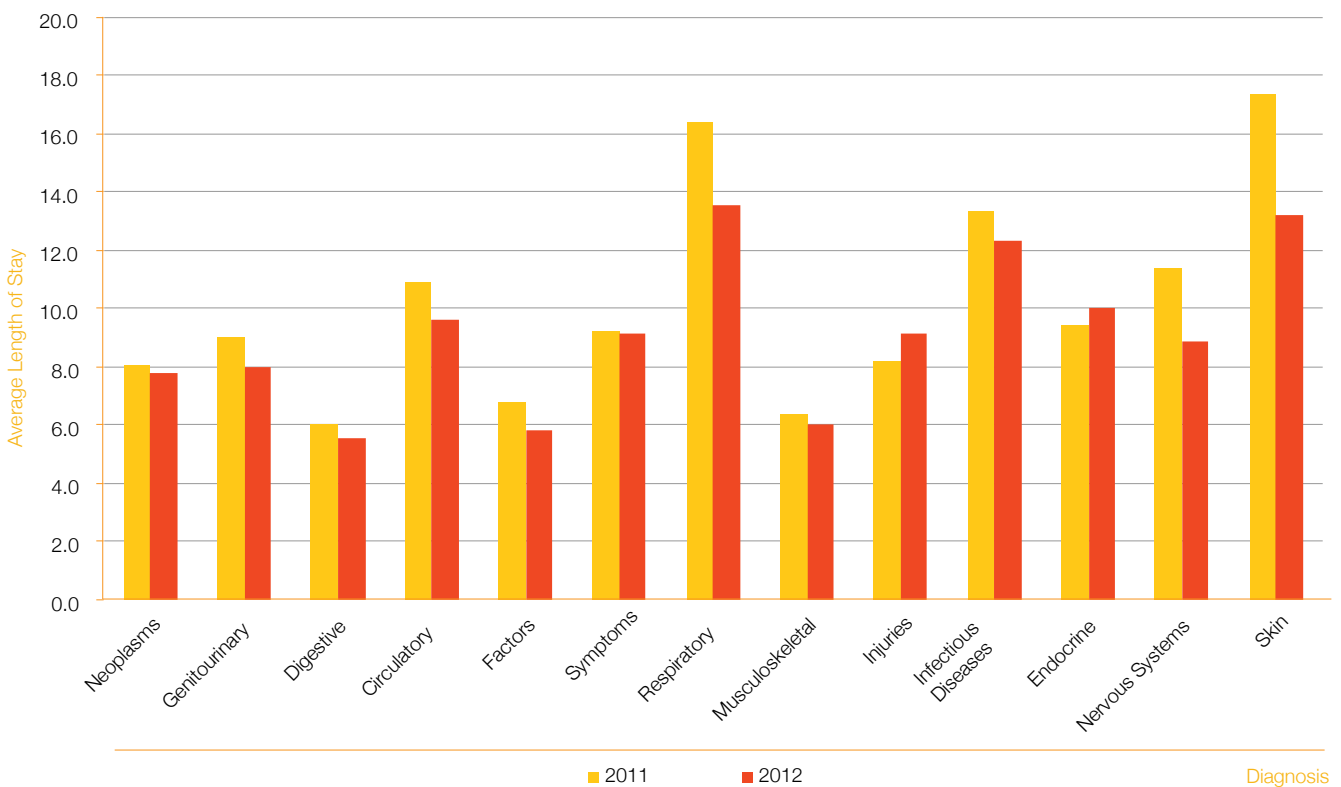
In graphs 11, 12 and 13, comparing the Average Length of Stay between 2011 and 2012 for each age group above 60 years old, we can see a reduction for most diagnoses.

Graph 11 – Distribution of Average Length of Stay in the Age Range Between 60 and 74 years old



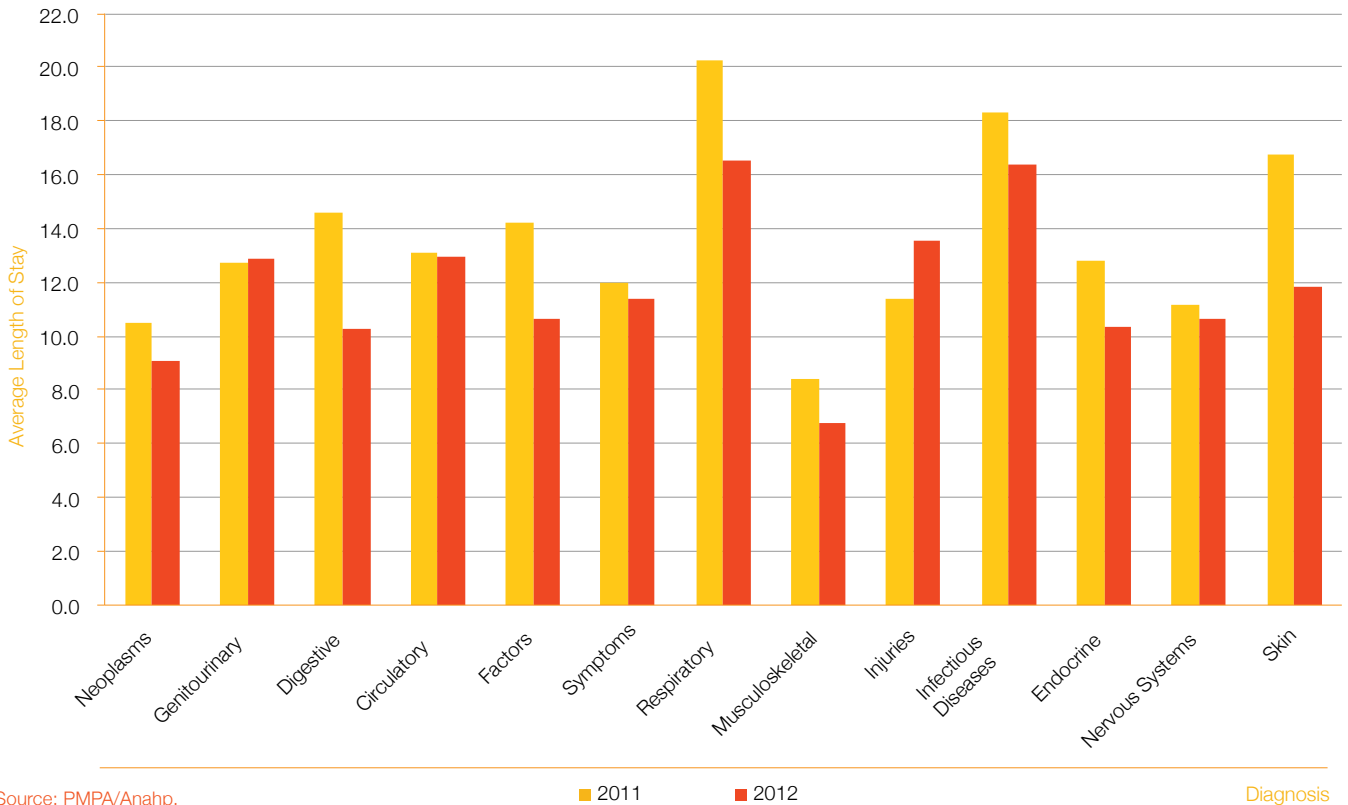
Source: PMPA/Anahp.

Graph 12 – Distribution of Average Length of Stay in the Age Range Between 75 and 89 years old



Source: PMPA/Anahp.

Graph 13 – Distribution of Average Length of Stay in the Age Range Above 90 years old

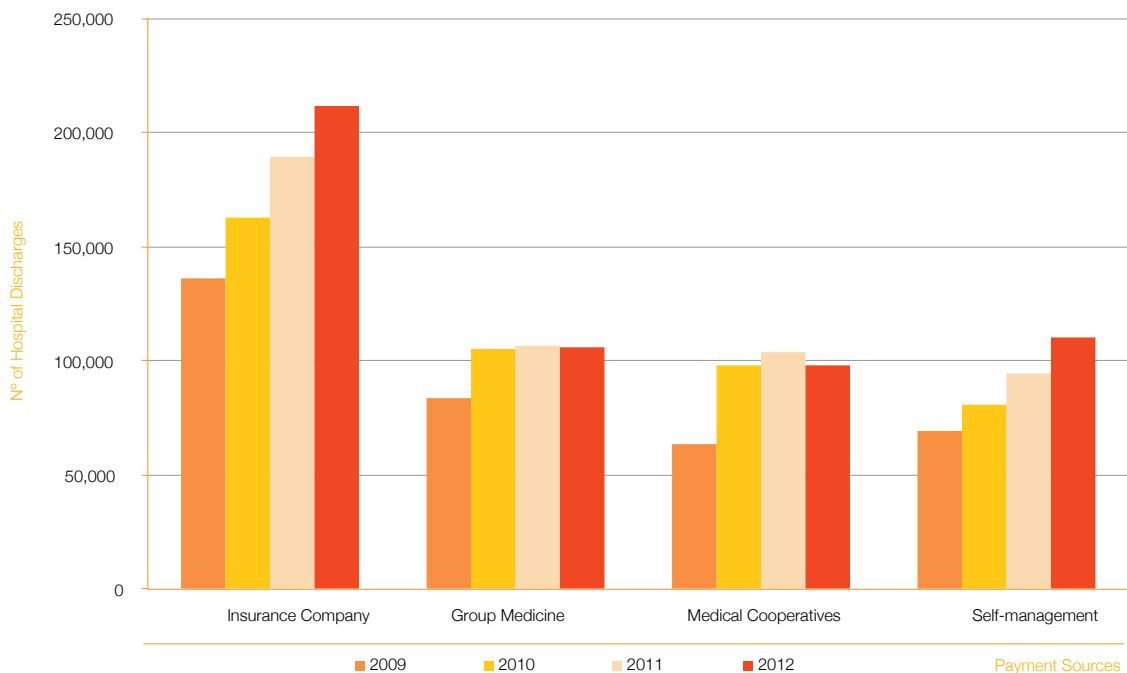


Source: PMPA/Anahp.

With regards to sources of funding of hospitalization, we can evaluate the 2012 distribution by source of payment (Graphs 14 and 14a). The historical series shows the number of cases serviced according to main payment sources – the first graph

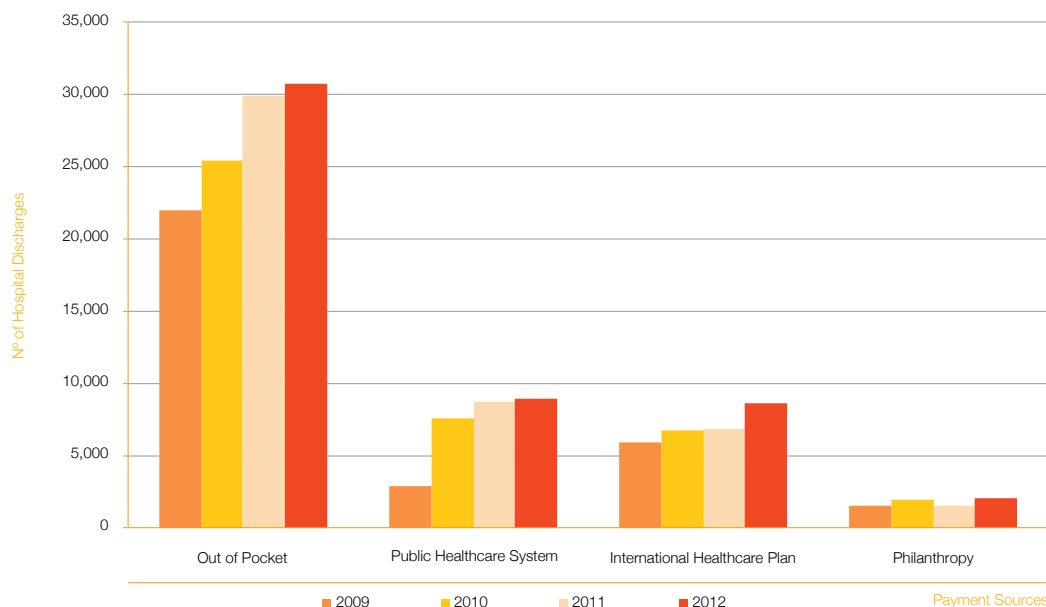
comprises the most frequent payment sources, and the second graph the less frequent ones. Insurance companies prevail in the studied series, followed by companies in the modalities Group Medicine, Medical Cooperatives and Self-management.

Graph 14 – Annual Distribution of Main Payment Sources



Source: PMPA/Anahp.

Graph 14a – Distribution of Hospital Discharges According to Less Frequent Payment Sources



Source: PMPA/Anahp.

The number of patients from insurance companies and self-management has been increasing in hospitals, whereas the number of patients from group medicine has remained stable in the past three years and the number of patients from medical cooperatives has dropped as source of funding. The number of private out-of-pocket payments, service programs exclusively for users of SUS (Universal Public Healthcare System), patients with international healthcare plans and philanthropic patients has increased in the past three years. The number of patients with international healthcare plans has increased the most when we compared the years 2011 and 2012 (25%).

selected indicators began in January 2007. The monitored indicators attempt to provide support and incentives for best practices and enhanced safety in clinical care services.

In 2012, data of 39 hospitals were received, corresponding to 85% of the Anahp hospitals.

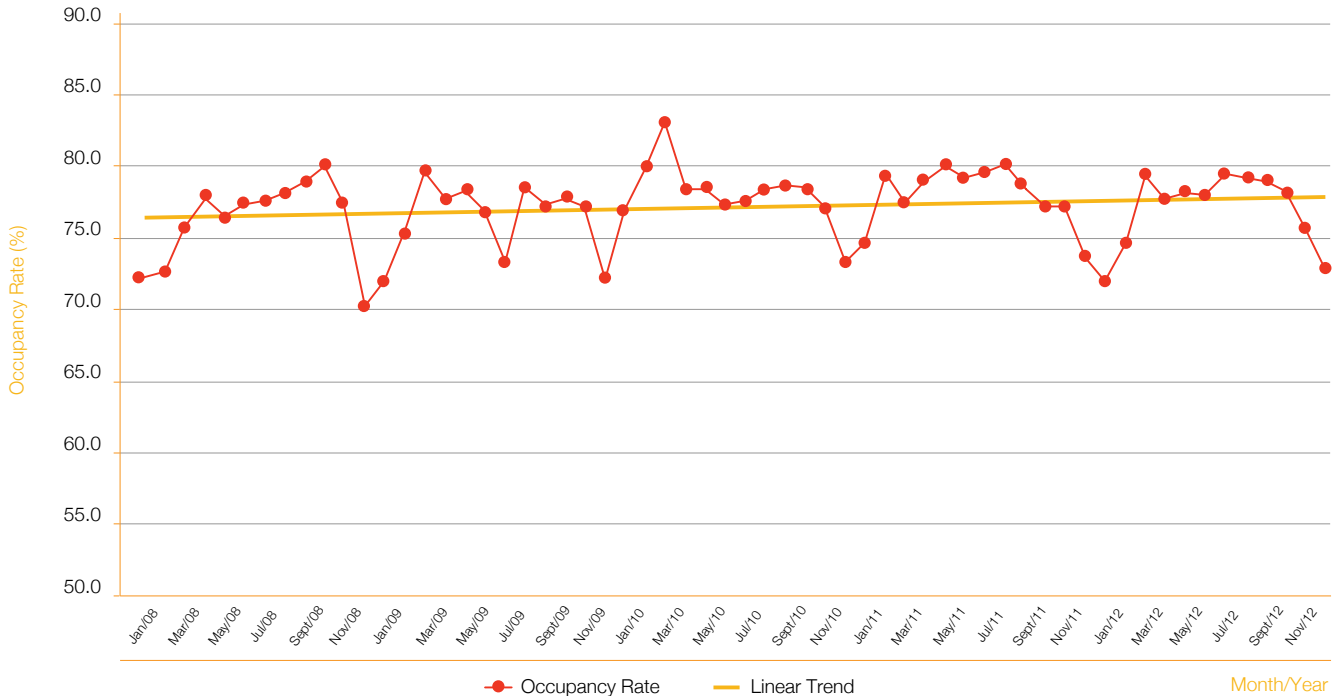
Indicators related to healthcare performance enable the assessment of important dimensions in clinical governance: bed management efficiency; analysis of results of surgical activities, productivity and healthcare efficiency. Concerning efficiency of available bed management, hospitals have shown a linear growth trend of occupancy rates, at approximately 78% in 2012 (Table 5/Graph 15). The rates in January and December 2012 had lower values if compared to 2011.

Healthcare Performance – Analysis of Monthly Data Collection, consolidation and analysis of monthly data and

Healthcare Management Indicators

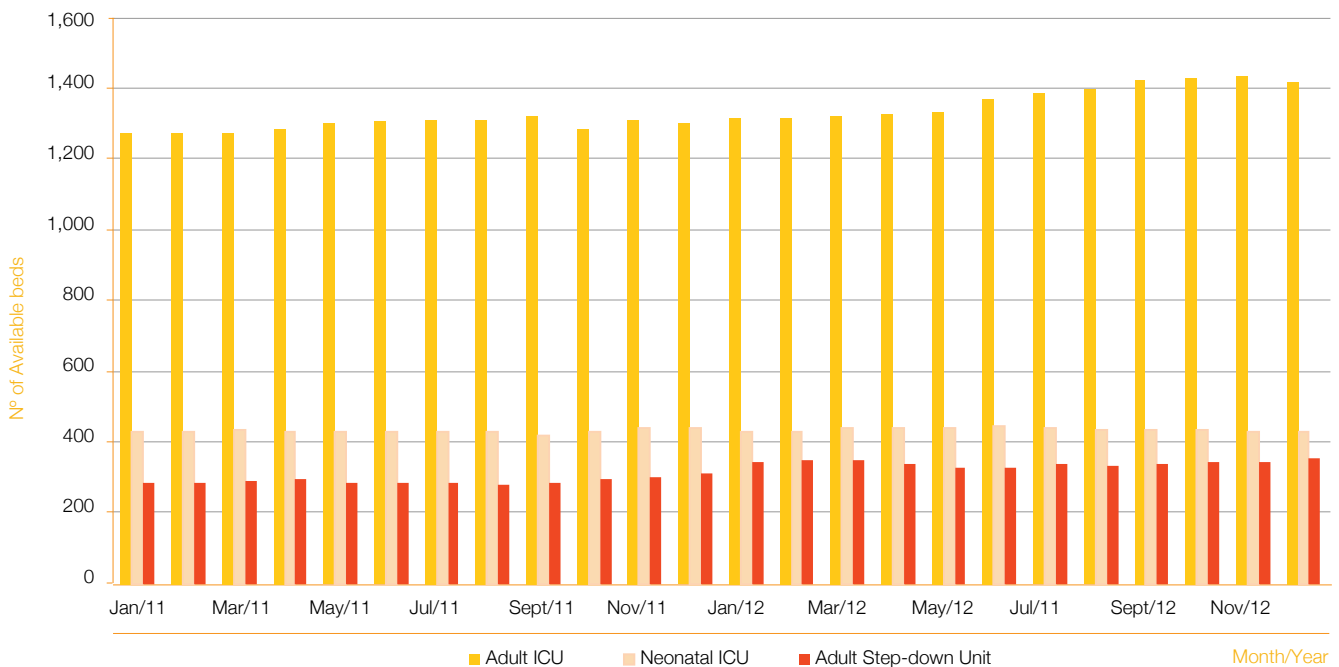
- Operational Occupancy Rate (patients-day/available beds-day*100) – Beds: Overall, adult and neonatal ICUs and step-down Unit;
- Average Length of Stay (patients-day/hospital discharges);
- Turnover Rate (hospital discharges/available beds);
- Bed Turnover Interval (100-occupancy rate*average length of stay/occupancy rate);
- Rate of Patients Submitted to Surgical Procedures (surgical patients/hospital discharges*100);
- Rate of Surgeries per Patient (number of surgeries/surgical patients);
- Surgical Mortality Rate (number of surgical deaths/surgical patients*100);
- Institutional Mortality Rate (number of deaths >= 24hs/hospital discharges*100); and
- Resident Patient Rate (number of patients with length of stay longer than 90 days/hospital discharges*100).

Graph 15 – Monthly Distribution and Linear Trend of Occupancy Rate



Source: PMPA/Anahp.

Graph 16 – Monthly Distribution of Available Beds – Step-down Units and ICUs



Source: PMPA/Anahp.

The hospitals operate a considerable number of beds in ICUs for adults (including coronary ICUs), pediatric and neonatal patients. In 2012, 11 hospitals informed data concerning step-down beds. We can see a substantial increase in the number of ICU beds for adults and step-down beds.

The number of ICU beds and step-down beds, as well as their respective increase throughout 2011 and 2012 is shown in Graph 16. The proportion of intensive care beds has increased from 15% to 30% among associated hospitals of Anahp, depending whether they have maternity units. The proportion between intensive care beds and the total number of hospital beds have been increasing since 2007.

Assistance Performance

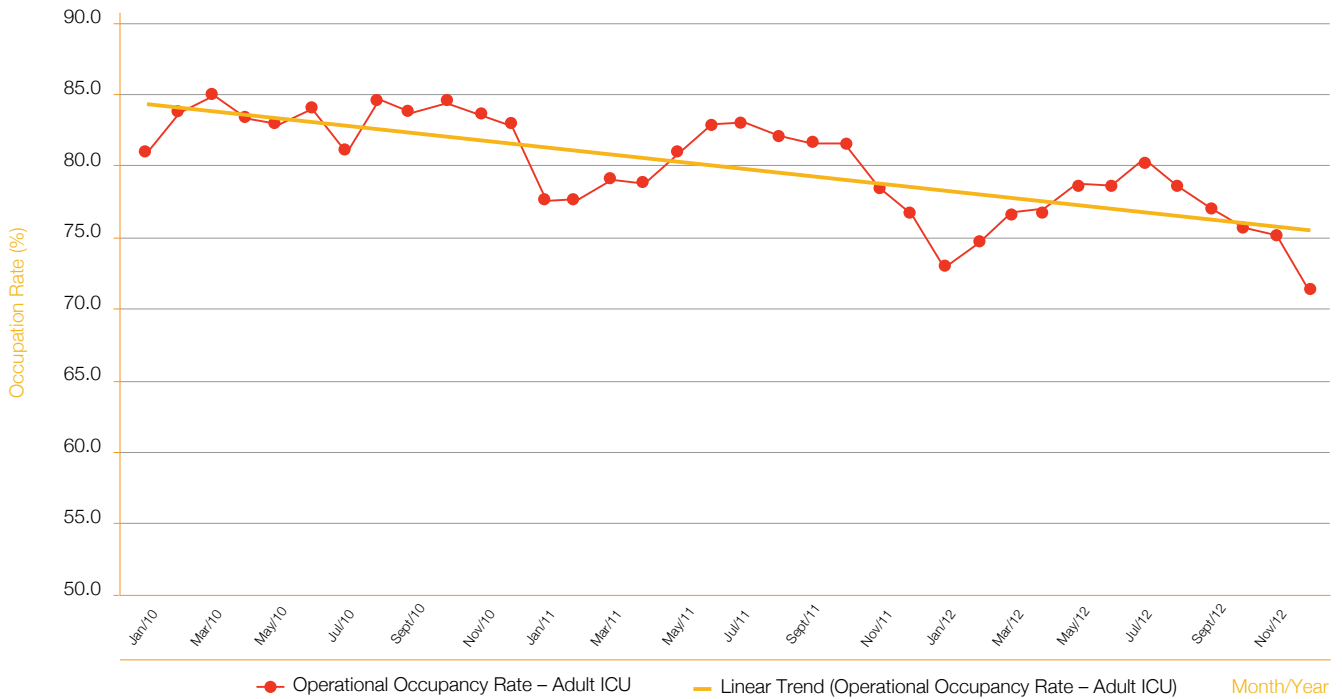
On one hand, there is an increasing trend in the number of outpatient surgical procedures performed on day-hospital basis and, on the other hand, there is the expansion of intensive care and step-down beds. This healthcare organization model has expanded and resulted in better utilization of critical beds and decrease in length of stay of patients with more severe conditions, who require more complex and intensive clinical care.

As for the quality of care provided in ICUs, reasons for observed mortality in comparison with the expected indicator, based on severity scores, are monitored. As seen in Table 5, this rate was below 1 during the entire year, with 0.64 average.

An aspect that has to be regularly analyzed and monitored is adult ICU occupancy rate, since rates above 85% are related to the increase in the number of adverse events and less safety for patients and professionals.

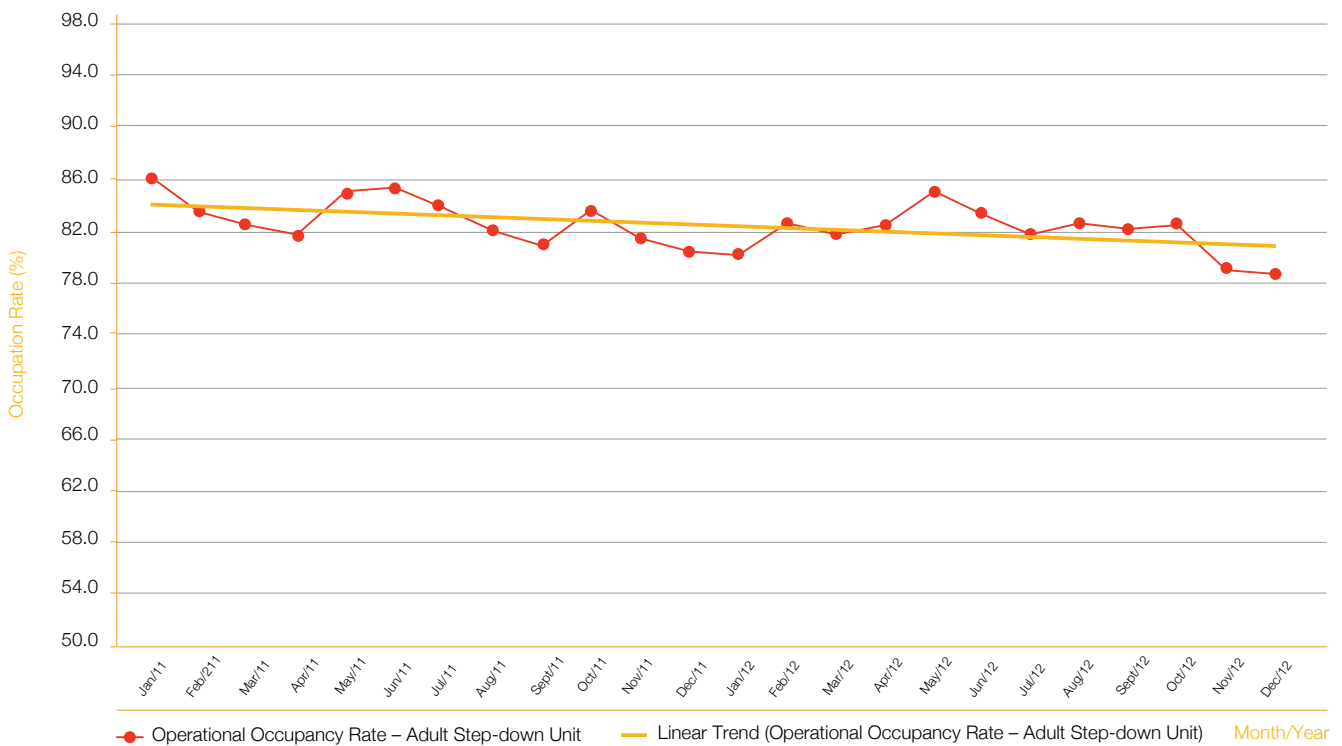
It is most likely that the increase in the number of ICU beds provided and mainly due to the increase of step-down beds that the occupancy rates in adult ICUs dropped, whereas in step-down units they increased in 2012. (Graphs 17 and 18)

Graph 17 – Monthly Distribution of Occupation Rate - Adult ICU



Source: PMPA/Anahp.

Graph 18 – Monthly Distribution of Occupancy Rate – Step-down Unit



Source: PMPA/Anahp.

The Average Length of Stay (Graph 19) shows an increasing trend if compared to 2009. It kept the annual average length of stay from 4 to 5 days. As previously showed, this period

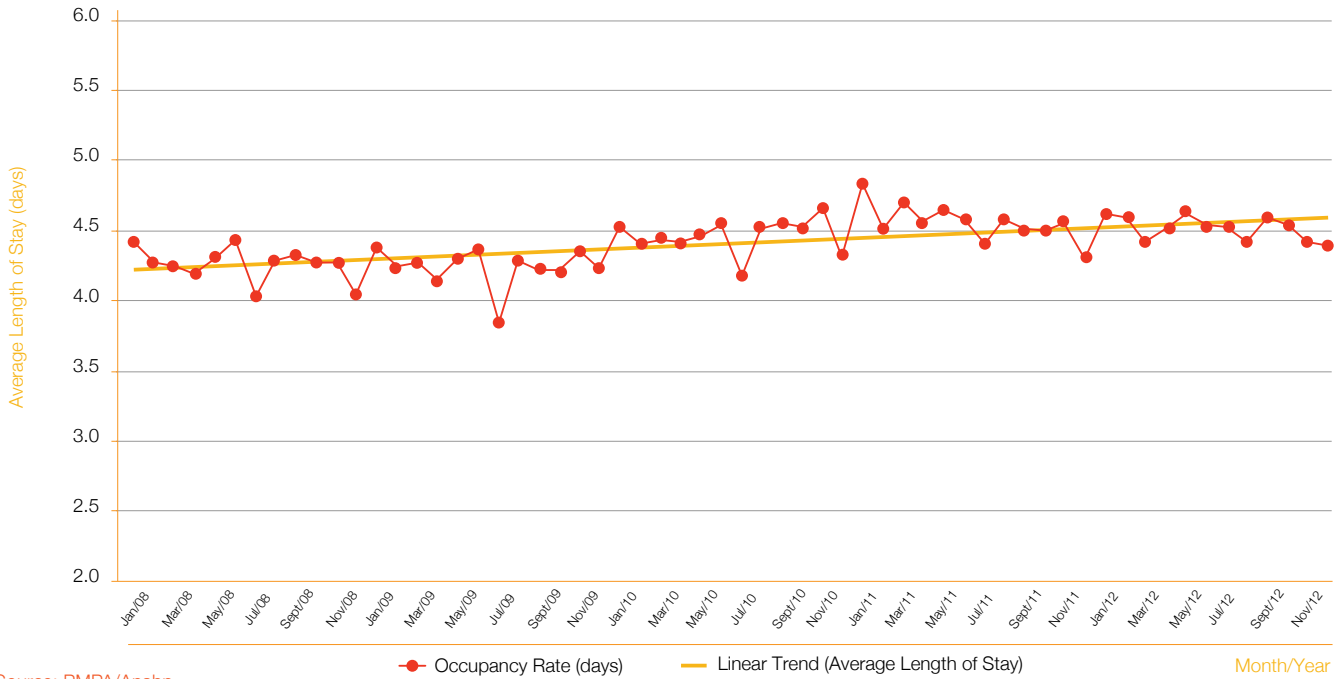
is directly related to the profile of the serviced population and hospital care model. The effective management of patients in great severity and complexity conditions contributed to reduce

Assistance Performance

the length of stay in various diagnoses in age groups above 60 years old. However, the rate of resident patients (Graph 20) continues to be a matter of great relevance. Since 2009, this trend is likely to increase. We could see that great efforts were

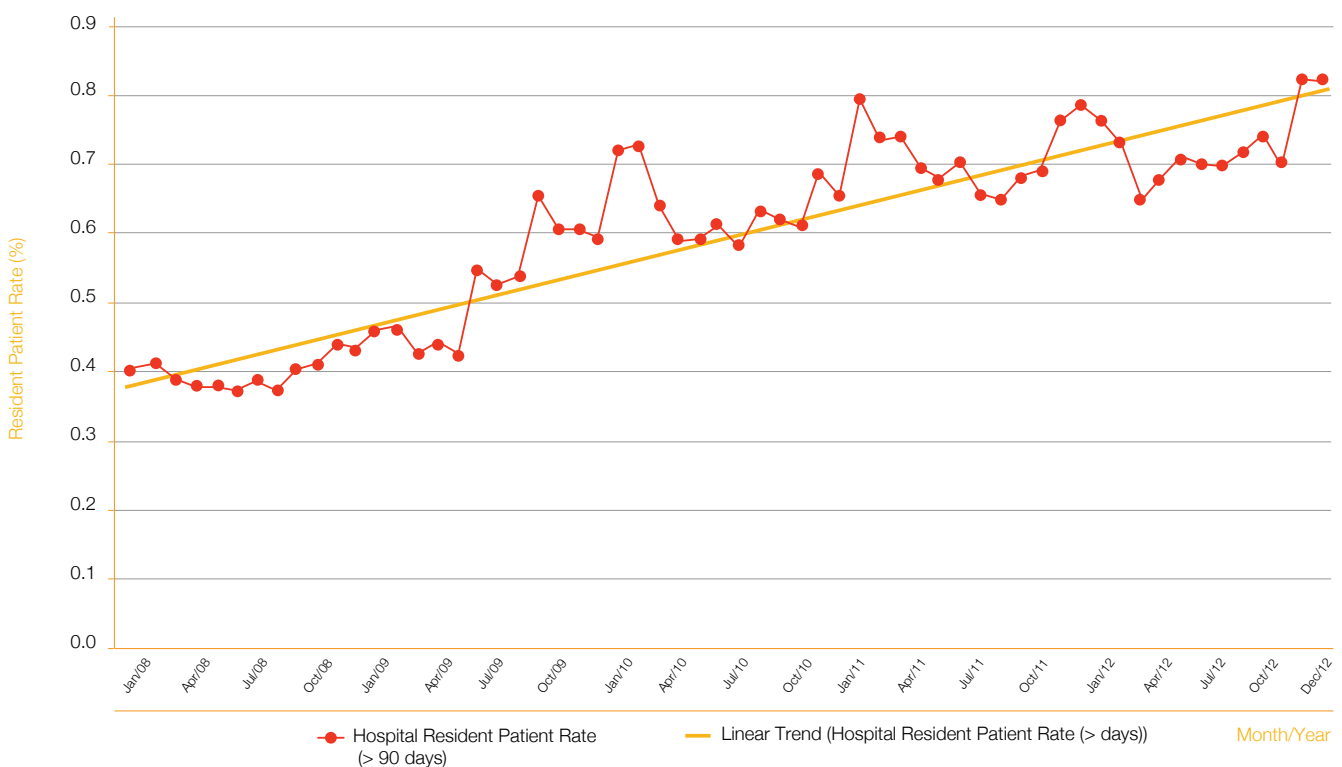
made to reduce it in 2012. The aging of the serviced population associated with cultural and social difficulties to look after elderly patients outside the hospital pose great challenges in care management that require continuous focus.

Graph 19 – Monthly Distribution and Linear Trend of Average Length of Stay



Source: PMPA/Anahp.

Graph 20 – Monthly Distribution and Linear Trend of Hospital Resident Patient Rate (> 90 days)

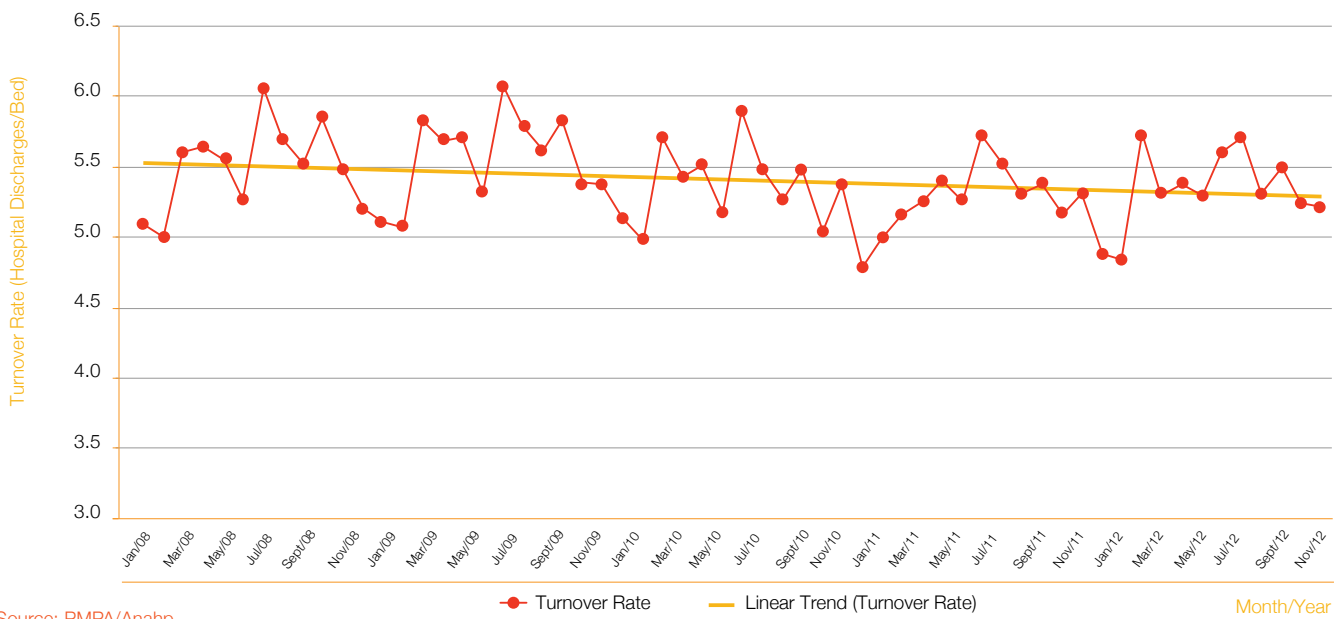


Source: PMPA/Anahp.

The Turnover Rate (Graph 21) and Bed Turnover Interval are related to Occupation Rate and Average Length of Stay. The increase in the length of stay implies lower turnover, in other words, less patients per bed. The Bed Turnover Interval – time the bed stays unoccupied (Graph 22) showed greater variation followed by the Vacancy Rate.

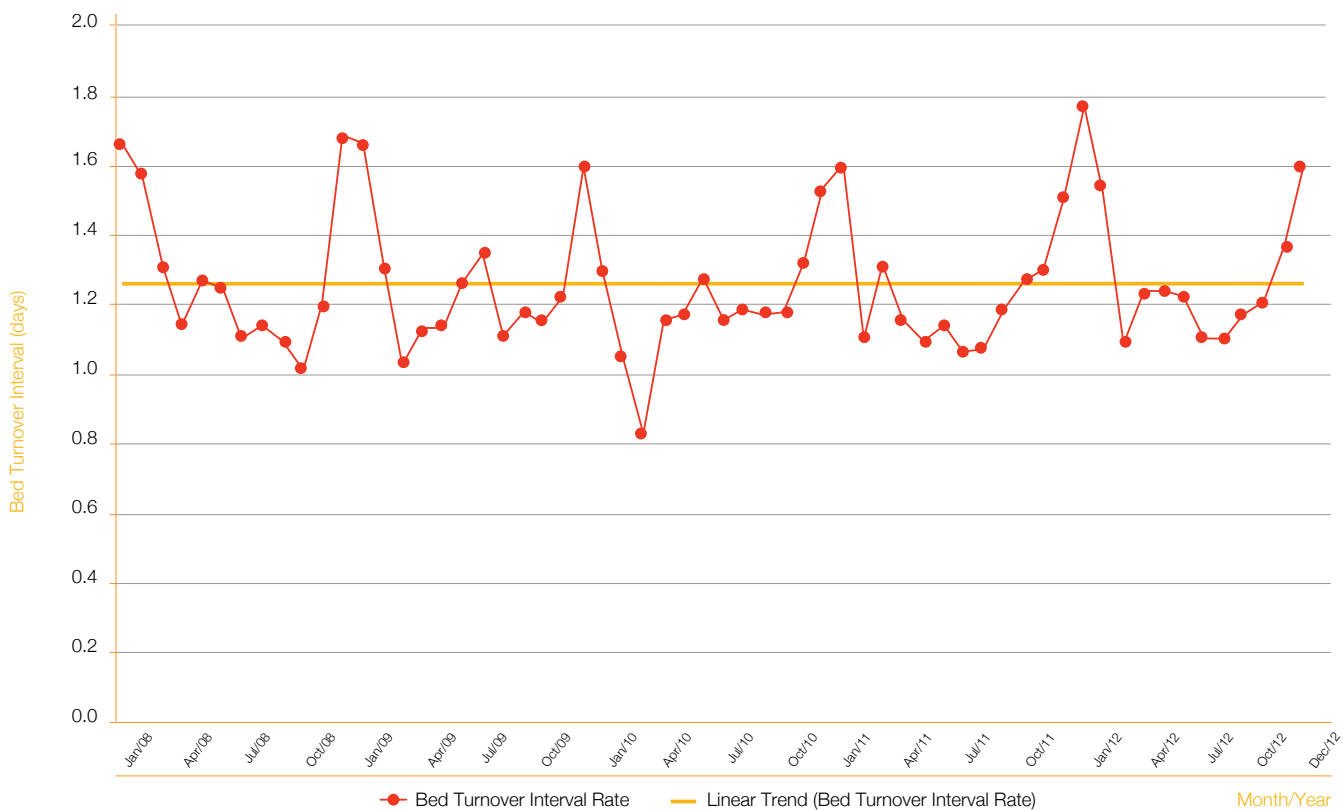
We can conclude that management and monitoring of beds by the teams and the involvement of clinical teams in discharging patients before 10 a.m. are still essential strategies to expand the operational capacity of hospitals without making investments to provide new beds.

Graph 21 – Monthly Distribution and Linear Trend of Turnover Rate



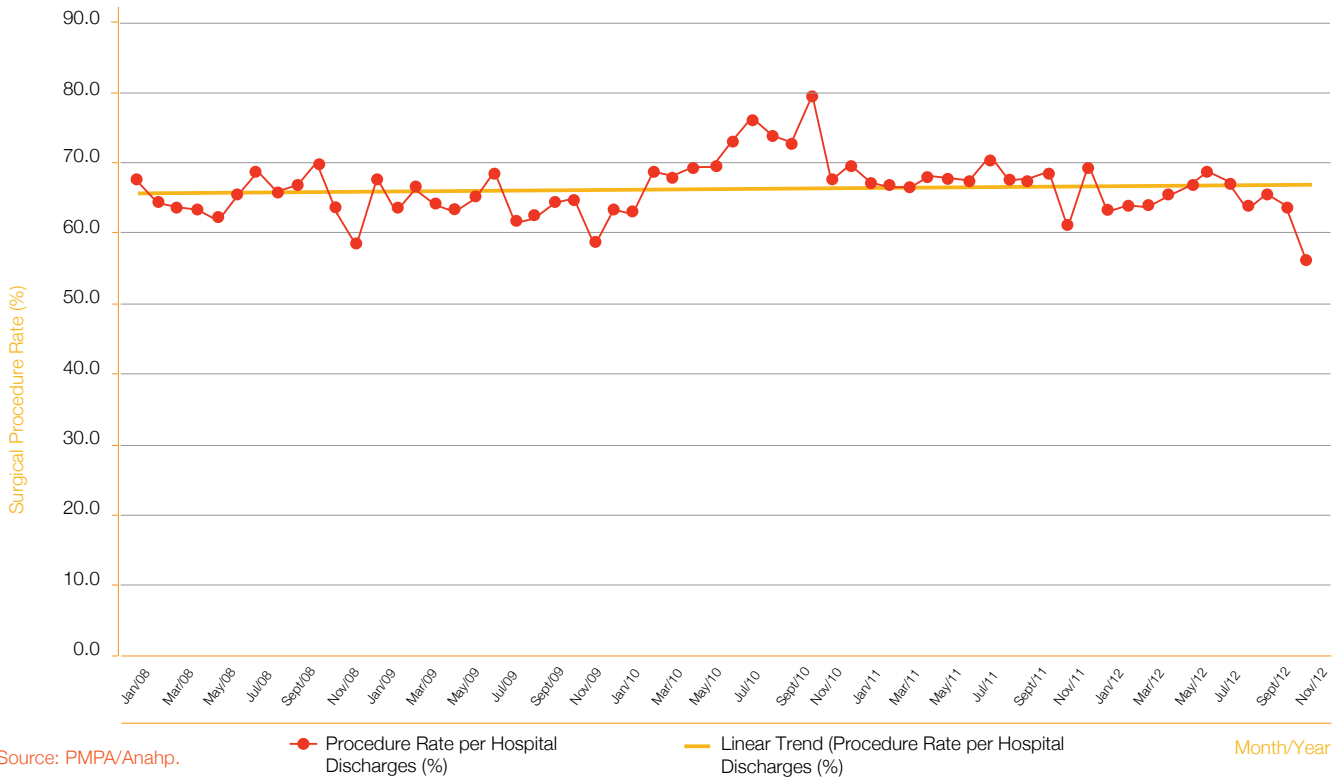
Source: PMPA/Anahp.

Graph 22 – Monthly Distribution and Linear Trend of Bed Turnover Interval



Source: PMPA/Anahp.

Graph 23 – Monthly Distribution and Linear Trend of Surgical Procedure Rate



Source: PMPA/Anahp.

When we compare 2012 with 2011, we can see a reduction in the number of surgical procedures and an increase in the number of hospital admissions related to clinical perinatology and oncology. The turnover of surgical patients is higher than that of clinical patients. Therefore, if it is maintained, it will result in greater length of stay.

Another aspect that must be highlighted is the analysis of the complexity of surgical patients. At hospitals of Anahp, there is a predominance of the surgical area in operational activities – 65% (Graph 23). The number of surgeries per patient dropped, whereas the average age of patients has slightly increased. These factors highlight the increase of patients in severe conditions undergoing surgical procedures.

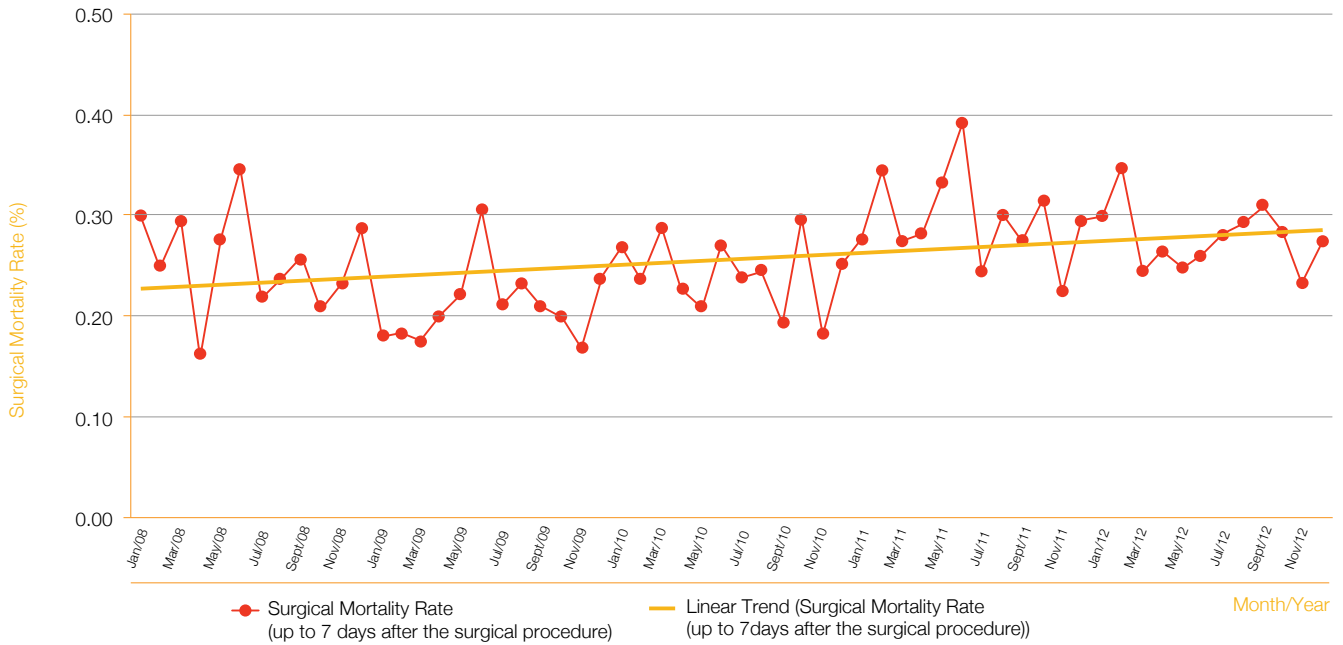
The most proper way to monitor surgical patients in severe conditions is using the standard score for Anesthetic Risk Assessment (ASA – American Society of Anesthesiology). This score is recorded in the patient’s anesthesia form, which is not still available in computerized reports in most hospitals. We expect to start collecting this indicator by 2014. The number of surgeries per patient is an indication of the surgery mix, in which the proportion of surgeries per patient evidences as the most significant ones plastic surgeries, surgeries on children, digestive tract surgeries and other low complex procedures. The reduction of this rate indicates the increase of high complex procedures. (Table 5)

The Surgical Mortality Rate shows an increasing trend in the series related to the complexity of procedures and due to the increase of the age of patients undergoing surgeries, which is linked to the increase of severity and anesthetic risks to surgical patients. (Graph 24 – Table 5)

The analysis of the Institutional Mortality Rate should be adjusted to patients in severe conditions and to the complexity of services. The more complex the hospital is, the higher the number of patients with severe conditions treated and the higher the risk of life will be. Longevity and the increase in the number of oncology patients in all hospitals are indications of increased severity and complexity of the treated population. Even maternity care which was considered low risk now poses great life risks with the increase in the number of women having their first child and getting pregnant between 35 and 44 years old.

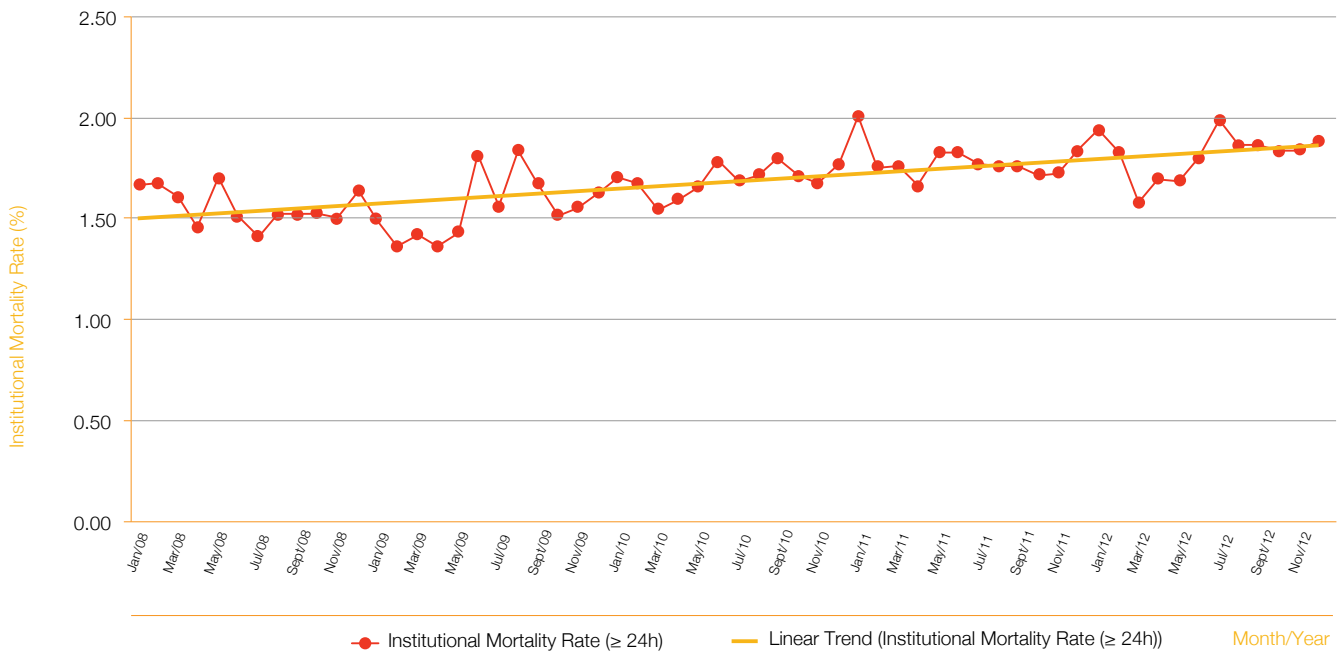
The rate tends to increase, reaching an annual average of 1.8% (Graph 25). The increase of median age and prevalence of co-morbidities contributed to this raise. Benchmarked against the Institutional Mortality Rates of the monitoring system coordinated by the Hospital Quality Committee (CQH) of Associação Paulista de Medicina, published in PROHASA Indicators No. 66, the rates of Anahp hospitals are lower than the 2.71% median seen by CQH for general hospitals and 2.6% for hospital with certification (accredited).

Graph 24 – Monthly Distribution and Linear Trend of Surgical Mortality Rate



Source: PMPA/Anahp.

Graph 25 – Monthly Distribution and Linear Trend of Institutional Mortality Rate



Source: PMPA/Anahp.



Clinical Care Quality and Safety

In recent years, Anahp Hospitals have incorporated more than an accreditation model towards quality of care

The Quality and Safety indicators have been interpreted considering the structure and profile of the hospitals. Thus, they are comparable to data from large and high complexity hospitals.

Anahp member hospitals are committed with quality and safety measures considering that in the past five years more than an accreditation model have been incorporated by the organizations, considering their advantage relative to clinical care process and market requirements. Taking part in the accreditation process places the group of hospitals at a differentiated level of investment in safety and quality. It may also be assessed by the clinical indicators, especially those related with clinical care associated-infections and best practices.

In 2012, some indicators have been included such as Laterality Marking Rate (which measures compliance with surgical checklist concerning surgical site marking) and Compliance Rate with Patient Chart Completeness and Medication Error Rates (active search). In 2011, Prophylactic Antibiotic Therapy Rate, which follows quality and safety standards compliance in surgical procedures started to be collected and data will be presented for the first time. The results of Medication Error Rates will not be approached by the present publication, because few hospitals have submitted their data, even though more hospitals joined the data report in the second half of 2012. The Quality and Safety indicators have been interpreted considering the structure and profile of the hospitals. Thus, they are comparable to data from large and high complexity hospitals. The results with data and indicators are presented in Tables 5 and 5a.

This concern may be evidenced by the results of indicators and increase in safety of clinical care processes.

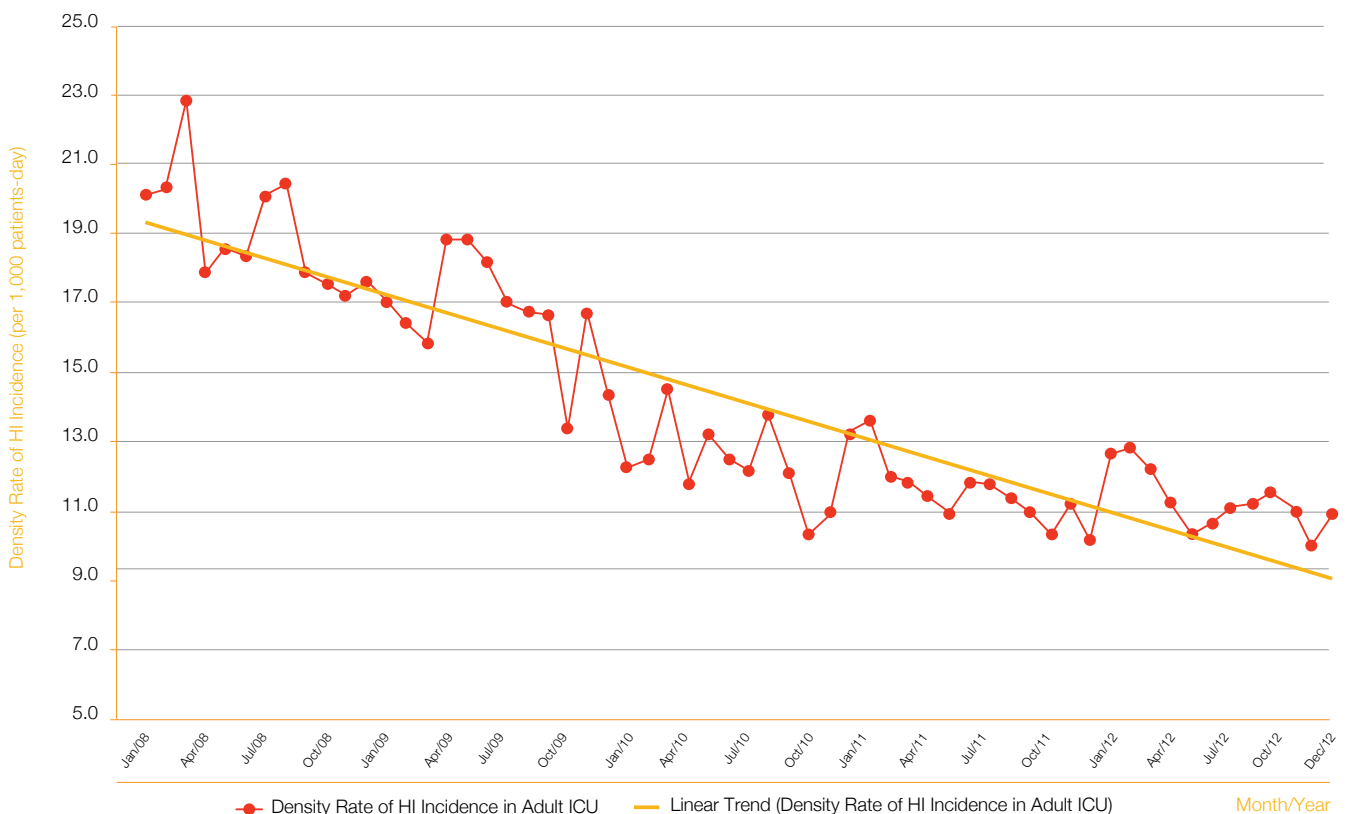
Clinical Care Quality and Safety Indicators

- Density Rate of Hospital Infection (HI) Incidence in Adult ICU, Neonatal ICU and Step-Down Unit
- Density Rate of HI Incidence Associated with Central Venous Catheter in Adult ICU, Neonatal ICU and Step-Down Unit
- Utilization Rate of Central Venous Catheter in Adult ICU, Neonatal ICU and Step-Down Unit
- Surgical Site Infection Rate
- Rate of Prophylactic Antibiotic Therapy
- Rate of Laterality Marking
- Rate of Compliance with Patient Chart Completeness
- Pressure Ulcer Rate

The Density Rate of Hospital Infection Incidence (N of hospital infections/ N patients-day x 1000) is related with Rate of Utilization of Invasive Procedures in ICU, that is, the more the procedures are used, the higher the risk of hospital infection acquisition. The implementation and compliance of clinical teams to the bundles (care package) in the ICU, especially for the use of central venous catheter and mechanical ventilation, have contributed to a more appropriate indication and the timeliest removal of the device. These integrated actions have determined major reduction in incidence of device-associated

infections. The Density Rate of the General Infection Incidence in the ICU presented significant reduction (Graph 26). There has been smaller reduction than in 2012, compared to 2010 and 2011. The reduction of Density Rates of Incidence in these units have evidenced greater safety in patient care and better results of the healthcare system, especially considering the increase in median age of patients and the greater prevalence of comorbidities. These factors have increased the intrinsic risk of patients developing healthcare-related infections.

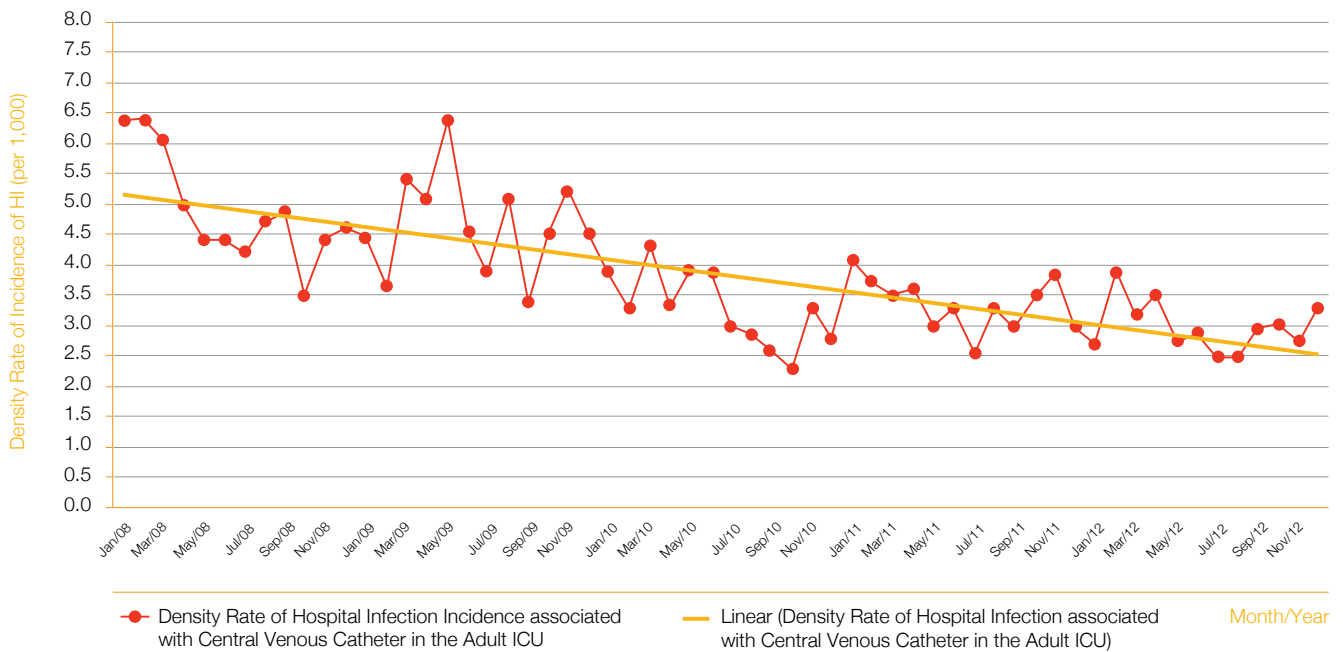
Graph 26 – Monthly Distribution of Density Rate of HI Incidence (per 1,000 patients-day) in Adult ICU and Linear Trend



Assistance Performance

The Density Rates of HI incidence associated with Central Venous Catheter in adult ICU have also suffered significant reduction, as shown by Graph 27.

Graph 27 – Monthly Distribution of Density Rates of HI Incidence associated with Central Venous Catheter (CVC) (per 1,000 catheter-day) in Adult ICU and the respective Linear Trend

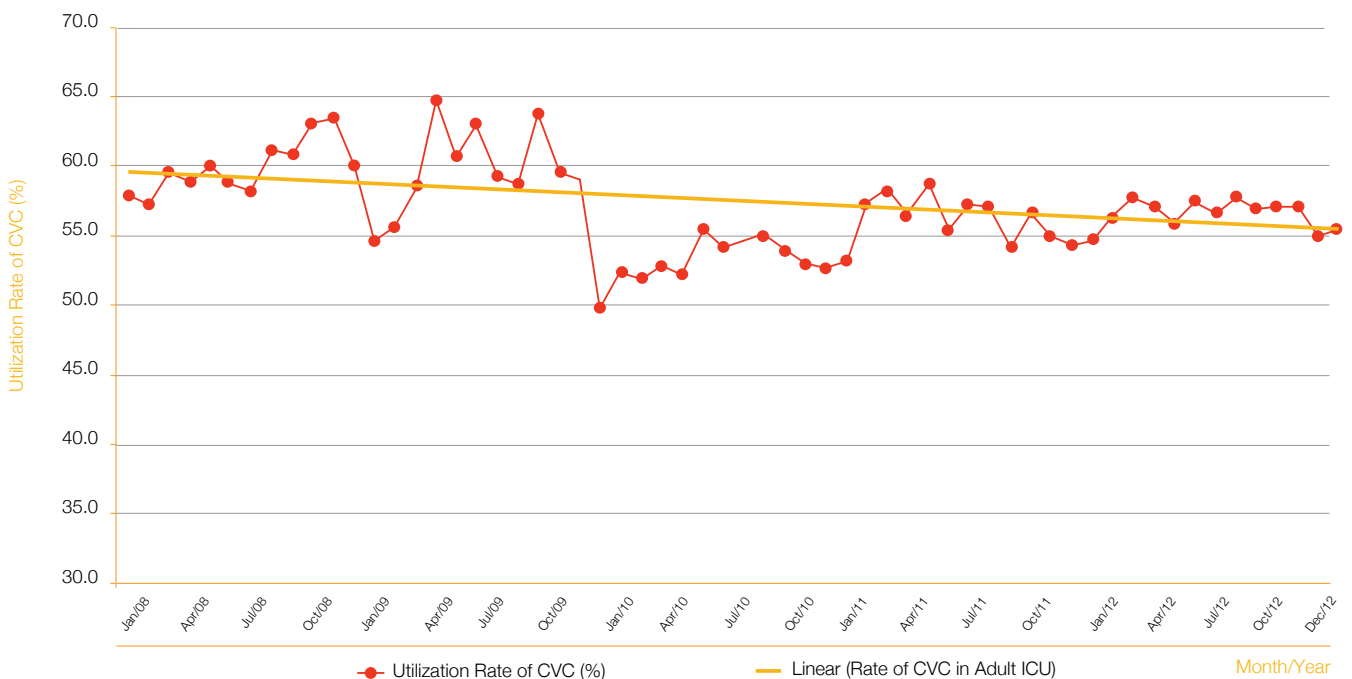


Source: PMPA/Anahp.

This reduction is associated with lower Rate of Utilization of Central Venous Catheter. The Rate of Utilization has ranged from 56% to 58% in Adult ICU. It is important to point out that

the Utilization Rate has had minor variability between 2011 and 2012, suggesting greater standardization in management approach (Graph 28).

Graph 28 – Monthly Distribution of Utilization Rate (%) of Central Venous Catheter in Adult ICUs



Source: PMPA/Anahp.

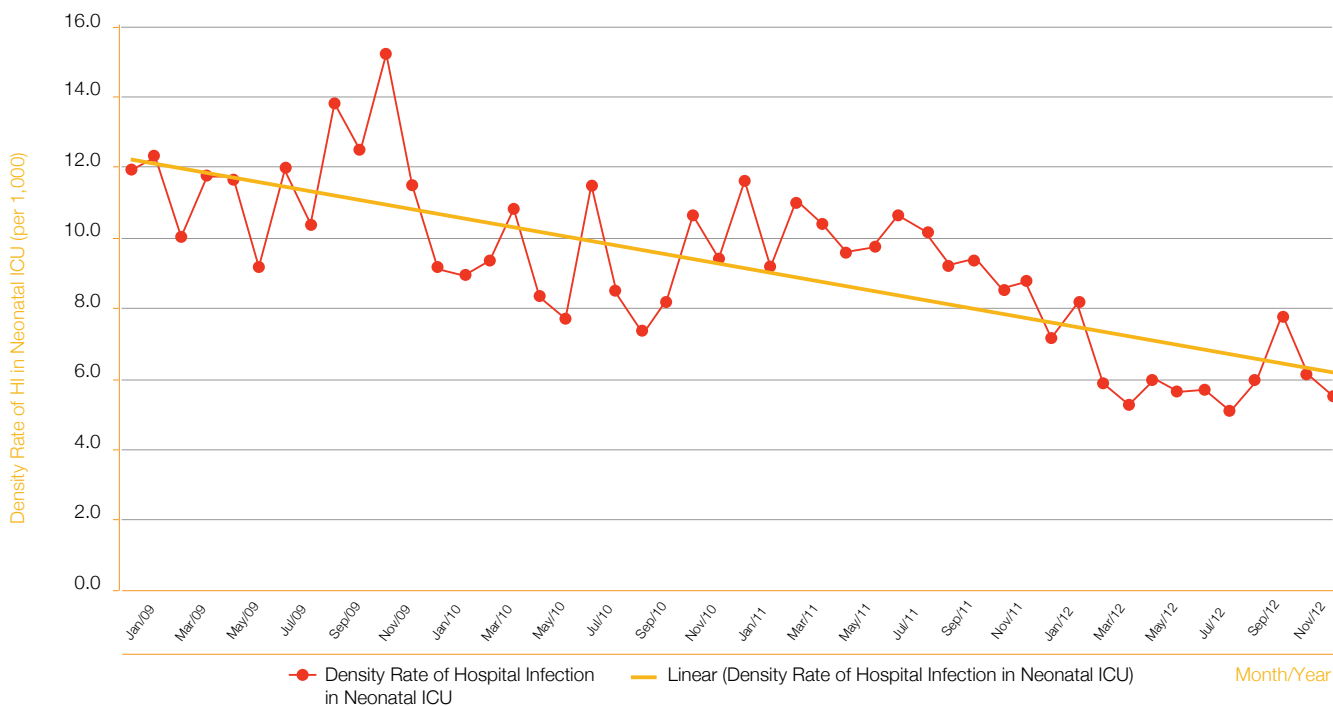
The quality in the ICU is one of the key aspects of hospital management. The reduction of infection risk related with care and prevention of complications to patients is a continuous effort to improve the organizations. These actions resulted in faster return to daily life, lower social cost, smaller proportion of disability and better quality of life. It also leads to lower risk of readmissions, which is associated with reduction in Hospital Length of Stay, representing significant savings for healthcare organizations.

In the neonatal ICU we could notice a significant reduction in Incidence Rate of HI (Graph 29). The rates went from about

10/1,000 to 12/1,000 to 4/1,000 to 6/1,000. This reduction is related to the appropriate use of venous catheter and appropriate indication of mechanical ventilation in the neonatal ICU. The Utilization Rate ranged from 21% to 31%, lower than what was observed in 2011 (Table 5a).

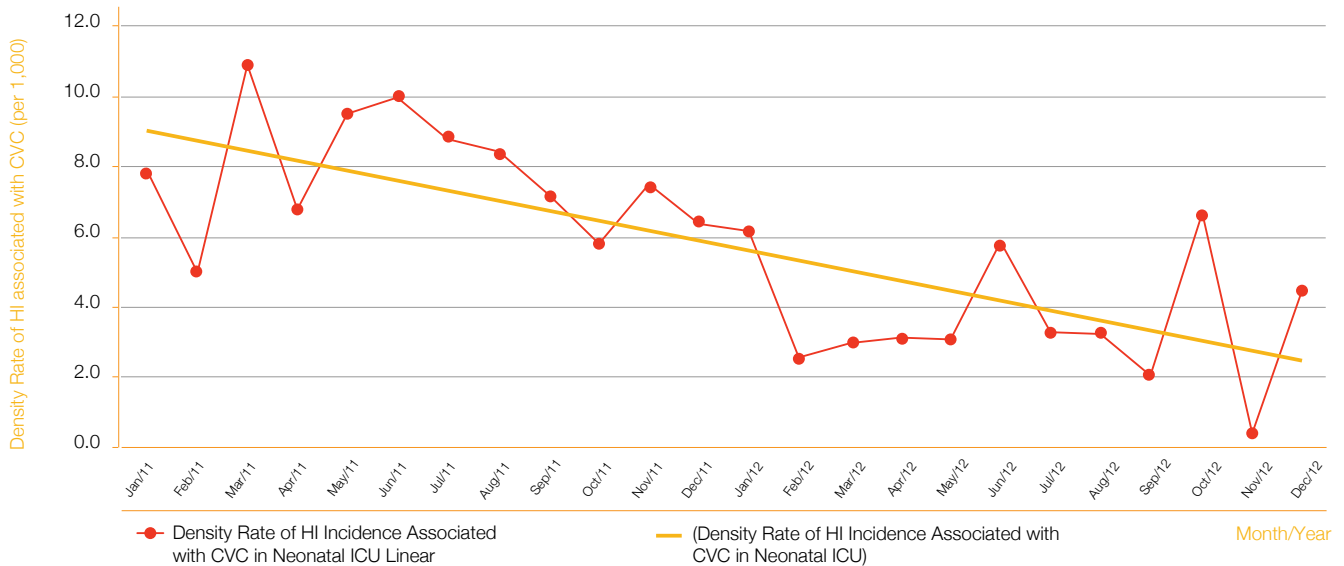
Density Rate of CVC-associated Infection Incidence in the Neonatal ICU presented a significant decrease, which can be visualized in Graph 30.

Graph 29 – Monthly Distribution of Density Rate of HI Incidence (per 1,000 patient-day) in Neonatal ICU and Linear Trend



Source: PMPA/Anahp.

Graph 30 – Monthly Distribution of Density Rate of HI Associated with CVC (per 1,000 Catheter-day) in Neonatal ICU and the Respective Linear Trend

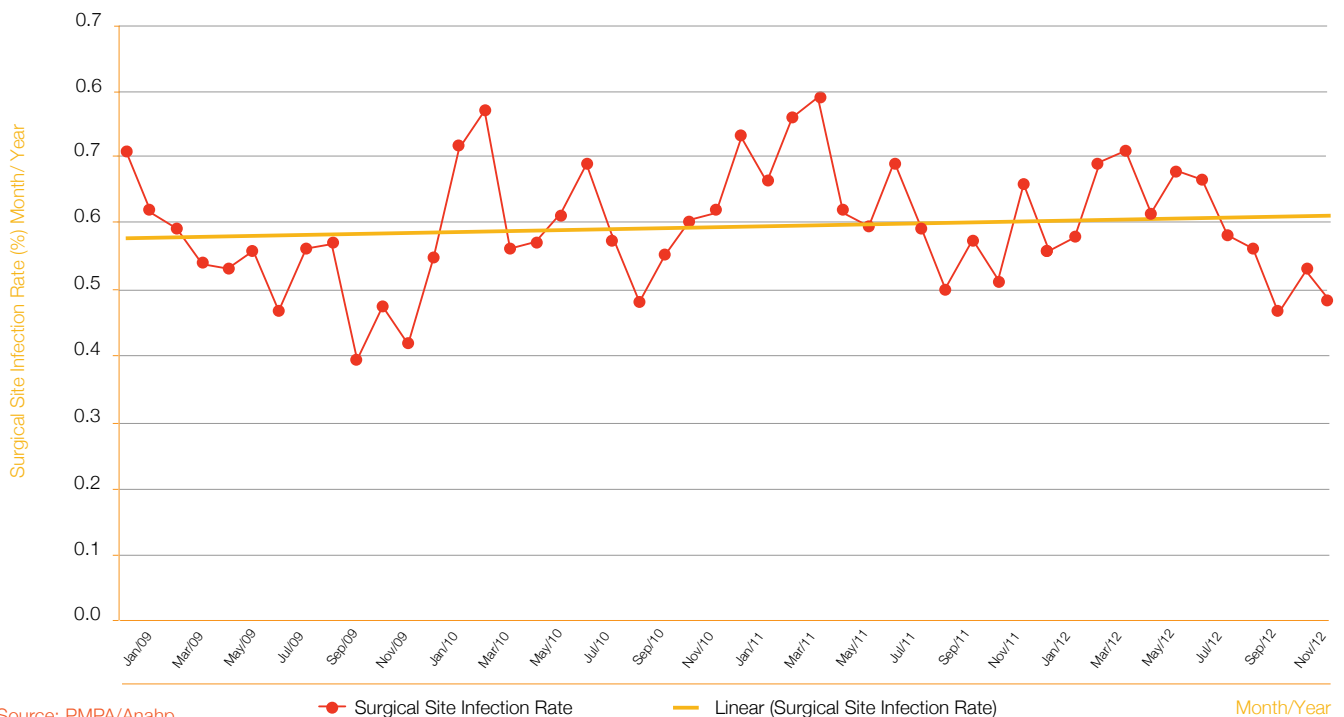


Source: PMPA/Anahp.

In the Step-Down Unit the hospitals monitor the Density Rates of HI Incidences, the Utilization Rates of CVC and the Density Rates of Systemic Infection associated with CVC. In 2012, 11 hospitals presented Step-Down beds, most of them with monitored infection rates. The Density Rates of Step-Down Unit Incidence have also presented reduction. The variation observed between 2/1,000 and 5.8/1,000 patients-day (tables 5 and 5a).

The Surgical Site Infection Rates (Graph 31) presented variation from 0.5% to 0.7% during 2012. There was mild increase in linear trend. This increase may be associated with major surgical complexity, as already pointed out. The data about infection are collected based on post-discharge active search, which requires major investments by the hospital infection control teams. The standardization to define the sample for some specific surgery groups still needs adjustments. In 2013, sample collection will be improved.

Graph 31 – Monthly Distribution of Surgical Site Infection Rate and the Respective Linear Trend

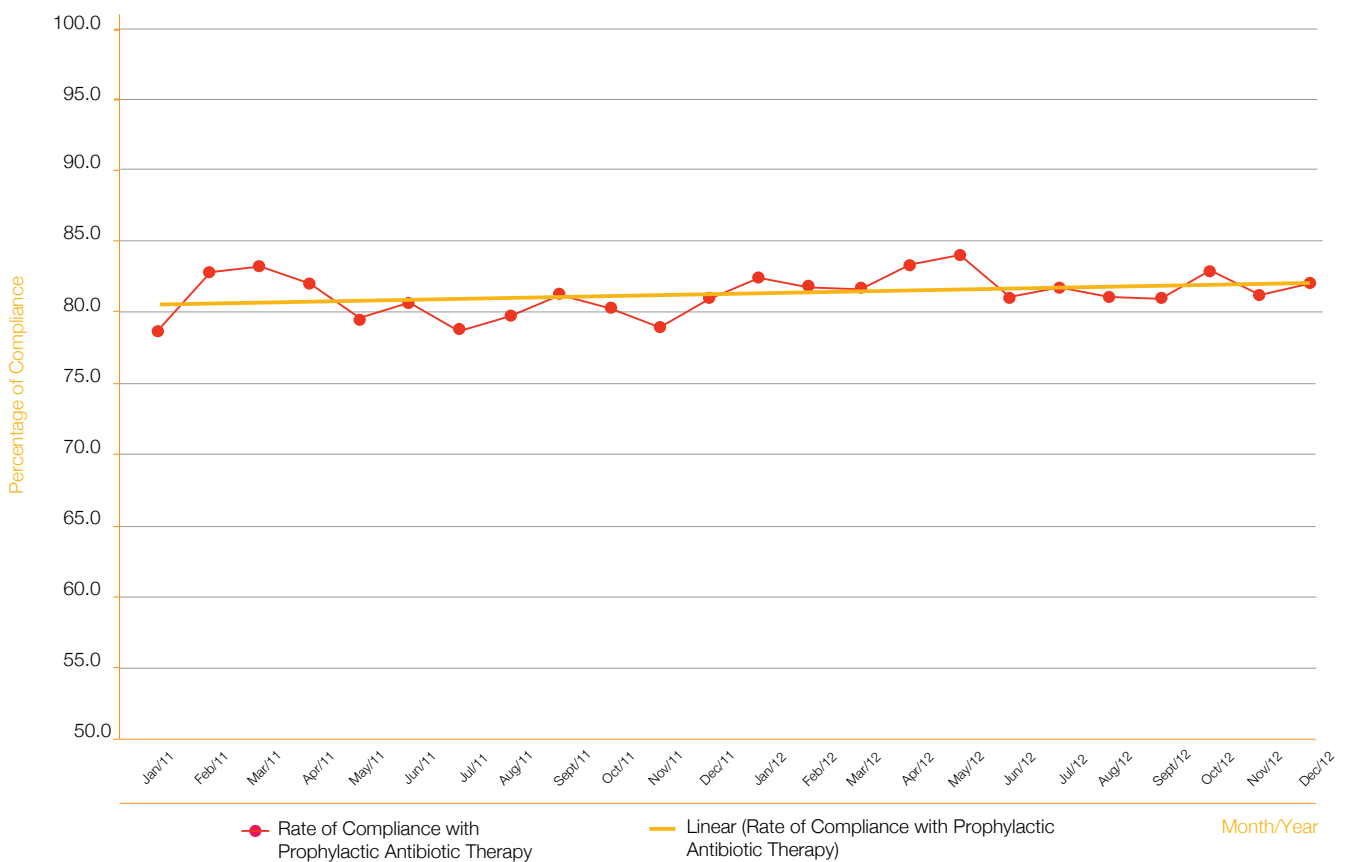


Source: PMPA/Anahp.

To assess the quality of care provided to surgical patients there are two indicators that are monitored. The first indicator, which has been followed up since 2011 – Rate of Compliance with Prophylactic Antibiotic Therapy – is comprised by three items: the application of the correct time of surgery, the scheme recommended by the best evidence for each type of surgery and the duration of the scheme. This component is what normally marks non-compliance with what is advocated. In Graph 32, we can see the compliance rate ranging from 80%

to 85%, showing minor trend of improvement (Table 5a). The second indicator, assessed since January 2012, is the Rate of Laterality Marking (in compliance with the surgical checklist items recommended by the World Health Organization). The range has varied between 86% and 97% compliance, mean of 92%. The goal to be achieved is 100% compliance with marking in all surgical procedures in which marking is indicated (Table 5a).

Graph 32 – Monthly Distribution of Compliance Rate with Prophylactic Antibiotic Therapy (%)



Source: PMPA/Anahp.

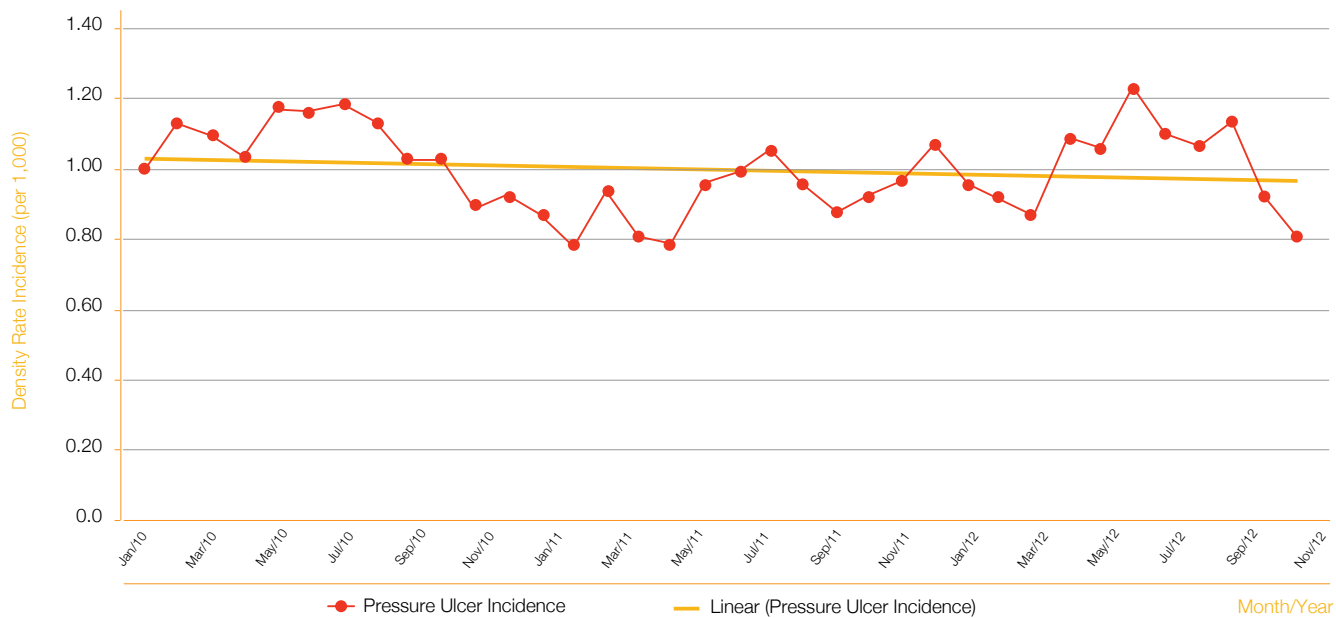
In relation to safety, in 2012 the level of patient chart completeness started to be monitored by the hospitals. Precise documentation is an essential element for the integration of the clinical care team and for continuity of patient care. Rate of Compliance with Patient Chart Completeness ranged between 81% and 92%, mean of 87% (Table 5a). This is one of the

quality standards that accreditation models expect to have continuously improved.

The Density Rate of Pressure Ulcer Incidence evidences nursing care in hospitals. Incorporated as of January 2010, it has presented long term reduction (Graph 33 – Tables 5 and 5a), showing improvement in nursing practice.

Assistance Performance

Graph 33 – Monthly Distribution of Density Rates of Pressure Ulcer Incidence (per 1,000 patient day) and Linear Trend



Source: PMPA/Anahp.



Clinical Care Protocols

Anahp Hospitals improve protocol management

Indicators present smaller variability and better clinical outcomes

Monitoring of clinical protocols in Anahp member hospitals is made by indicators that are followed up monthly. The purpose is to provide information to continuously improve clinical practice at the hospitals and ensure quality standards in care for the most prevalent pathologies and the main causes of mortality in Brazil.

Diseases of the Circulatory System are the main causes of death in all Brazilian regions. Acute myocardial infarction and ischemic cerebral vascular accident are the most relevant conditions that make people come to urgency and emergency departments in Brazilian hospitals. Mortality coefficients from these conditions have heterogeneous distribution in Brazilian regions, related with exposure to risk factors and age range of the population. The risk of dying from Diseases of the Circulatory System is higher in the South and Southeast regions of the country, according to information provided by the mortality database of DATASUS. Neoplasm (cancer) is the second main cause of death in the South and Southeast regions and External Causes rank first in Center-West, Northeast and North regions.

Anahp monitors the outcomes of clinical care for acute myocardial infarction, ischemic cerebral vascular accident and congestive heart failure, the latter having high prevalence in Brazil and requiring large amounts of resources if the patients do not receive the best evidence-based care. In 2012, 28 hospitals submitted data and indicators of their acute myocardial infarction protocols. For congestive heart failure, 24 hospitals submitted data and 18 hospitals for cerebral vascular accident. Monthly results of the indicators for year 2012 can be seen in Table 6.

Indicators – Clinical Care Protocols

Acute Myocardial Infarction (AMI)

- Door-to-Balloon Time (AMI with STEMI)
- Rate of Primary Angioplasty (with STEMI)
- Rate of Aspirin at Discharge
- Mean Length of Stay
- Mortality Rate

Ischemic Cerebral Vascular Accident

- Door-to-CT Time
- Rate of CT
- Mean Length of Stay
- Mortality Rate

Congestive Heart Failure

- Mean Length of Stay
- Mortality Rate
- Rate of Betablockers at Discharge (new)
- Rate of ACEI or ARB at Discharge (new)

Community-acquired Pneumonia (children, adults and elderly)

- Mean Length of Stay
- Mortality Rate
- Rate of Appropriate Antibiotic Therapy

Community Sepsis

- Mean Length of Stay
- Mortality Rate
- Rate of Appropriate Antibiotic Therapy

Videolaparoscopic Cholecystectomy and Inguinal Herniography

- Mean Length of Stay in Hours

Abdominal Hysterectomy

- Mean Length of Stay in Days

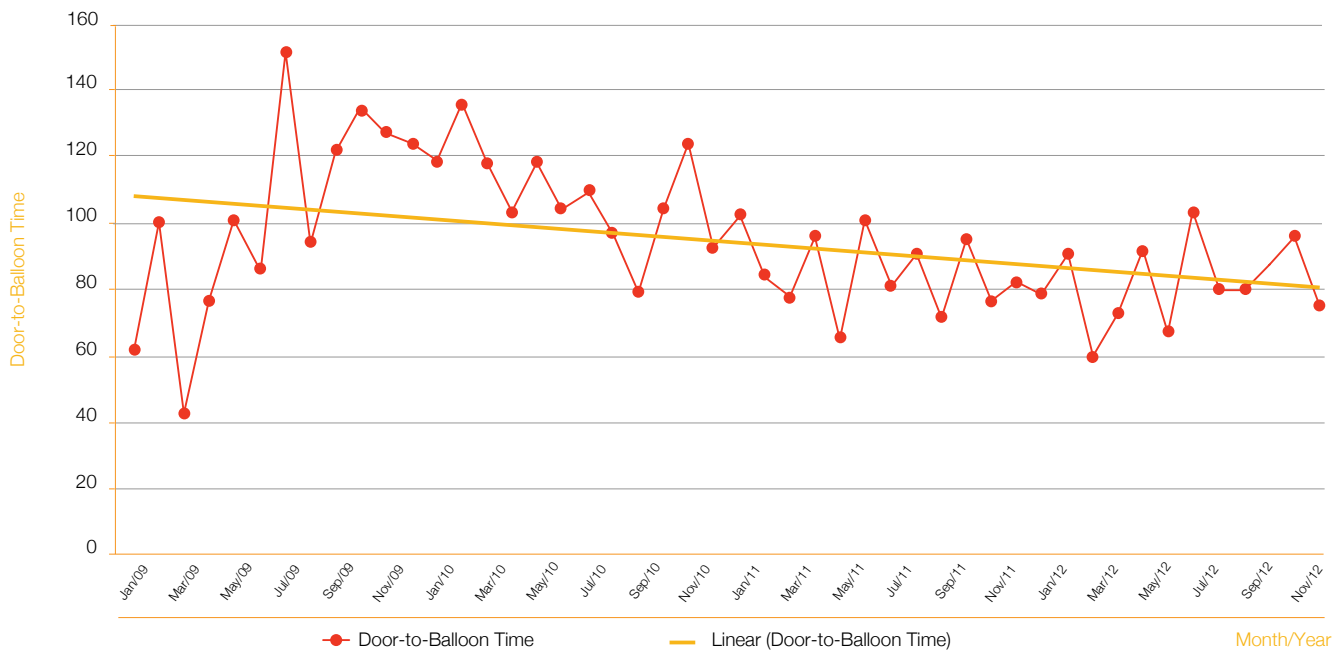
Rate of Compliance with DVT Prophylaxis (surgical cases)

Acute Myocardial Infarction

Indicators have been collected since 2007, but the charts are shown since 2009. In Graph 34 we can see Door-to-Balloon Time (time between patient's arrival at the hospital and performance of the procedure – PTA), which has shown a

decreasing trend, with mean of 83 minutes and median of 75 minutes. These data are within the national and international guidelines of Door-to-Balloon Time of 90 minutes.

Graph 34 – Monthly Distribution of Door-to-Balloon Time (minutes) and Linear Trend

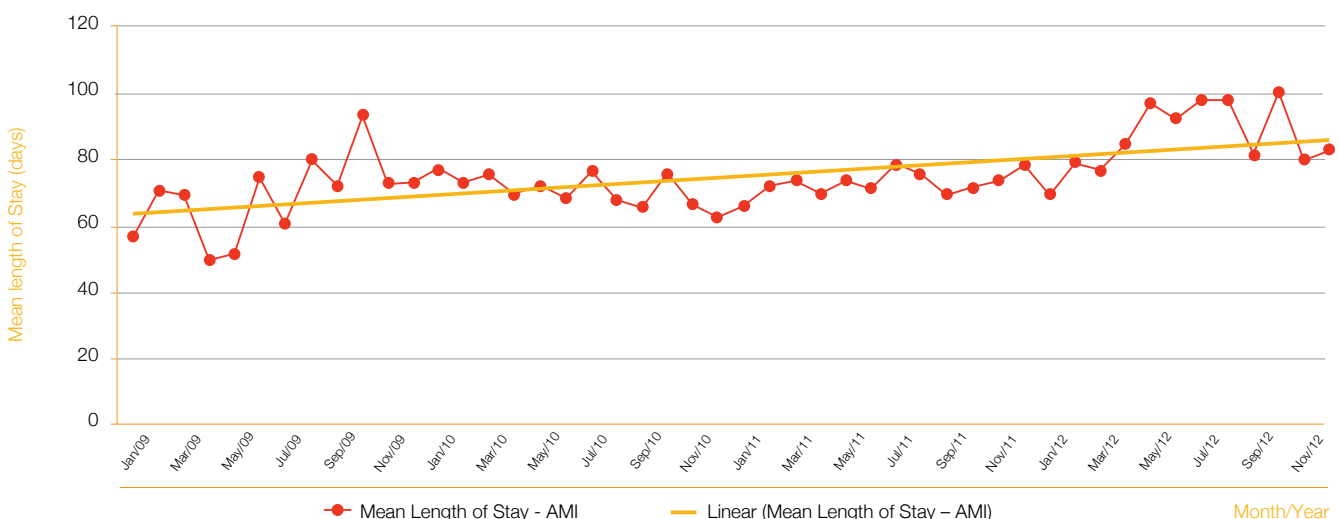


Source: PMPA/Anahp.

For cases of acute myocardial infarction, the recommended mean length of stay is six to eight days. In member hospitals, there has been an increasing linear trend of Length of Stay,

especially in the second half of 2012, ranging from 8 to 10 days (Graph 35 – Table 6). The prevalence of many comorbidities and higher median age have impacted this situation.

Graph 35 – Monthly Distribution of Mean Length of Stay of Patients with AMI and Linear Trend



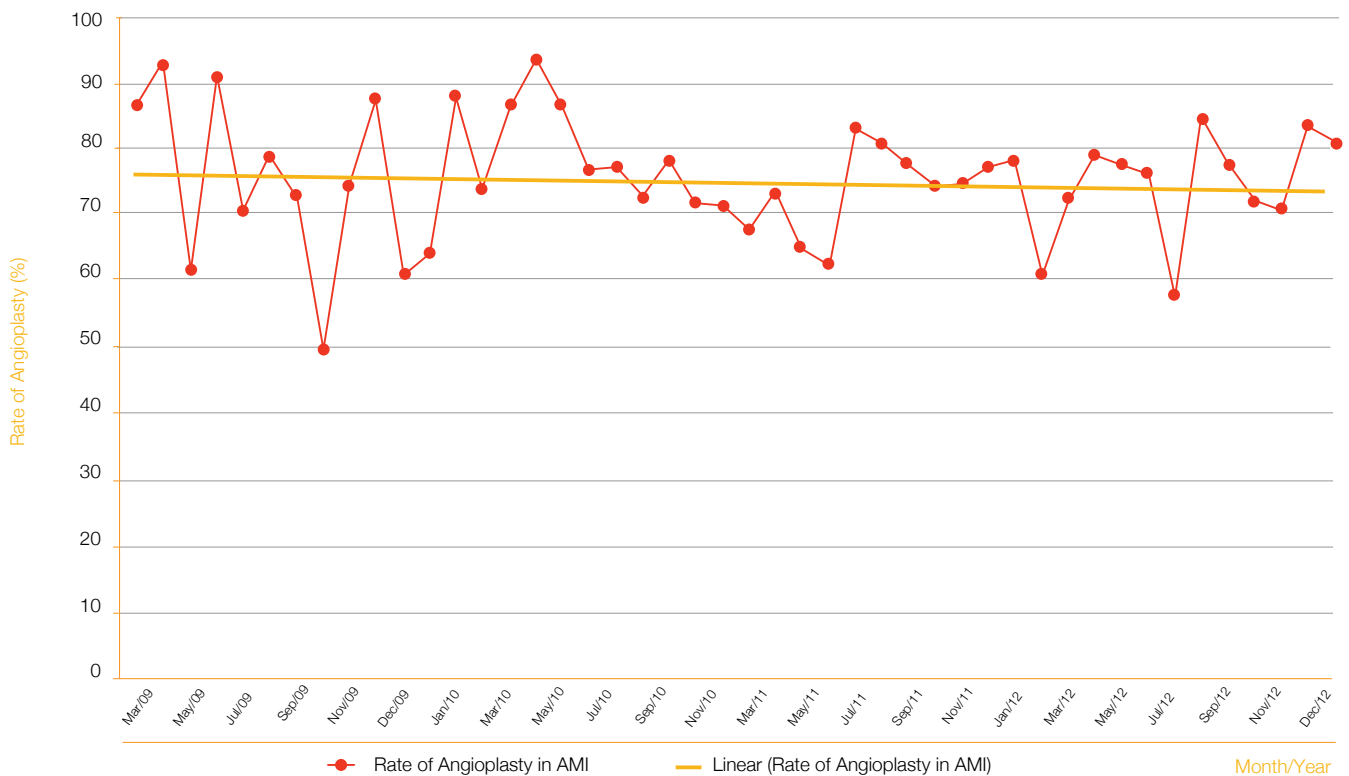
Source: PMPA/Anahp.

Assistance Performance

About one third of the acute myocardial infarction cases presented STEMI, which requires the performance of Primary Angioplasty. The Rate of Primary Angioplasty started to be appropriately collected as of March 2009. The values observed

in 2012 were within the average of 72%, ranging from 56% to 83% throughout the year. The goal is to reach the international standard – 80% to 85% - and reduce further the variability.

Graph 36 – Monthly Distribution of Primary Angioplasty Rate in Patients with AMI with STEMI and Linear Trend



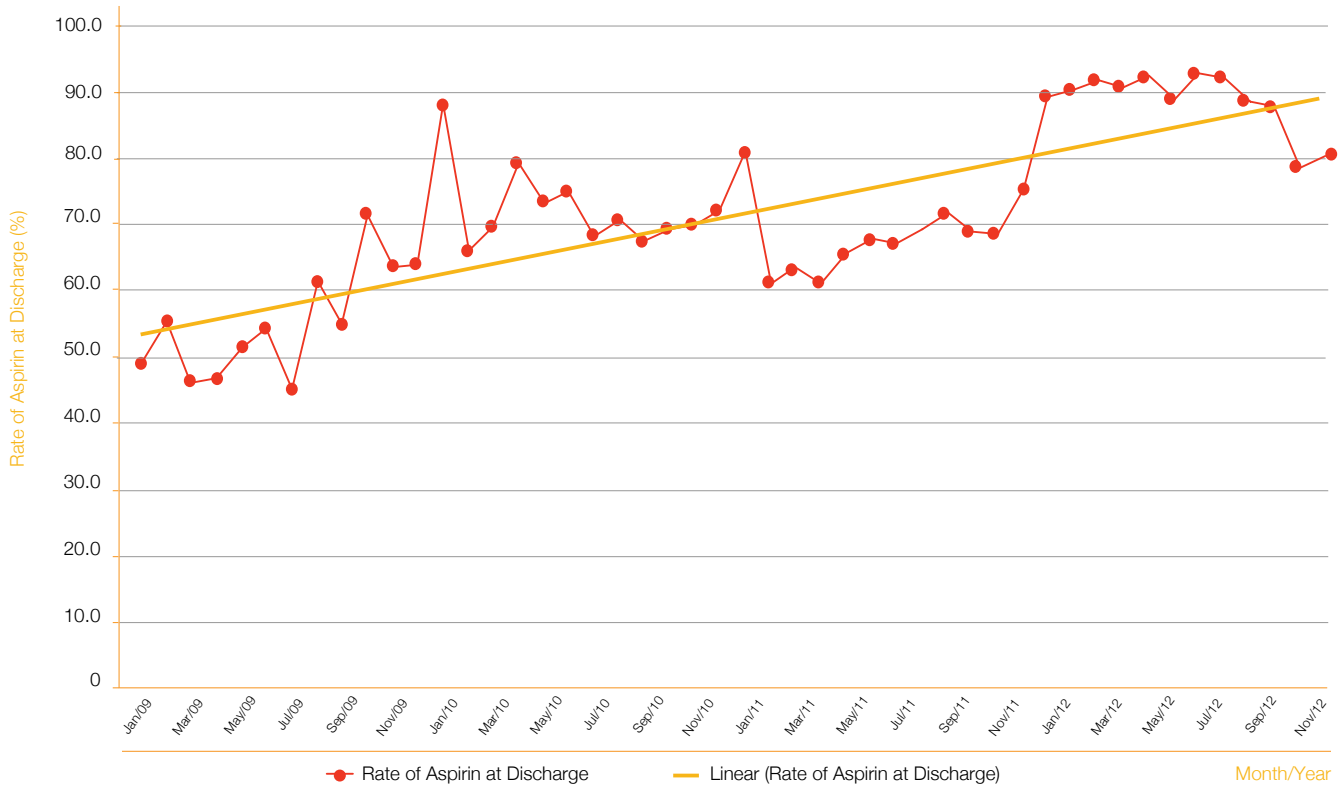
Source: PMPA/Anahp.

Another important indicator to follow up the best practices in acute myocardial infarction care is Rate of Aspirin at Discharge. In the series since 2009, this rate has represented an increasing linear trend (Chart 37 – Table 6). In 2012, the rates ranged from 77% to 92%, mean of 88%. This indicator has shown significant improvement compared to 2011 as a result of investments made, primarily by internationally accredited hospitals, to improve the documentation and collection of this indicator. The Mortality Rate in cases of acute myocardial infarction has presented reduction since 2009, as can be shown in Graph 38.

Months of August, September and October have contributed to reach an annual mean higher than that in 2011.

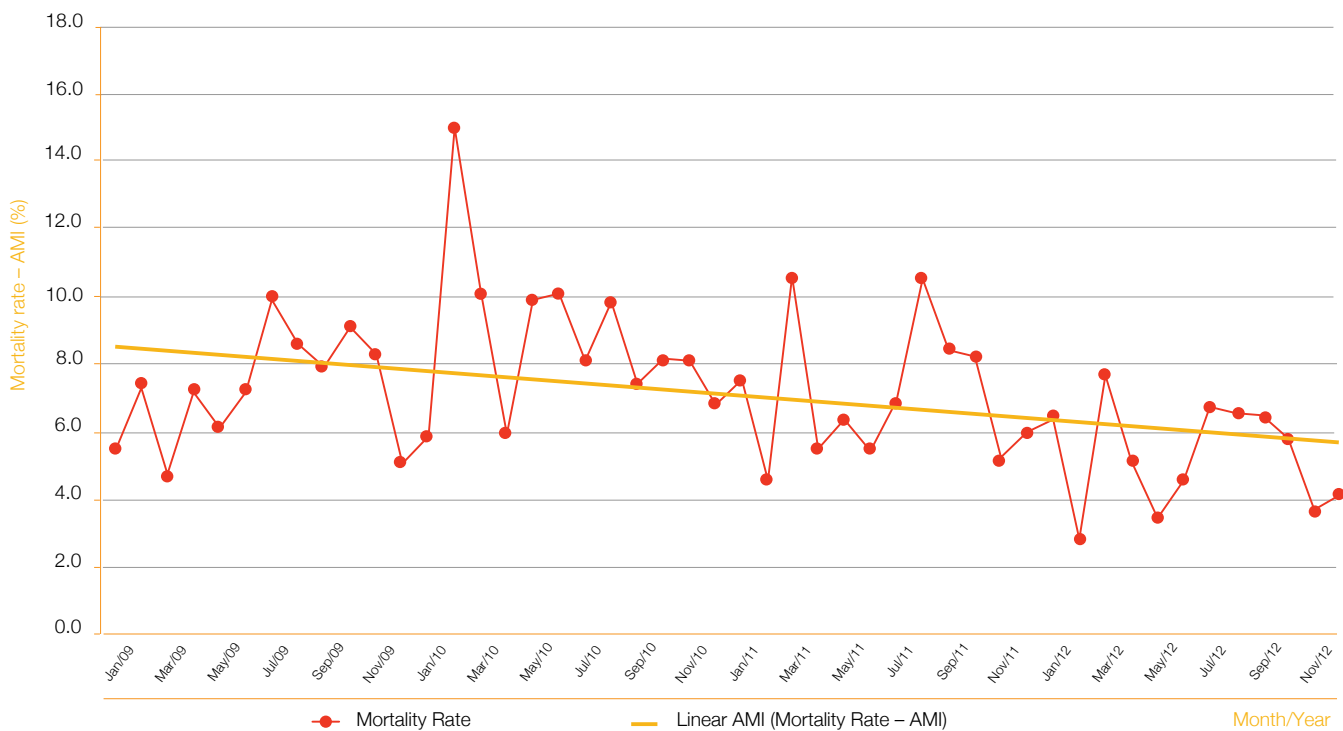
Considering the monitored indicators, we can state that acute myocardial infarction clinical care provided by Anahp hospitals, based on opportunity of treatment and outcomes, is within the standards advocated by the literature. It means enhanced safety and fewer complications to patients, lower social cost and increased savings to the healthcare system.

Graph 37 – Monthly Distribution of Rate of Aspirin at Discharge in Patients with AMI and Linear Trend



Source: PMPA/Anahp.

Graph 38 – Monthly Distribution of Mortality Rate in Patients with AMI and Linear Trend



Source: PMPA/Anahp.

Ischemic Cerebral Vascular Accident

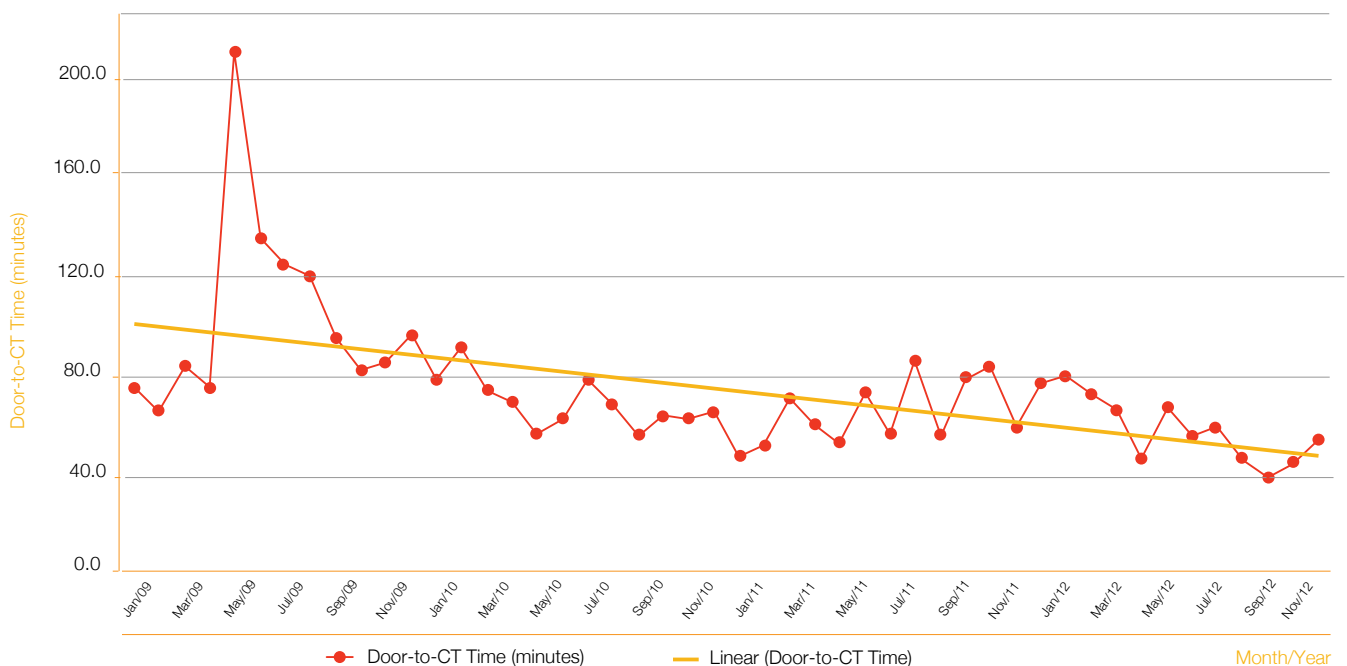
The population prevalence of systemic arterial hypertension, poor compliance to treatment and exposure to known risk factors such as smoking, alcohol abuse, excessive weight, lack of physical activity and stress have contributed to the incidence of ischemic cerebral vascular accidents (strokes). Studies have demonstrated that there is great heterogeneity in case distribution, especially when younger age groups are affected – 45 to 59 years.

Quick treatment after symptom onset and timely diagnosis of this type of case at admission in the emergency department are secondary prevention actions that define prognosis and level of disability when the event occurs. Quality of life of the patient and social impact to the families after discharge of the patient are directly affected by these actions.

The number of hospitals that have this protocol is smaller than the total number of hospitals that have protocols for other Circulatory System Conditions. Eighteen hospitals reported data and indicators about ischemic cerebral vascular accident (ICVA).

Monitoring of Door-to-CT Time impacts progression of the cases. The time interval is measured between arrival – admission in the emergency department and performance of a CT scan. In 2012, we could observe a continuously decreasing trend in this time interval, presenting less variability and mean of 51 minutes for Door-to-CT Time (Graph 39 – Table 6). A portion of the patients (12%) had indication for thrombolysis treatment. For these patients, Door-to-Thrombolysis Time is also monitored, which presented a mean of 62 minutes in 2012.

Graph 39 – Monthly Distribution of Door-to-CT Time in Patients with ICVA and Linear Trend



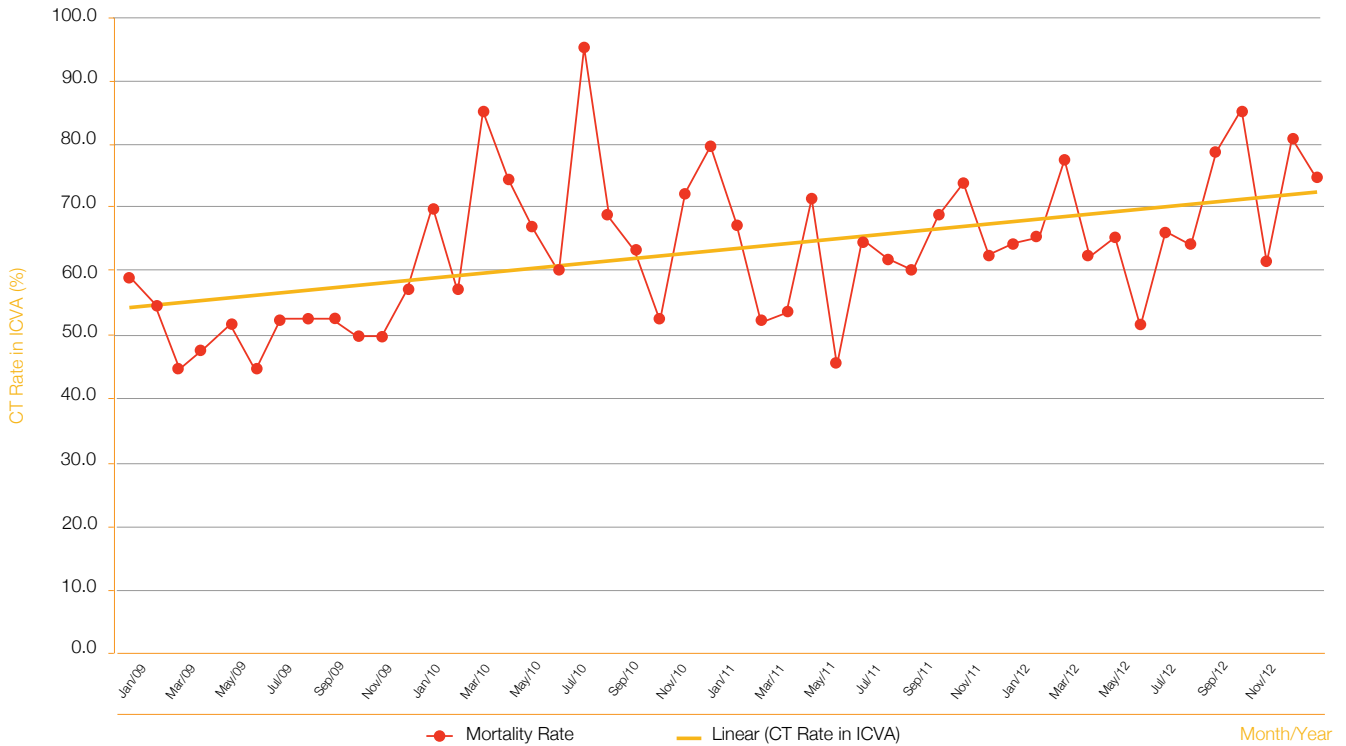
Source: PMPA/Anahp.

For 2012 annual mean, CT Rate was 69%. CT Rate has represented an increasing trend in the series (Graph 40). The results are within the expected range, but less variability is expected with time. The monitoring of this protocol has required increasing investments in standardization of management decisions and improvement in documentation.

The mean length of stay for ICVA has increased considerably in 2012, with variation between 9.0 and 15.2 days during the year (Graph 41 – Table 6). One contributing factor to these results is

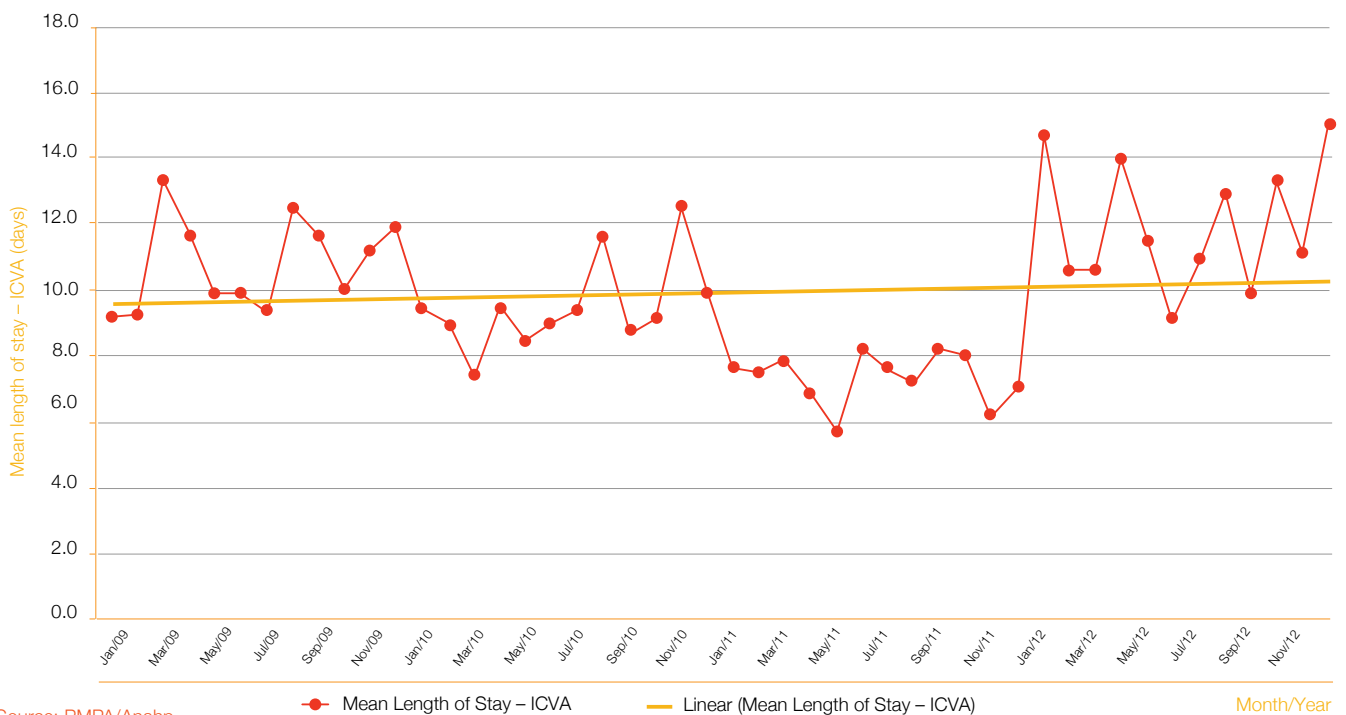
the increased median age of patients, based on the database previously presented. Another aspect to be mentioned is the expansion of access to patients with poor outpatient monitoring, which in general means patients with worse clinical conditions (greater level of decompensation of comorbidities) at admission into the hospital. The role of the healthcare system in appropriately managing cases of hypertension and diabetes is key for appropriate treatment of these cases in the hospital.

Graph 40 – Monthly Distribution of CT Rate in Patients with ICVA and Linear Trend



Source: PMPA/Anahp.

Graph 41 – Monthly Distribution of Mean Length of Stay of Patients with ICVA and Linear Trend

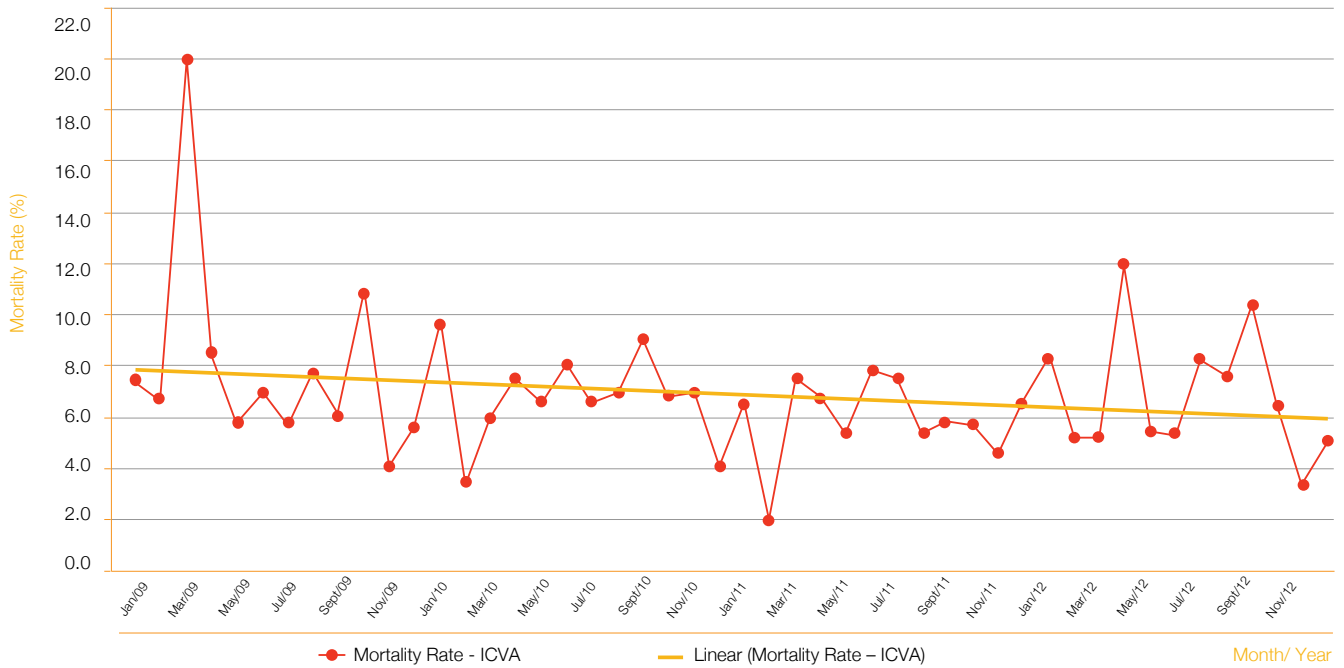


Source: PMPA/Anahp.

There is a trend in reducing Mortality Rates by ischemic cerebral vascular accident. The mean in 2012 was 6.9%, ranging from 3.4% to 12% (Graph 42 – Table 6). The variation in 2012 was

higher, explained by the previous considerations – older age of cases, prevalence of comorbidities and likely worsening of clinical status at admission.

Graph 42 – Monthly Distribution of Mortality Rate in Patients with ICVA and Linear Trend



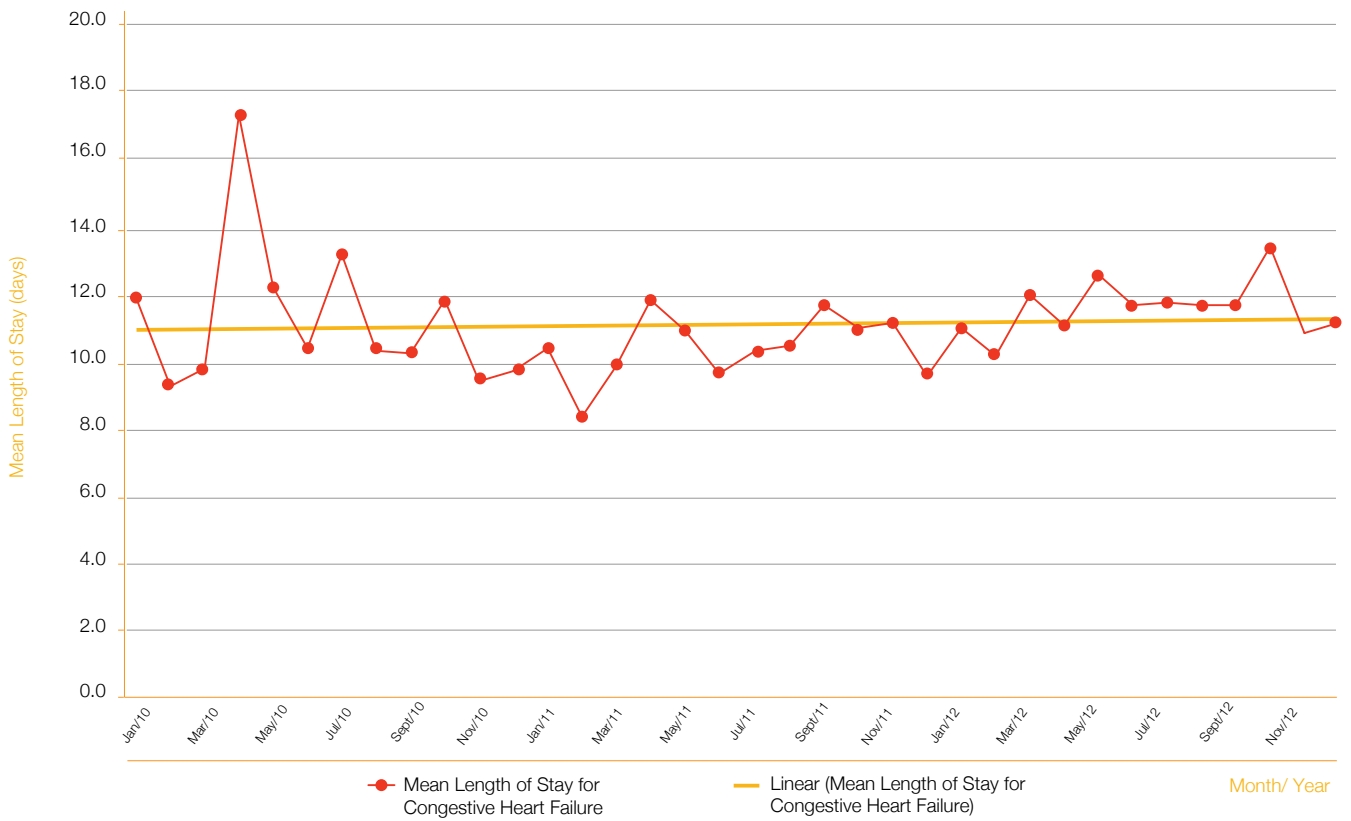
Source: PMPA/Anahp.

Congestive Heart Failure

The Protocol for Congestive Heart Failure (CHF) has been monitored since January 2010. In 2012 there was relevant information about 24 hospitals that have an implemented protocol. The median age of patients included in the protocol was 78 years, two years older than what was observed in 2011. There was a trend to have stable mean length of stay and reduction of mortality rate. The mean length of stay ranged between 10.3 and 11.7 days (Graph 43). Mortality rate in cases of congestive heart failure presented annual mean of 6.2% varying from 4.4 to 10.9 days (Graph 44 – Table 6).

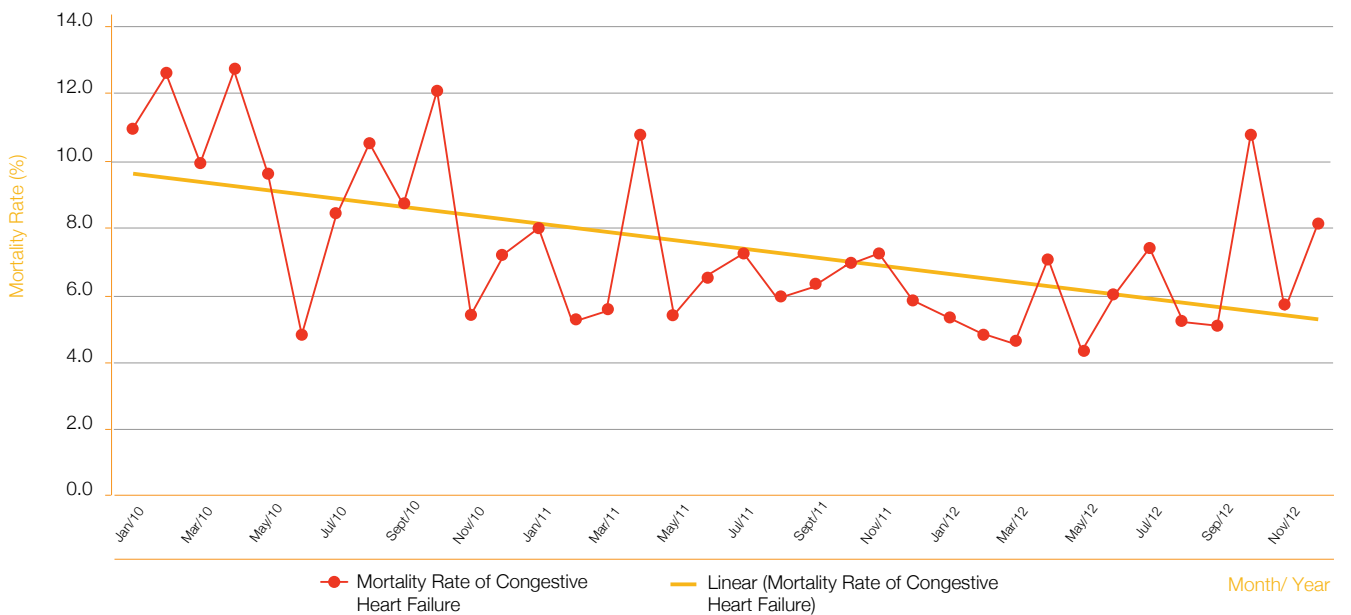
Considering the increase in median age of patients, the minor change in mean length of stay and lower mortality rates have shown indication of improvement in clinical care. For this specific disease, the follow up of readmissions and the use of hospital-day for follow up after discharge are efficient strategies to reduce the risk of new admissions and increase quality of life of the patients.

Graph 43 – Monthly Distribution of Mean Length of Stay for Patients with Congestive Heart Failure and Linear Trend



Source: PMPA/Anahp.

Graph 44 – Monthly Distribution of Mortality Rate in Patients with Congestive Heart Failure (CHF) and Linear Trend



Source: PMPA/Anahp.

As of 2012, the following rates were also monitored in the protocol – Rate of Betablockers at Discharge and Rate of Angiotensin Converting Enzyme Inhibitor (ACEI) or Angiotensin Renin Blocker (ARB) at Discharge. A small amount of cases have contraindication for use of these medications at discharge. The number of hospitals that collected the indicator in 2012 is still restricted, but it has expanded throughout the year, reason why the results will be communicated only in the next edition of Observatorio.

Community-Acquired Pneumonia

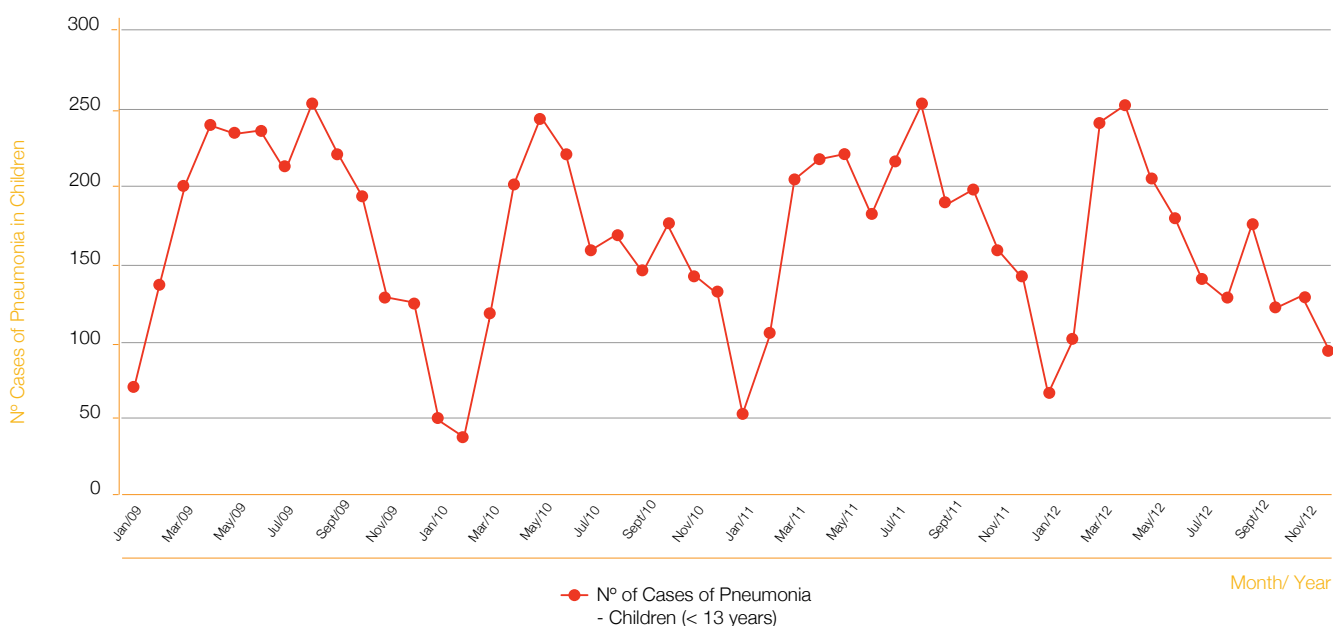
Community-acquired pneumonia has an increasingly important role as cause of mortality, especially over the age range of 60 years. Lethality has grown in recent years, especially in younger age ranges of the population. Inappropriate antibiotic prescription, late diagnosis – either because of delay in coming to the healthcare center or because of inappropriate diagnosis

at first, poor compliance to treatment and duration of treatment course have contributed to the increased lethality in these cases. It is important to point out that mismanagement of the cases increases the risk of progression into sepsis, a severe clinical syndrome with high mortality rate. The main risk groups for community-acquired pneumonia that may evolve into more severe cases are children with respiratory underlying diseases (such as asthma and bronchitis) and the elderly.

The project monitors the protocol for children and adults, focusing primarily on people over 60 years. Among the adults, most groups are formed by people over the age of 60 years.

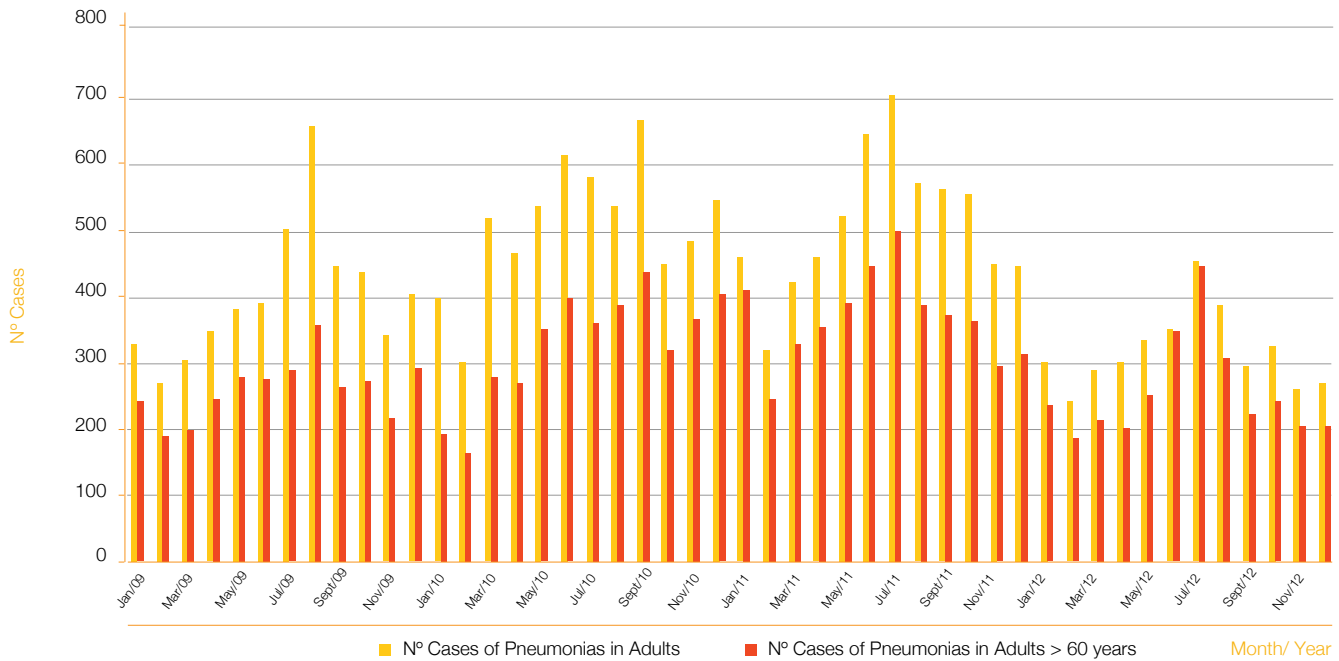
The cases of community-acquired pneumonia have seasonal variation and occur more frequently in winter. For children, the distribution is more characteristic (Graph 45). In adults, where cases are concentrated in the age range over 60 years, the pattern is also seasonal (Graph 46).

Graph 45 – Monthly Distribution of Community-Acquired Pneumonia Cases in Children (patients < 13 years)



Source: PMPA/Anahp.

Graph 46 – Monthly Distribution of Community-Acquired Pneumonia Cases in Adults and Subjects over 60 Years of Age

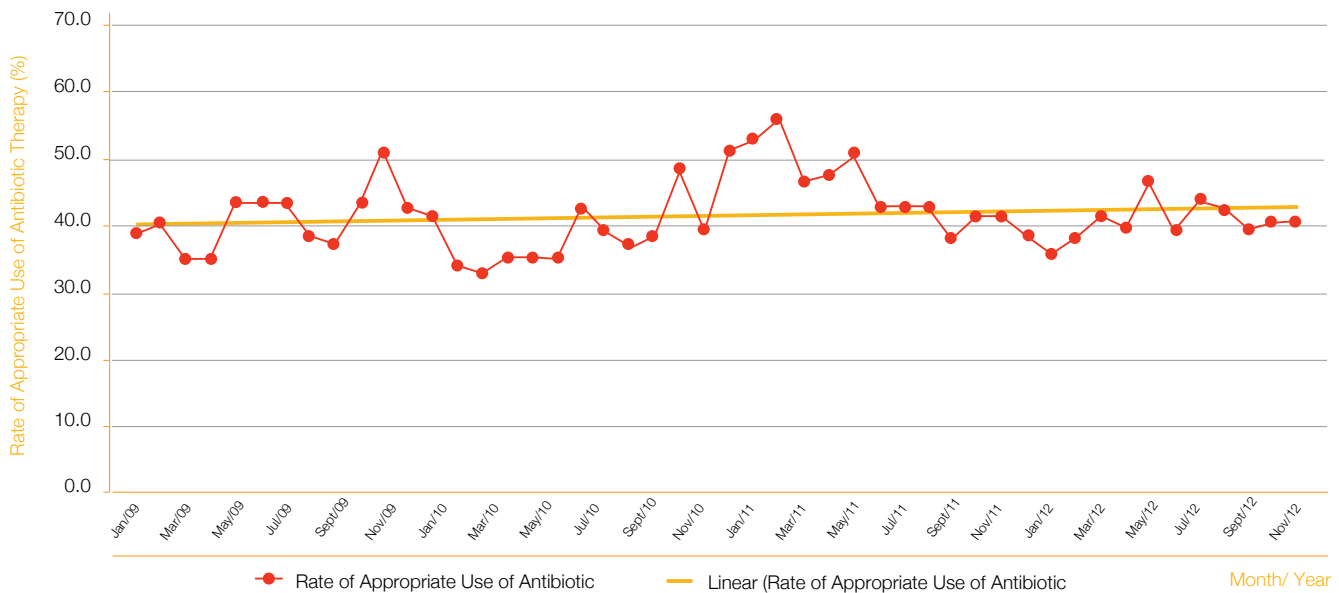


Source: PMPA/Anahp.

The Rate of Appropriate Use of Antibiotic Therapy (time, regimen and duration of treatment) to treat cases of Community-acquired pneumonia in adults, as provided by the protocol, has

improved in the analyzed series (Graph 47 – Table 6). The rate of compliance to what is recommended has been addressed by the hospitals, but it still needs improving.

Graph 47 – Monthly Distribution of Appropriate Use of Antibiotic Therapy Rate in Patients with Adult Community-Acquired Pneumonia and Linear Trend



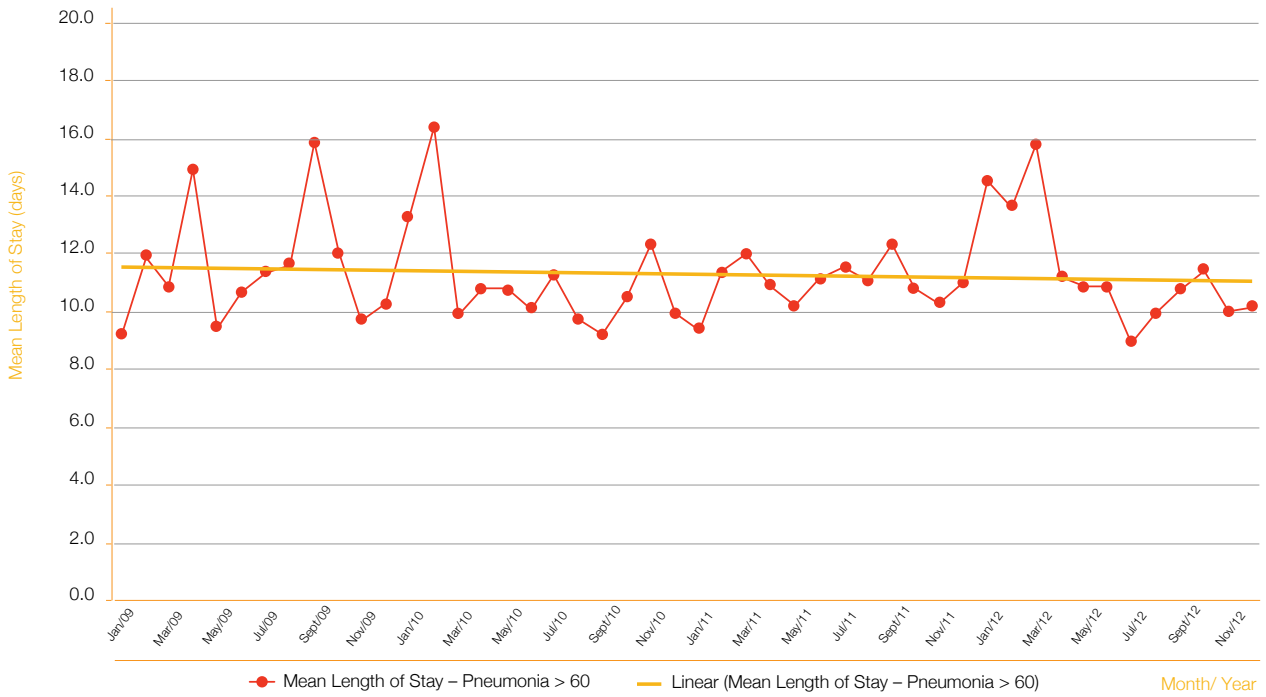
Source: PMPA/Anahp.

Assistance Performance

In cases of pneumonia in patients over 60 years, the mean length of stay had significant impact. Throughout the follow up

time, the trend was to reach stabilization of mean length of stay of about 11 days (Graph 48 – Table 6).

Graph 48 – Monthly Distribution of Mean Length of Stay of Patients with Community-Acquired Pneumonia Over 60 Years and Linear Trend

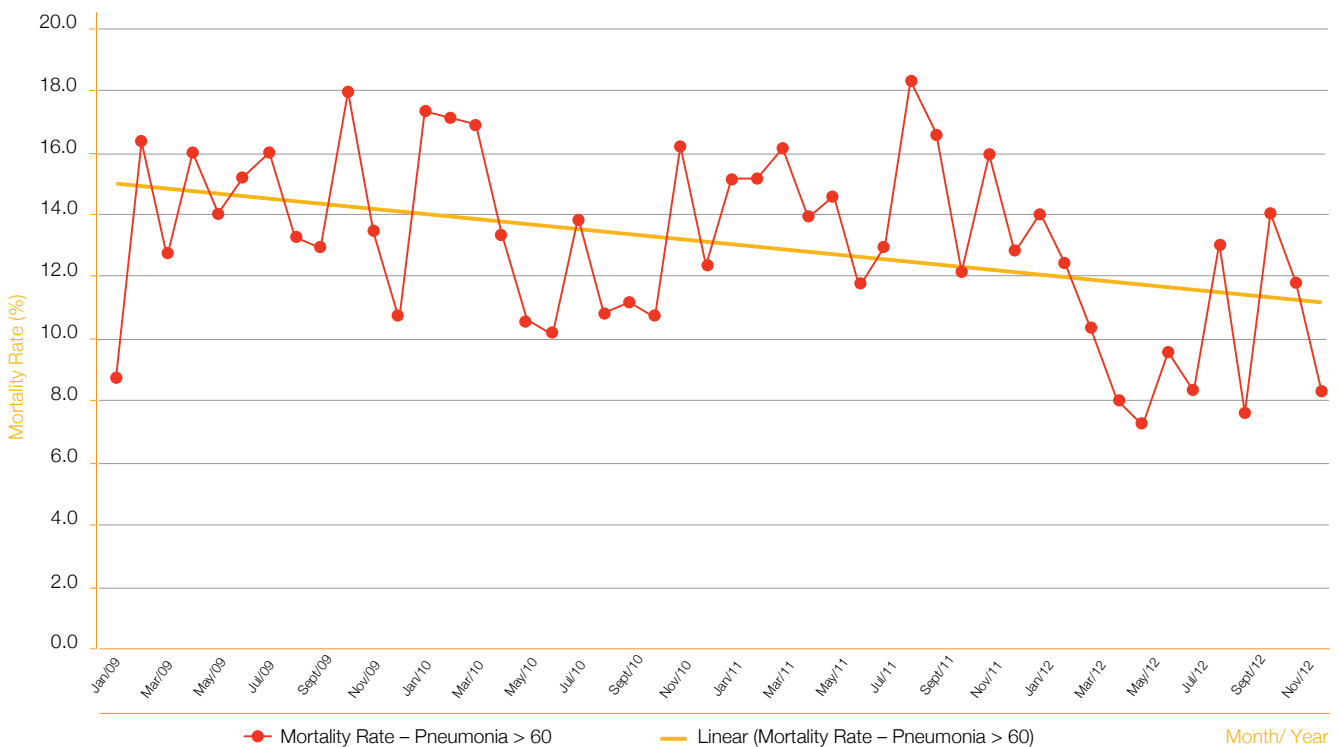


Source: PMPA/Anahp.

The Rate of Mortality associated with Community-Acquired Pneumonia in adults presented mean of 8.3% in 2012. In cases of people over 60 years, the observed Mortality Rate was on average 10.3% (Graph 49). There has been a reduction in Mortality Rate throughout the analyzed period, with significant

improvement in 2012. It may reflect the emphasis that hospitals have placed on improving elderly patient management and prevention of complications, as well as investments to increase the coordinated action in such cases.

Graph 49 – Monthly Distribution of Mortality Rate in Patients Over 60 Years with Community-Acquired Pneumonia and Linear Trend



Source: PMPA/Anahp.

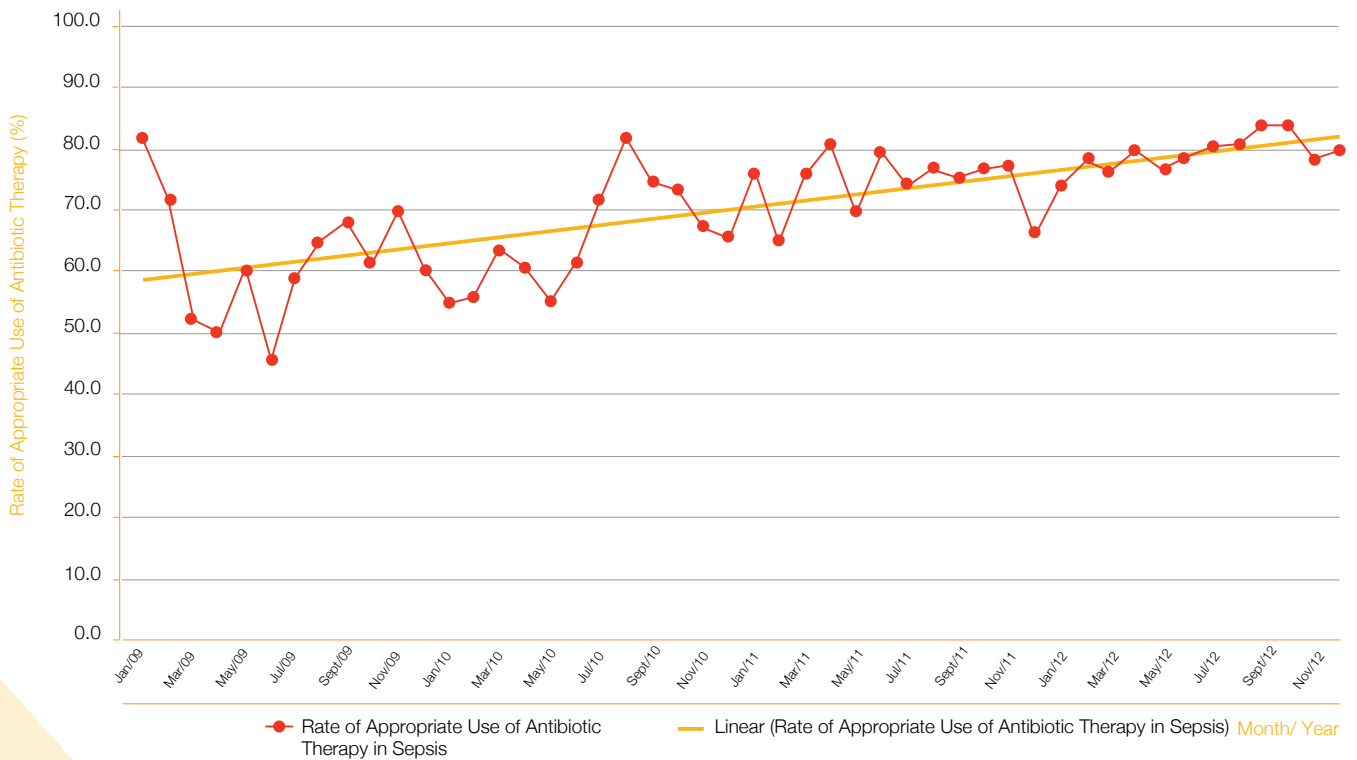
Community Sepsis

Monitoring of indicators related with institutional protocol of sepsis acquired in the community was followed by 22 hospitals in 2012. The mean length of stay in the analyzed series ranged from 14 to 33 days, requiring critical hospital resources. However, the number of documented cases went down

between 2011 and 2012.

The rate of appropriate antibiotic therapy to treat Community Sepsis presented a linear trend of increased compliance. In 2012, the mean was 80.3% with year variation of 67% to 85% (Graph 50 – Table 6).

Graph 50 – Monthly Distribution of Rate of Appropriate Use of Antibiotic Therapy in Patients with Sepsis and Linear Trend

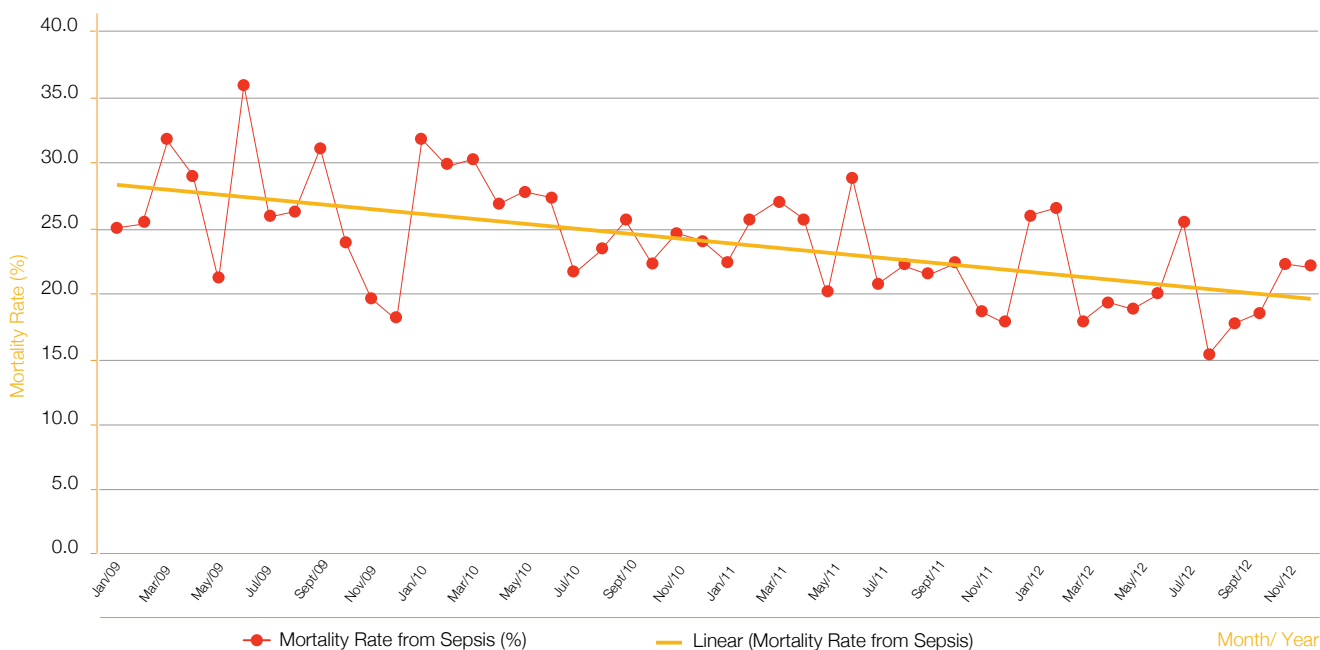


Source: PMPA/Anahp.

In Graph 51, we can see the trend to reduce Mortality Rates from this disease, with mean of 20.4% in 2012. In the case of sepsis, increased compliance to correct antibiotic therapy and

significant reduction of Mortality Rates have evidenced most precise care and best outcomes at Anahp member hospitals.

Graph 51 – Monthly Distribution of Mortality Rate in Patients with Sepsis and Linear Trend



Source: PMPA/Anahp.

Surgical Procedures and Deep Venous Thrombosis Prophylaxis

In 2012, a new indicator started to be collected for elective surgical procedures – Compliance Rate to Deep Venous Thrombosis Prophylaxis in surgical cases. Seventeen hospitals provided results, mean of 57.9% for 2012, ranging from 51% to 82% throughout the year (Table 6).

Since 2007, mean length of stay in hours was monitored for videolaparoscopic cholecystectomy and inguinal herniorrhaphy. Concerning abdominal hysterectomy, mean length of stay in days was also monitored.

The mean length of stay for videolaparoscopic cholecystectomy

has varied in the historic series, with mean of 34.3 hours for the procedure in 2012. For herniorrhaphy, we observed an increase from 2011 to 2012, going up to 32.9 hours. Since 2010, there has been a change in pattern of care, with increase on Length of Stay, which is related with the attempt to avoid postoperative pain (Table 6).

For abdominal hysterectomy, there has been no change in number of reporting hospitals, but a reduction by 20% in number of procedures performed in the year, compared to 2011. The mean length of stay was maintained stable at 2.5 days.

Table 5 – Management and Clinical Quality Data

| Operational and Clinical Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-----------|-----------|-----------|-----------|-----------|
| N° of installed beds | 5,513 | 6,272 | 6,453 | 7,632 | 9,576 |
| N° of operational bed | 5,047 | 6,040 | 6,144 | 7,263 | 9,071 |
| Operational beds-day | 1,824,735 | 2,187,619 | 2,234,514 | 2,635,500 | 3,309,167 |
| N° of operating rooms | 286 | 331 | 334 | 377 | 462 |
| N° of patients-day | 1,387,365 | 1,675,829 | 1,716,441 | 2,073,827 | 2,598,324 |
| N° of hospital discharges (discharge + death + external transfer) | 323,830 | 396,564 | 408,308 | 466,639 | 571,630 |
| N° of patients with stay (>= 90 days) | 95 | 129 | 177 | 250 | 344 |
| N° of deaths >= 24 hours | 5,054 | 6,121 | 6,259 | 7,818 | 10,103 |
| N° of total deaths | 6,426 | 7,927 | 7,594 | 9,226 | 12,098 |
| N° of patients undergoing surgical procedures | 215,608 | 258,941 | 264,371 | 331,545 | 387,850 |
| N° of total surgeries | ND | ND | 300,105 | 419,355 | 511,442 |
| N° of surgical deaths | 525 | 657 | 552 | 800 | 1,148 |
| N° of clean surgeries | ND | ND | 144,891 | 142,119 | 185,417 |
| N° of surgical site infections | ND | ND | 759 | 851 | 1,165 |
| N° of operational beds – Adult ICU | ND | ND | ND | 982 | 1,312 |
| N° of operational beds-day – Adult ICU | ND | ND | ND | 352,028 | 477,737 |
| N° of hospital infections – Adult ICU | 3,576 | 4,296 | 3,558 | 3,665 | 4,370 |
| N° of central venous catheter-associated hospital infections – Adult ICU | 582 | 660 | 590 | 518 | 721 |
| N° of patients-day – Adult ICU | 174,433 | 223,795 | 212,063 | 294,250 | 381,747 |
| N° of catheter-day – Adult ICU | 101,223 | 134,285 | 125,427 | 158,612 | 215,950 |
| N° of operational beds – Neonatal ICU | ND | ND | ND | 332 | 436 |
| N° of operational beds-day – Neonatal ICU | ND | ND | ND | 115,866 | 158,099 |
| N° of hospital infections – Neonatal ICU | ND | ND | 909 | 816 | 1,018 |
| N° of central venous catheter-associated hospital infections – Neonatal ICU | ND | ND | ND | ND | 246 |
| N° of patients-day – Neonatal ICU | ND | ND | 77,869 | 90,515 | 104,150 |
| N° of catheter-day – Neonatal ICU | ND | ND | ND | 25,637 | 31,927 |
| N° of operational beds – Adult Step-Down Unit | ND | ND | ND | ND | 294,4 |
| N° of operational beds-day – Adult Step-Down Unit | ND | ND | ND | ND | 107,203 |
| N° of hospital infections – Step-Down Unit | ND | ND | ND | ND | 397 |
| N° of central venous catheter-associated hospital infections – Step-Down Unit | ND | ND | ND | ND | 38 |
| N° of patients-day – Step-Down Unit | ND | ND | ND | ND | 88,287 |
| N° of catheter-day – Step-Down Unit | ND | ND | ND | ND | 22,492 |

| | 2012 | | | | | | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|-----------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Annual |
| | 9,362 | 9,420 | 9,486 | 9,496 | 9,510 | 9,527 | 9,531 | 9,535 | 9,581 | 9,551 | 9,584 | 9,527 | 9,509 |
| | 9,000 | 9,102 | 9,148 | 9,163 | 9,179 | 9,221 | 9,231 | 9,236 | 9,275 | 9,308 | 9,340 | 9,192 | 9,200 |
| | 280,727 | 268,713 | 287,317 | 278,416 | 288,403 | 280,376 | 290,228 | 289,838 | 282,821 | 293,131 | 282,178 | 286,272 | 3,408,420 |
| | 445 | 445 | 444 | 444 | 449 | 444 | 447 | 447 | 447 | 446 | 451 | 447 | 446 |
| | 202,239 | 201,278 | 229,913 | 217,802 | 226,866 | 220,043 | 232,603 | 231,372 | 224,947 | 230,929 | 214,732 | 208,775 | 2,641,499 |
| | 43,849 | 43,925 | 52,204 | 48,388 | 49,177 | 48,598 | 51,505 | 52,544 | 48,995 | 50,924 | 48,835 | 47,826 | 586,770 |
| | 340 | 325 | 342 | 333 | 355 | 345 | 363 | 382 | 370 | 360 | 409 | 399 | 360 |
| | 845 | 795 | 816 | 814 | 819 | 869 | 1,015 | 971 | 909 | 927 | 892 | 896 | 10,568 |
| | 951 | 912 | 930 | 932 | 957 | 1,003 | 1,151 | 1,078 | 1,065 | 1,013 | 997 | 1,018 | 12,007 |
| | 30,855 | 27,927 | 33,616 | 30,951 | 32,337 | 32,588 | 35,743 | 35,645 | 31,217 | 33,572 | 31,372 | 27,002 | 382,825 |
| | 40,052 | 35,592 | 43,221 | 40,157 | 41,545 | 41,158 | 46,346 | 46,043 | 40,241 | 44,094 | 40,862 | 33,876 | 493,187 |
| | 92 | 97 | 82 | 82 | 80 | 85 | 101 | 104 | 96 | 95 | 73 | 74 | 1,061 |
| | 13,146 | 13,220 | 14,207 | 13,113 | 13,679 | 13,091 | 15,075 | 17,163 | 14,342 | 15,898 | 14,349 | 12,141 | 169,424 |
| | 72 | 75 | 97 | 92 | 83 | 88 | 99 | 98 | 79 | 72 | 74 | 57 | 986 |
| | 1,330 | 1,332 | 1,338 | 1,342 | 1,350 | 1,374 | 1,391 | 1,403 | 1,431 | 1,436 | 1,439 | 1,425 | 1,383 |
| | 40,590 | 38,222 | 40,765 | 39,640 | 41,435 | 40,856 | 42,730 | 43,090 | 42,615 | 42,621 | 41,475 | 42,115 | 496,154 |
| | 355 | 348 | 363 | 325 | 321 | 327 | 366 | 364 | 362 | 341 | 296 | 308 | 4,076 |
| | 43 | 61 | 54 | 57 | 49 | 50 | 47 | 46 | 53 | 53 | 45 | 52 | 610 |
| | 28,088 | 27,095 | 29,801 | 28,990 | 31,172 | 30,742 | 32,941 | 32,453 | 31,397 | 30,574 | 29,716 | 28,289 | 361,258 |
| | 15,952 | 15,687 | 17,084 | 16,291 | 17,953 | 17,497 | 19,108 | 18,542 | 17,994 | 17,555 | 16,436 | 15,784 | 205,883 |
| | 353 | 357 | 365 | 365 | 366 | 372 | 363 | 360 | 361 | 359 | 355 | 354 | 361 |
| | 10,628 | 10,023 | 10,834 | 10,568 | 11,021 | 10,509 | 10,442 | 10,458 | 10,006 | 10,540 | 10,030 | 10,278 | 125,337 |
| | 51 | 59 | 48 | 41 | 45 | 42 | 43 | 36 | 45 | 57 | 46 | 42 | 555 |
| | 12 | 6 | 7 | 6 | 5 | 10 | 6 | 5 | 4 | 13 | 1 | 9 | 84 |
| | 7,133 | 7,277 | 8,222 | 7,833 | 7,509 | 7,484 | 7,557 | 7,108 | 7,633 | 7,350 | 7,531 | 7,608 | 90,245 |
| | 1,953 | 2,263 | 2,306 | 1,871 | 1,595 | 1,715 | 1,808 | 1,514 | 1,875 | 1,959 | 1,886 | 2,014 | 22,759 |
| | 324 | 329 | 329 | 319 | 306 | 306 | 317 | 312 | 320 | 326 | 326 | 333 | 321 |
| | 9,794 | 9,440 | 10,077 | 9,454 | 9,360 | 9,047 | 9,733 | 9,804 | 9,559 | 9,215 | 8,958 | 9,449 | 113,890 |
| | 39 | 43 | 33 | 31 | 26 | 47 | 39 | 39 | 29 | 21 | 15 | 25 | 387 |
| | 6 | 3 | 4 | 5 | 2 | 2 | 2 | 2 | 0 | 3 | 2 | 2 | 33 |
| | 8,316 | 8,314 | 8,762 | 8,338 | 8,620 | 8,106 | 8,475 | 8,656 | 8,366 | 8,150 | 7,484 | 7,844 | 99,431 |
| | 1,907 | 2,440 | 2,363 | 2,385 | 2,309 | 2,566 | 2,632 | 2,447 | 2,523 | 2,111 | 1,936 | 2,164 | 27,783 |

Table 5a – Management and Clinical Quality Indicators

| Operational and Clinical Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|------|------|------|------|------|
| Occupancy rate | 76.0 | 76.6 | 76.8 | 78.7 | 78.5 |
| Mean length of stay | 4.3 | 4.2 | 4.2 | 4.4 | 4.5 |
| Turnover rate | 5.3 | 5.5 | 5.5 | 5.4 | 5.3 |
| Bet turnover interval | 1.36 | 1.30 | 1.28 | 1.20 | 1.24 |
| Rate of resident patients at the hospital (> 90 days) | 0.4 | 0.4 | 0.5 | 0.6 | 0.7 |
| Rate of general hospital mortality (>= 24 h) | 1.6 | 1.5 | 1.5 | 1.7 | 1.8 |
| Rate of operative mortality (up to 7 days after the surgical procedure) | 0.2 | 0.3 | 0.2 | 0.2 | 0.3 |
| Operational occupancy rate adult ICU | ND | ND | ND | 83.6 | 79.9 |
| Density rate of hospital infections – adult ICU | 20.6 | 19.1 | 16.7 | 12.5 | 11.4 |
| Utilization rate of central venous catheter – adult ICU | 58.0 | 60.1 | 59.1 | 53.9 | 56.6 |
| Density rate of central venous catheter-associated hospital infection in the adult ICU | 5.7 | 4.9 | 4.7 | 3.3 | 3.3 |
| Observed/ expected mortality ratio in the adult ICU | ND | ND | ND | ND | 0.63 |
| Operational occupancy rate in the neonatal ICU | ND | ND | ND | 78.1 | 65.9 |
| Density rate of hospital infections – neonatal ICU | ND | ND | 11.8 | 9.0 | 9.8 |
| Utilization rate of central venous catheter – neonatal ICU | ND | ND | ND | 28.3 | 31 |
| Density rate of central venous catheter-associated hospital infection in the neonatal ICU | ND | ND | ND | 1.9 | 7.7 |
| Operational occupancy rate in the step-down unit | ND | ND | ND | ND | 82 |
| Density rate of hospital infections – step-down unit | ND | ND | ND | ND | 4.5 |
| Utilization rate of central venous catheter – step-down unit | ND | ND | ND | ND | 25.5 |
| Density rate of central venous catheter-associated hospital infection in the step-down unit | ND | ND | ND | ND | 1.69 |
| Surgical site infection rate | ND | ND | 0.5 | 0.6 | 0.6 |
| Rate of compliance to prophylactic antibiotic therapy | ND | ND | ND | ND | 80.1 |
| Pressure ulcer rate (per 1,000 patient-day) | ND | ND | ND | 1.1 | 0.91 |
| Rate of surgery per patient | ND | ND | 1.13 | 1.26 | 1.32 |
| Rate of procedures per discharge (%) | 67 | 65 | 64.7 | 71.0 | 67.8 |
| Rate of surgical site marking | ND | ND | ND | ND | ND |
| Rate of compliance to patient chart completeness | ND | ND | ND | ND | ND |

| | 2012 | | | | | | | | | | | | |
|--|------|------|------|------|------|------|------|------|------|------|------|------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Annual |
| | 72.0 | 74.9 | 80.0 | 78.2 | 78.7 | 78.5 | 80.1 | 79.8 | 79.5 | 78.8 | 76.1 | 72.9 | 77.5 |
| | 4.6 | 4.6 | 4.4 | 4.5 | 4.6 | 4.5 | 4.5 | 4.4 | 4.6 | 4.5 | 4.4 | 4.4 | 4.5 |
| | 4.9 | 4.8 | 5.7 | 5.3 | 5.4 | 5.3 | 5.6 | 5.7 | 5.3 | 5.5 | 5.2 | 5.2 | 5.3 |
| | 1.79 | 1.54 | 1.10 | 1.25 | 1.25 | 1.24 | 1.12 | 1.11 | 1.18 | 1.22 | 1.38 | 1.62 | 1.31 |
| | 0.8 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.8 | 0.7 | 0.8 | 0.8 | 0.7 |
| | 1.9 | 1.8 | 1.6 | 1.7 | 1.7 | 1.8 | 2.0 | 1.8 | 1.9 | 1.8 | 1.8 | 1.9 | 1.8 |
| | 0.3 | 0.3 | 0.2 | 0.3 | 0.2 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.2 | 0.3 | 0.3 |
| | 69.2 | 70.9 | 73.1 | 73.1 | 75.2 | 75.2 | 77.1 | 75.3 | 73.7 | 71.7 | 71.6 | 67.2 | 72.8 |
| | 12.6 | 12.8 | 12.2 | 11.2 | 10.3 | 10.6 | 11.1 | 11.2 | 11.5 | 11.2 | 10.0 | 10.9 | 11.3 |
| | 56.8 | 57.9 | 57.3 | 56.2 | 57.6 | 56.9 | 58.0 | 57.1 | 57.3 | 57.4 | 55.3 | 55.8 | 57.0 |
| | 2.7 | 3.9 | 3.2 | 3.5 | 2.7 | 2.9 | 2.5 | 2.5 | 2.9 | 3.0 | 2.7 | 3.3 | 3.0 |
| | 0.67 | 0.74 | 0.86 | 0.63 | 0.60 | 0.60 | 0.65 | 0.55 | 0.62 | 0.51 | 0.55 | 0.66 | 0.64 |
| | 67.1 | 72.6 | 75.9 | 74.1 | 68.1 | 71.2 | 72.4 | 68.0 | 76.3 | 69.7 | 75.1 | 74.0 | 72.0 |
| | 7.1 | 8.1 | 5.8 | 5.2 | 6.0 | 5.6 | 5.7 | 5.1 | 5.9 | 7.8 | 6.1 | 5.5 | 6.2 |
| | 27.4 | 31.1 | 28.0 | 23.9 | 21.2 | 22.9 | 23.9 | 21.3 | 24.6 | 26.7 | 25.0 | 26.5 | 25.2 |
| | 6.1 | 2.7 | 3.0 | 3.2 | 3.1 | 5.8 | 3.3 | 3.3 | 2.1 | 6.6 | 0.5 | 4.5 | 3.7 |
| | 84.9 | 88.1 | 87.0 | 88.2 | 92.1 | 89.6 | 87.1 | 88.3 | 87.5 | 88.4 | 83.5 | 83.0 | 87.3 |
| | 4.7 | 5.2 | 3.8 | 3.7 | 3.0 | 5.8 | 4.6 | 4.5 | 3.5 | 2.6 | 2.0 | 3.2 | 3.9 |
| | 22.9 | 29.3 | 27.0 | 28.6 | 26.8 | 31.7 | 31.1 | 28.3 | 30.2 | 25.9 | 25.9 | 27.6 | 27.9 |
| | 3.1 | 1.2 | 1.7 | 2.1 | 0.9 | 0.8 | 0.8 | 0.8 | 0.0 | 1.4 | 1.0 | 0.9 | 1.2 |
| | 0.5 | 0.6 | 0.7 | 0.7 | 0.6 | 0.7 | 0.7 | 0.6 | 0.6 | 0.5 | 0.5 | 0.5 | 0.6 |
| | 82.5 | 81.7 | 81.5 | 83.8 | 84.5 | 80.7 | 81.7 | 80.8 | 80.6 | 83.2 | 80.9 | 82.0 | 82.0 |
| | 1.1 | 1.0 | 0.9 | 0.9 | 1.1 | 1.1 | 1.2 | 1.1 | 1.1 | 1.1 | 0.9 | 0.8 | 1.0 |
| | 1.30 | 1.27 | 1.29 | 1.30 | 1.28 | 1.26 | 1.30 | 1.29 | 1.29 | 1.31 | 1.30 | 1.25 | 1.29 |
| | 70.4 | 63.6 | 64.4 | 64.0 | 65.8 | 67.1 | 69.4 | 67.8 | 63.7 | 65.9 | 64.2 | 56.5 | 67.8 |
| | 92.1 | 85.7 | 90.0 | 93.4 | 93.6 | 90.3 | 91.0 | 90.8 | 97.0 | 91.4 | 92.6 | 96.6 | 92.0 |
| | 88.6 | 91.0 | 91.6 | 91.3 | 91.1 | 87.1 | 88.9 | 86.7 | 79.5 | 82.6 | 80.8 | 83.3 | 86.9 |

Table 6 – Indicators of Selected Protocols

| Pathologies Indicator | Indicators | Un. | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|--|---------|------|------|------|------|------|
| Acute Myocardial Infarction (AMI) | Door-to-balloon | minutes | 127 | 111 | 110 | 108 | 86 |
| | Mean length of stay | days | 5.4 | 7.9 | 7.0 | 7.2 | 7.4 |
| | Rate of angioplasty | % | 28.3 | 42.1 | 79.9 | 75.5 | 72.2 |
| | Rate of aspirin at discharge | % | 38.3 | 58.0 | 53.6 | 70.6 | 66.9 |
| | Mortality rate | % | 7.1 | 8.6 | 7.0 | 5.0 | 3.7 |
| Ischemic Cerebral Vascular Accident (ICVA) | Door-to-ct | minutes | 122 | 102 | 97 | 61 | 53 |
| | Door-to-thrombolysis | minutes | ND | ND | 27 | 96 | 69 |
| | Mean length of stay | days | 9.1 | 10.4 | 11.1 | 9.7 | 7.6 |
| | Ct rate | % | 22.0 | 36.7 | 48.4 | 70.0 | 60.4 |
| | Mortality rate | % | 7.7 | 7.7 | 8.1 | 6.9 | 6.1 |
| Congestive Heart Failure (CHF) | Mean length of stay | days | ND | ND | ND | 11.5 | 10.7 |
| | Mortality rate | % | ND | ND | ND | 9.1 | 6.7 |
| Pneumonia in Children | Mean length of stay – pneumonia < 13 years | days | 4.9 | 5.6 | 4.9 | 4.8 | 5.8 |
| | Rate of appropriate antibiotic therapy < 13 years | % | 22.6 | 33.2 | 32.3 | 73.1 | 60.9 |
| | Mortality rate – pneumonia < 13 years | % | 0.5 | 1.0 | 0.6 | 0.5 | 0.6 |
| Pneumonia in Adults | Mean length of stay – pneumonia in adults | days | 7.1 | 11.1 | 9.8 | 8.7 | 10.3 |
| | Rate of appropriate use of antibiotic therapy in adults with pneumonia | % | 17.2 | 26.8 | 41.2 | 38.4 | 46.0 |
| | Mortality rate – pneumonia adults | % | 8.5 | 9.4 | 9.8 | 9.0 | 10.6 |
| | Mean length of stay – pneumonia > 60 years | days | ND | ND | 11.6 | 10.9 | 11.1 |
| | Mortality rate – pneumonia > 60 | % | ND | ND | 13.9 | 12.9 | 14.6 |
| Sepsis | Mean length of stay - sepsis | days | 6.9 | 13.6 | 12.0 | 16.5 | 17.4 |
| | Rate of appropriate use of antibiotic therapy in sepsis | % | 12.2 | 37.6 | 62.6 | 67.1 | 75.4 |
| | Mortality rate from sepsis | % | 61.7 | 27.7 | 25.8 | 25.9 | 22.6 |
| Surgical | Rate of compliance to dvt prophylaxis | % | ND | ND | ND | ND | ND |
| | Mean length of stay in hysterectomy | days | 1.5 | 2.2 | 1.7 | 2.6 | 3.6 |
| | Mean length of stay in videolaparoscopic cholecystectomy | hours | 34.0 | 43.2 | 34.3 | 24.8 | 36.0 |
| | Mean length of stay in inguinal herniorrhaphy | hours | 27.0 | 25.7 | 17.9 | 19.8 | 31.7 |

| | 2012 | | | | | | | | | | | | |
|--|------|------|------|------|------|------|------|------|------|------|------|------|--------|
| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Annual |
| | 80 | 91 | 62 | 74 | 92 | 69 | 103 | 81 | 81 | 88 | 96 | 77 | 83 |
| | 7.1 | 8.0 | 7.8 | 8.6 | 9.7 | 9.3 | 9.8 | 9.8 | 8.3 | 10.0 | 8.1 | 8.3 | 8.8 |
| | 59.0 | 70.0 | 76.7 | 75.6 | 74.1 | 55.5 | 82.8 | 75.9 | 70.0 | 68.6 | 81.1 | 79.1 | 71.6 |
| | 88.2 | 89.2 | 90.8 | 89.5 | 91.4 | 87.8 | 91.8 | 91.0 | 87.3 | 86.8 | 77.1 | 79.0 | 87.9 |
| | 4.8 | 3.0 | 4.6 | 4.7 | 4.8 | 3.6 | 2.6 | 6.9 | 5.5 | 6.6 | 2.9 | 6.3 | 4.7 |
| | 69 | 73 | 65 | 59 | 39 | 59 | 48 | 52 | 38 | 31 | 36 | 47 | 51 |
| | 77 | 70 | 55 | 53 | 91 | 67 | 33 | 29 | 63 | 63 | 109 | 37 | 62 |
| | 14.9 | 10.9 | 10.9 | 14.3 | 11.9 | 9.4 | 11.2 | 13.2 | 10.2 | 13.5 | 11.4 | 15.2 | 12.1 |
| | 64.2 | 78.1 | 60.9 | 64.1 | 48.6 | 65.5 | 62.8 | 79.3 | 87.0 | 59.8 | 81.8 | 74.6 | 68.7 |
| | 8.4 | 5.3 | 5.3 | 12.0 | 5.5 | 5.3 | 8.3 | 7.6 | 10.4 | 6.5 | 3.4 | 5.1 | 6.9 |
| | 11.2 | 10.3 | 12.1 | 11.2 | 12.7 | 11.8 | 11.9 | 11.8 | 11.8 | 13.5 | 11.0 | 11.3 | 11.7 |
| | 5.4 | 4.9 | 4.6 | 7.1 | 4.4 | 6.1 | 7.5 | 5.3 | 5.2 | 10.9 | 5.6 | 8.2 | 6.2 |
| | 4.3 | 4.9 | 4.8 | 5.0 | 4.9 | 5.6 | 6.2 | 5.9 | 6.8 | 5.8 | 4.6 | 6.2 | 5.4 |
| | 50.0 | 65.1 | 51.1 | 49.1 | 44.4 | 62.2 | 31.7 | 60.9 | 49.4 | 43.9 | 32.3 | 38.2 | 48.7 |
| | 0.0 | 0.0 | 0.0 | 0.9 | 0.9 | 0.0 | 0.0 | 0.0 | 1.3 | 1.8 | 0.0 | 0.0 | 0.5 |
| | 13.6 | 12.2 | 13.9 | 11.2 | 9.1 | 11.6 | 10.2 | 9.8 | 10.1 | 10.0 | 9.5 | 9.1 | 10.8 |
| | 38.7 | 36.1 | 38.5 | 41.7 | 39.9 | 46.6 | 39.5 | 43.9 | 42.9 | 39.6 | 40.8 | 40.9 | 40.9 |
| | 11.7 | 9.5 | 8.7 | 6.0 | 4.2 | 9.4 | 7.5 | 10.1 | 6.5 | 10.2 | 9.2 | 6.7 | 8.3 |
| | 14.6 | 13.7 | 15.9 | 11.3 | 11.0 | 10.9 | 9.0 | 10.1 | 10.8 | 11.5 | 10.1 | 10.2 | 11.3 |
| | 14.1 | 12.4 | 10.3 | 8.0 | 7.2 | 9.6 | 8.3 | 13.1 | 7.6 | 14.1 | 11.8 | 8.3 | 10.3 |
| | 32.5 | 17.6 | 14.0 | 16.8 | 17.6 | 33.1 | 15.4 | 17.5 | 17.2 | 13.5 | 14.3 | 14.5 | 18.1 |
| | 74.8 | 79.2 | 77.4 | 80.9 | 77.6 | 79.8 | 81.5 | 81.9 | 84.8 | 84.7 | 79.4 | 80.9 | 80.3 |
| | 26.0 | 26.6 | 17.7 | 19.3 | 18.8 | 19.8 | 25.4 | 15.3 | 17.6 | 18.5 | 22.2 | 22.0 | 20.4 |
| | 81.9 | 64.0 | 61.9 | 54.8 | 51.3 | 57.7 | 55.7 | 52.6 | 54.1 | 52.4 | 53.5 | 55.2 | 57.9 |
| | 2.6 | 2.7 | 2.5 | 2.5 | 2.2 | 2.6 | 2.6 | 2.5 | 2.3 | 2.5 | 2.5 | 2.5 | 2.5 |
| | 38.3 | 41.9 | 36.6 | 36.6 | 34.8 | 36.8 | 30.4 | 29.3 | 30.9 | 32.4 | 29.9 | 33.9 | 34.3 |
| | 25.6 | 58.3 | 29.0 | 42.9 | 28.9 | 24.3 | 24.1 | 25.8 | 37.0 | 30.8 | 38.3 | 30.0 | 32.9 |

Institutional Profile of Anahp Hospitals

Casa de Saúde São José

Hospital A. C. Camargo

Hospital Alemão Oswaldo Cruz

Hospital Aliança

Hospital Anchieta

Hospital Bandeirantes

Hospital Barra D'Or

Hospital Copa D'Or

Hospital do Coração-HCor

Hospital Esperança

Hospital Israelita Albert Einstein

Hospital Mãe de Deus

Hospital Mater Dei

Hospital e Maternidade Brasil

Hospital e Maternidade Santa Joana

Hospital Memorial São José

Hospital Meridional

Hospital Moinhos de Vento

Hospital Monte Sinai

Hospital Nipo-Brasileiro

Hospital Nossa Senhora das Graças

Hospital Nove de Julho

Hospital Porto Dias

Hospital Português

Hospital Pró-Cardíaco

Hospital Quinta D'Or

Hospital Samaritano

Hospital Santa Catarina

Hospital Santa Genoveva

Hospital Santa Joana

Hospital Santa Luzia

Hospital Santa Rosa

Hospital São Camilo Pompeia

Hospital São José

Hospital São Lucas

Hospital São Lucas de Aracajú

Hospital São Luiz Itaim

Hospital São Luiz Jabaquara

Hospital São Rafael

Hospital Saúde da Mulher

Hospital Sírio-Libanês

Hospital Vera Cruz

Hospital VITA Batel

Hospital VITA Curitiba

Hospital VITA Volta Redonda

Hospital viValle

Real Hospital Português

Vitória Apart Hospital



CASA DE SAÚDE SÃO JOSÉ

Brief History of the Organization

Casa de Saúde São José (CSSJ) was founded in 1923 by Sisters of Santa Catarina Congregation and has been recognized for its personalized and humane care, aligned with investments in technology and qualified labor, provided efficiency and tender care to patients, family members and physicians.

First hospital in Rio de Janeiro to be accredited by ONA – National Accreditation Organization, in 2004, Casa de Saude Sao Jose obtained in 2011 the international accreditation granted by the Canadian Council on Health Services Accreditation (CCHSA), certifying that the hospital has practices as good as many other hospitals in the world.

Carrying out approximately 1.9 thousand surgeries per month, Casa de Saúde São José is considered one of the hospitals with the highest surgical volume (surgery x bed) in the country, focusing on high complexity surgeries and covering over 30 different specialties. Moreover, the organization promotes constant investments in state-of-the-art technologies, so as to provide greater comfort and safety to patients.

Highlights 2012

In compliance with the continuous modernization process, CSSJ has strongly invested in restructuring the Operative Unit I, the largest at the hospital, including eight rooms and intelligent surgical suites, opened in November 2012 to provide enhanced comfort to physicians and patients.

The operative suites offer the integration of all devices in one single point, supporting physicians' ergonomics during the surgery. Another new aspect comprises the lights on the room corners, enabling anesthesiologists to work without impacting the surgical field, generating greater visual comfort. Because devices are suspended, the rooms require less cleaning time between surgeries. The space may be used by physicians for any type of surgical procedure. The hospital expects to have an addition of two similar rooms by 2014.

In 2012, other significant important investments were made in medical technology, such as the acquisition of a Pentero, a neurosurgical microscope that provides significant change to the approach of cerebral tumors, cervical microsurgery and bone marrow tumors.

This device has a number of features similar to these in a digital camera, enabling the increase in field depth and automatic high speed focus. Through these features, surgeons can access points that they could not visualize before. Another landmark was the opening of a new Cath Lab facility with the modern device Artis Zee Floor, by Siemens. It provides fully digital images, which deliver more accurate information for angiology and catheterism exams. The area is currently getting prepared for the accreditation process.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1923 |
| Built up area | 30,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 222 |
| Number of beds in ICUs | 56 |
| Number of registered doctors | 6,328 |
| Number of actives employees | 1,300 |
| Number of emergency | 9,279 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 19,639 |
| Number of surgeries per year (except deliveries) | 23,593 |
| Number of deliveries per year | 3,126 |
| Number of tests performed at the Diagnostics and Therapy Unit | 406,433 |
| Gross Revenues (in million R\$): | 259.0 |



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HOSPITAL A.C. CAMARGO

Brief History of the Organization

Acknowledged as a world reference in oncology, A.C. Camargo is a philanthropic organization created in 1953. The hospital treats over 800 types of tumors identified by medicine, divided into more than 40 specialties, with excellent treatment success rates (about 70% for adults, compared to the largest cancer centers in the world). Thanks to the interconnection between best practices in prevention, diagnosis, treatment, teaching and research A.C. Camargo has found its success. In an integrated and multidisciplinary way, it sees 15,000 new patients every year coming from all over the country and abroad, totaling over 1 million procedures (visits, tests, hospital admission, surgeries, chemotherapy and radiotherapy, among others). Its clinical staff is comprised by a team of over 500 specialists, out of which 200 are distributed in 18 oncology specialties: Surgeons, radiotherapists, pathologists and radiologists, most of them bearing their Master or PhD training. Moreover, the hospital has the support of over 2,900 healthcare professionals. A reference in oncology research, the hospital was responsible for publishing 159 papers in 2012 in key relevant periodicals. Since its foundation, A.C. Camargo has already diagnosed and treated over 700,000 patients, gathering one of the largest samples of cancer treatment in the country. In the area of prevention, it promotes programs directed to the needy population offering presentations, preventive tests and early diagnosis, which amounted to a total of 40,000 visits in 2012.

Highlights 2012

On June 25, 2012, the Hospital opened its new building named Tower Professor Dr. Ricardo Renzo Brentani. The Tower is part of Complex A.C. Camargo and has expanded the hospital admission capacity by 37%, including 120 more beds, totaling 441 and comprising one of the largest oncology infrastructures in the world. In July 2012, the Advanced Oncology Center of the Hospital, located in Santo Andre, has received the top excellence level of National Accreditation Organization (ONA). The certification was granted with no additional recommendation made by auditors. In 2012, A.C. Camargo gathered five important acknowledgements in the market: It was elected by Anuario 360º Epoca Negócios as the best company in Brazil in the healthcare industry and it was ranked as the 6th best company in the general ranking; it was also ranked as number 1 medical care organization by Anuário Valor 1000; it was mentioned by edition 500 of the Best Companies of magazine IstoÉ Dinheiro as one of the best in Healthcare, and by the 4th consecutive year it ranked among the Best and the Largest companies by magazine Exame. The hospital was also elected by the fourth time as one of the best companies to work in according to Guia Você S/A Exame. In January 2013, the organization was awarded ISO 14001 certification, showing that it has an effective environmental management system, consolidating its commitment with the environmental preservation.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2010) | |
| Non Profit Organization | |
| Founded in | 1953 |
| Built up area | 70,000 m ² |
| Clinical staff organization | closed |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 392 |
| Number of beds in ICUs | 46 |
| Number of registered doctors | 543 |
| Number of actives employees | 2,905 |
| Number of emergency | not applicable |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 15,706 |
| Number of surgeries per year (except deliveries) | 11,632 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | not applicable |
| Gross Revenues (in million R\$): | 623.0 |



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HOSPITAL ALEMÃO OSWALDO CRUZ

Brief History of the Organization

Vocation: This is the word that clearly translates what the German origin brings to healthcare. Built on solid bases, Hospital Alemão Oswaldo Cruz has been making history and developing special skills to strengthen tradition, with eyes focused on progress. The results are impressive: Over 96,000 m² of constructed area, more than 5,000 physicians, different specialty centers and one of the best healthcare service in the country. And the structural expansion has not stopped there: A new 25-floor building has just been opened. It means that key areas, such as ICU and OR, have been expanded. In such case, new technologies have not been incorporated only in healthcare applications: The organization has moved even farther and included technology breakthroughs in the construction of the building. The construction has followed strict environmental criteria set forth by LEED - Leadership in Energy and Environmental Design, providing for rational use of water, use of renewable energy, certified wood and air quality control plan.

The hospital has been accredited by Joint Commission International (JCI), the main healthcare accreditation agency in the world, showing the commitment with continuous improvement, ensuring better and safer environment to our patients.

The vocation is confirmed every year, showing that it is possible to be new. Always.

Highlights 2012

Opened in December 2012, Building E, the new building that is part of Hospital Alemão Oswaldo Cruz complex, has required about R\$ 240 million in investments. The areas were planned and tested so that they would be transformed into safe and pleasant spaces, aligned with the Relationship-Based Care – RBC, the care model adopted by the hospital.

Including 25 floors, the new building has provided expansion in number of hospital beds to 351 total, including regular wards, step-down unit and ICU.

Moreover, the surgical unit has gained new high complexity rooms, increasing the number to a total 22 operative rooms.

Building E was built according to the strictest environmental criteria set forth by Leadership in Energy and Environmental Design – LEED.

The main intention is to be certified and become a reference for this type of construction in Brazil. There was rational use of water, optimization of power efficiency, no use of CFC (chlorofluorocarbon) and use of renewable energy, certified wood and air quality control plan.

The corridors have a lighting system that operates depending on the time.

In 2012, on December 22, Joint Commission International accreditation was renewed for three more years. As a result of reaccreditation, the hospital now begins its 4th year of international recognition.

Characteristics

| | |
|--------------------------------------|--------------------------------------|
| Full Associate Hospital (since 2002) | |
| Non Profit Organization | |
| Founded in | 1897 |
| Built up area | 96,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 278 |
| Number of beds in ICUs | 44 |
| Number of registered doctors | 5,231 |
| Number of actives employees | 1,914 |
| Number of emergency | 56,857 |
| Number of emergency visits | 7,976 |
| Number of outpatients visits | 16,764 |
| Number of surgeries per year (except deliveries) | 21,145 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 142,832 |
| Gross Revenues (in million R\$): | 447.2 |



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HOSPITAL ALIANÇA

Brief History of the Organization

The creation of Complexo Hospitalar Aliança started in 1982 with an innovative proposal to integrate in the same area Hospital and Medical Center Aliança.

The opening was on October 18, 1990, placing the organization into Bahia's medical-hospital context as a new reference in healthcare.

In addition to the open clinical staff, it has an in-house team that is responsible for providing care at the emergency department, neonatology, intensive care unit and addressing the complications experienced by inpatients in other units.

In the 77 offices located in the Medical Center, there are professionals of different specialties and a 100-seat conference room, where internal and external scientific meetings are held.

In the year 2000, the pediatric unit was expanded thanks to the opening of Centro Aliança de Pediatria, which includes emergency, urgency, emergency department, outpatient surgery and hospital admission.

Three values define Aliança way of being: Excellence, Integrity and Improvement.

Highlights 2012

In recent years, Hospital Aliança has made major investments in management improvement.

The organization has carried on with the broad program of leadership capacity building, supported by Fundação Dom Cabral – a reference business school in Latin America.

Aliança has adopted the result-based management model, constantly improved.

In 2012, for the third consecutive year, it was awarded Top of Mind Bahia in private hospital category.

Aliança is, therefore, vigilant of the fierce competition in the market and maintains its intention of providing excellent services.

In 2012, client satisfaction rates remained above 90%.

In the same period, there was very low hospital infection rate, reaching 1.7%, an indicator within the range recommended by the World Health Organization (WHO) (below 5%).

In 2013, investments have been made on new devices that will start operating at the areas of imaging diagnosis, OR, ICU and central supply sterilization, ensuring quick care with excellence.

Characteristics

Full Associate Hospital | Founder
(since 2001)

Non Profit Organization

Founded in 1990

Built up area 29,216 m²

Clinical staff organization opened

Hospital accreditation in progress

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 203 |
| Number of beds in ICUs | 42 |
| Number of registered doctors | 2,773 |
| Number of actives employees | 1,504 |
| Number of emergency | 72,501 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 12,881 |
| Number of surgeries per year (except deliveries) | 7,156 |
| Number of deliveries per year | 2,077 |
| Number of tests performed at the Diagnostics and Therapy Unit | 713,548 |
| Gross Revenues (in million R\$): | 206.0 |



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HOSPITAL ANCHIETA

Brief History of the Organization

On December 6, 1995, Hospital Anchieta opened its doors in full operation and with the necessary resources to build bridges and overcome potential and real obstacles, common to globalized healthcare projects.

To reach the current level, the Hospital decided that conceptual and practical consistency was required in all projects, implementing total quality management. Based on it, constant investments were made by Anchieta, a landmark in healthcare in the Federal District.

The organization is one of the most complex healthcare private organizations in the country as a result of its infrastructure, including outpatient care, diagnosis and hospital back up services for high complexity care. It is also a benchmarking in Quality Management in the Healthcare industry.

In 2000, Hospital Anchieta received its first ISO accreditation. Since then, risk management and patient safety were already organizational priorities.

Hospital Anchieta – HA has grown and improved a lot. It was awarded in 2002 the certificate of accreditation ONA level I; in 2003, level II and in 2006, level III.

In the past seven years, it was recognized and received the Top Of Mind for private hospitals in DF, awarded 5 types.

Highlights 2012

Restructuring Clinical Governance;

- Delivery of one more inpatient unit (nephrology);
- Investments in Social Responsibility actions aimed to community through diversified development presentations delivered at Instituto Anchieta de Ensino e Pesquisa – IAEP.

- It has also provided programs such as Moving Standard and Pregnancy Course. with a record of participants: 300 in 2012;

- Restructuring of general storage and pharmacy;
- Creation of an employee lounge;
- Preparation of a strategic planning for 2020.

2013 Projects:

- Construction of new neonatal and pediatric ICU;
- Construction of new surgical unit with high level of complexity.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1995 |
| Built up area | 60,374 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 168 |
| Number of beds in ICUs | 40 |
| Number of registered doctors | 516 |
| Number of actives employees | 881 |
| Number of emergency | 250,413 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 11,934 |
| Number of surgeries per year (except deliveries) | 4,812 |
| Number of deliveries per year | 1,588 |
| Number of tests performed at the Diagnostics and Therapy Unit | 610,971 |
| Gross Revenues (in million R\$): | 126.9 |



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HOSPITAL BANDEIRANTES

Brief History of the Organization

Hospital Bandeirantes was opened on May 7, 1945 when Professor Dr Domingos Lerario founded Hospital Antonio Lerario in Liberdade district, in São Paulo, comprising 30 beds and a team of 30 physicians.

Thirty years later, in 1975, the organization received its definite name - Hospital Bandeirantes – which triggered a process of market technology progression, which is still in place till today.

The hospital, the first of the four that comprise Grupo Saúde Bandeirantes, is a high-complexity general hospital with integrated care in all medical specialties, focusing on cardiovascular, transplantation, specialized surgery and clinical and surgical oncology facility, humanized care and latest generation devices.

It has been awarded ONA level III (Excellence in National Accreditation Organization), in addition to providing comfort and safety to patients and family members, thanks to its privileged location (200 m from the subway station) and its own helipad.

The organization also has a Research and Teaching Institute (IEP) that encourages research studies and the promotion of courses and scientific events, in addition to supporting the participation of physicians and other healthcare professionals in national and international events.

Highlights 2012

Hospital Bandeirantes has invested in excellence nursing care, with permanent training and qualification of professionals, and it is responsible for performing complex procedures, such as heart surgeries, bone marrow transplant kidney, liver and pancreas transplant with excellent results.

This work was recognized by the State Department of Health of Sao Paulo, which has disclosed in 2012 that the hospital has one of the best success rates in surgical procedures.

In 2012, the hospital was reaccredited by the National Accreditation Organization (ONA) reaching the level of excellence; it was also recognized by its Social-Environmental Responsibility by IT Mídia, due to the waste recycling policy.

In 2013, we have already started the process of international accreditation with ASA. – Canadian Accreditation- Qmentum and opened the new radiotherapy center with one of the most experienced teams in the country.

The organization will increase by 30% the service capacity expanding its emergency department. In the first half of 2013, the operative unit will have 14 fully equipped rooms prepared to perform of any complex surgery. Until the end of the year, 10 more ICU beds are expected, totaling 68 available beds. In the long run, the Group intends to focus on the specialties of oncology, cardiology, trauma, spine and pain, and obesity management.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2009) | |
| Non Profit Organization | |
| Founded in | 1975 |
| Built up area | 26,000 m² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 240 |
| Number of beds in ICUs | 58 |
| Number of registered doctors | 3,000 |
| Number of actives employees | 1,514 |
| Number of emergency | 82,342 |
| Number of emergency visits | 47,162 |
| Number of outpatients visits | 13,095 |
| Number of surgeries per year (except deliveries) | 8,579 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 118,681 |
| Gross Revenues (in million R\$): | 248.0 |



Rua Barão de Iguape, 209 - Liberdade
São Paulo - SP - 01507-000
11 3345-2000 - www.gruposaudemandeirantes.com.br



HOSPITAL BARRA D'OR

Brief History of the Organization

Considered as a reference of quality in the capital city of Rio de Janeiro (RJ), Hospital Barra D'Or has celebrated 15 years in 2013, consolidated as a healthcare role model in the region of Barra da Tijuca and nearby districts.

Thanks to the dedication of the multidisciplinary staff, it maintains the focus on constant pursuit for Healthcare Quality, associated with humanized practices of care.

Barra D'Or is characterized as a widely experienced hospital in caring for critically ill patients, including victims of multiple traumas and emergencies, providing care in different specialties, such as clinical, surgical, orthopedic and ophthalmic.

Within its facility, Barra D'Or has 46 intensive care beds, distributed into general, coronary and postoperative ICU, in addition to nine operative rooms.

As a result of its experience and quality, it is capable of performing different catheter laboratory interventions. One of the examples is primary coronary angioplasty, which is used to treat cases of acute myocardial infarction.

Highlights 2012

In 2012, Hospital Barra D'Or was reaccredited by National Accreditation Organization (ONA) and Accreditation Canada.

The general ICU, with 16 beds, was renovated complying with high technology standards, including two beds with complete isolation. Latest generation respirators were purchased and the continuous monitoring system was also replaced.

The Technological Devices of the OR have been updated due to the acquisition of HD video, surgical arc devices, anesthesia devices and new surgical tables, including specific tables for morbid obesity patients.

The cath lab was restructured and a new state-of-the-art high technology angiography device was incorporated.

The main purpose of the Hospital is to bring together modern technology and highly qualified staff, considering the technical and human standpoints.

The hospital also develops group work with patients' family members to talk about prevention, quality of life and health.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1998 |
| Built up area | 12,332 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 166 |
| Number of beds in ICUs | 46 |
| Number of registered doctors | 183 |
| Number of actives employees | 1,660 |
| Number of emergency | 79,221 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 10,894 |
| Number of surgeries per year (except deliveries) | 7,113 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 81,687 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



Av. Ayrton Senna, 2541 - Barra da Tijuca
Rio de Janeiro - RJ - 22775-002
21 2430-3646 - www.barrador.com.br



HOSPITAL COPA D'OR

Brief History of the Organization

Hospital Copa D'Or was opened in May 2000, born from the desire to create a new hospital model in Rio de Janeiro.

A hospital that could bring together state-of-the-art technology, highly qualified professionals and five-star services; a place where people would feel confident and comfortable to take care of their health.

Located in Copacabana, South area of the city of Rio de Janeiro, the Hospital is known for its top quality level and it is identified as one of the most important medical centers in the country.

Excellent services, technical competence, constant investments in technology, and latest generation treatment provided with respect and human touch are the main traits of the hospital.

It was the first private hospital in Rio de Janeiro to be accredited by Joint Commission International – JCI and it can be compared to be best in the world.

High complexity medical care is the highlight of the hospital and to maintain the very high level of operation in this segment the hospital has a top academic medical team, trained and specialized in the most prestigious medical educational organizations in Brazil and abroad.

There are over 270 available beds, distributed into inpatient wards, ICU, step-down unit, pediatrics, emergency - adult and pediatric, coronary unit and day clinic.

Highlights 2012

In 2012, Hospital Copa D'Or celebrated its 12th anniversary and achieved the certificate of International Center of Excellence in Bariatric and Metabolic Surgery by SBCBM (Sociedade Brasileira de Cirurgia Bariátrica e Metabólica) and by Surgical Review Corporation, the most important center in the world to qualify operative units. It became the first hospital in Rio de Janeiro to reach this acknowledgement of quality and safe care provided to bariatric patients.

There are dedicated facilities and over 30 professionals in this center, which operated on about 250 patients in 2013.

The center has follow up provided by the multidisciplinary team with physicians, nurses, dietitians, psychologists and physical therapists, in addition to a dedicated infrastructure to meet this patient profile. The title of Center of Excellence is directed to hospital units whose practices are considered models of patient quality and safety. The qualification was the result of one year of reorganization of the facility and the teams at Copa D'Or.

"This certificate recognized the actions of Rede D'Or Sao Luiz in its pursuit for qualification to become a national reference center in care", stated the Clinical Director of the Hospital, Arnaldo Prata, who coordinated the creation of the Center of Excellence in Bariatric and Metabolic Surgery.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 2000 |
| Built up area | 23,785 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 223 |
| Number of beds in ICUs | 57 |
| Number of registered doctors | 1,289 |
| Number of active employees | 2,200 |
| Number of emergency | 109,714 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 12,240 |
| Number of surgeries per year (except deliveries) | 7,402 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 19,464 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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Rio de Janeiro - RJ - 22031-010
21 2545-3600 - www.copador.com.br



HOSPITAL DO CORAÇÃO - HCor

Brief History of the Organization

Nationally and internationally recognized as a center of excellence in diagnosis and treatment of heart diseases, HCor – Hospital do Coração focuses on medical care in specialties such as orthopedics, neurology, neurosurgery, oncology, vascular surgery, urology, gastroenterology and pulmonology, providing the same care and attention as to which is dedicated to cardiology care.

HCor, a nonprofit philanthropic entity, maintained by Associação do Sanatório Sírio, started its activities in 1976 and throughout its 37 years of operation, has consolidated its role as a creator and driver of new technologies, treatment, humanized care and development of national and international research studies in healthcare.

The Hospital, one of the six members of the Program Hospitals of Excellence Working for SUS of the Ministry of Health, by means of its philanthropic activity, has contributed to the development of SUS – Universal Public Healthcare System – providing state-of-the-art resources and qualified professional know-how which enable transfer of new technologies, in addition to human resource capacity building and production of research studies of major relevance to the population. To the current period 2012-2014 there will be 36 projects with investments that exceed R\$110 million.

A strategic area of HCor is its teaching and research institute (IEP). Created in 2007, IEP-HCor is one of the major clinical research centers in the country. Recent projects were published in the most significant scientific periodicals in the world. HCor is the only South American hospital that has presented twice the session Late Breaking Clinical Trials.

Highlights 2012

In 2012, HCor has maintained its process of organic growth and created new differentiated services. It opened its advanced diagnostic unit HCor Cidade Jardim, which has imaging diagnosis, clinical analyses, endoscopic exams and differentiated services for clinical checkup and women's healthcare.

In the beginning of 2013 HCor conquered the 3rd reaccreditation award by Joint Commission International (JCI). In addition, in 2012, it became the first hospital in Latin America to obtain two accreditation certificates by JCI in Disease Specific Programs for Myocardial Infarction (AMI) and Heart Failure (CHF), showing excellence in treatment of cardiovascular diseases, becoming one of the main national and international reference centers in cardiology.

In 2013, the hospital will open its new building, constructed just across from the main Hospital Complex. The interconnection between the two buildings will be made by a suspended walkway and an underground tunnel at Rua Desembargador Eliseu Guilherme. The unit will comprise 45 new rooms, a convention center equipped with the most modern technological resources, and two hybrid surgical rooms – one focused on neurosurgery hybrid procedures and another one dedicated to cardiology. Designed based on sustainability concepts, it is qualified as a green building. This same year, the construction of the new building will be started, close by HCor complex, to house the Integrated Oncology Center – HCor Onco.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1976 |
| Built up area | 48,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 238 |
| Number of beds in ICUs | 78 |
| Number of registered doctors | 1,110 |
| Number of actives employees | 2,156 |
| Number of emergency | 36,995 |
| Number of emergency visits | 142,682 |
| Number of outpatients visits | 9,538 |
| Number of surgeries per year (except deliveries) | 6,239 |
| Number of deliveries per year | 40 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,587,563 |
| Gross Revenues (in million R\$): | 334.0 |



Rua Desembargador Eliseu Guilherme, 147 - Paraíso
 São Paulo - SP - 04004-030
 11 3053-6611 - www.hcor.com.br



HOSPITAL ESPERANÇA

Brief History of the Organization

Resulting from architecture and infrastructure modern technology, Hospital Esperança was opened in August 2000 by Capibaribe River, in Pernambuco capital, nationally recognized as the second medical region in Brazil.

There have been a number of reasons for Hospital Esperança to be confirmed as one of the most advanced hospital complexes in the country.

The highlights are the humanized care, apartment suites, ICU and operative unit. Moreover, there are other factors that confirm the supporting pillars defined by the complex: innovation, precision, respect and breakthrough initiatives.

Based on joint action with Rede D'Or São Luiz, Hospital Esperança has made investments in renovating its facilities, expanding and acquiring devices that can provide more humanized and efficient care.

The whole work philosophy and the quality policies are focused on patient care and safety. Hospital Esperança has been accredited as level III - Excellence by National Accreditation Organization (ONA) and is getting ready for the accreditation by Canadian Council on Health Service Accreditation (CCHSA), comprising international recognition for healthcare services.

Highlights 2012

In 2012, Hospital Esperança delivered to the population a new emergency department, with renovated facility, which will improve the clinical care provided to the region.

It has become one of the largest private hospital centers in North and Northeast of the country.

As a result of R\$30 million in investments to carry on with the expansion plan, the first stage of the project included 60 new beds and two new surgical rooms in June 2012. A total of 100 more beds comprising inpatients, adult ICU, cardiology and pediatric beds. Therefore, the inpatient capacity increased by 60%, providing greater comfort and expansion of bed options. The vertical project counts on four new elevators (which will improve the follow of care and ensure agility of procedures), oncology center and 300 parking lot spaces.

In an attempt to provide increasingly qualified treatment, the emergency department has adopted the Smart Track methodology. Some new clinical protocols based on the best hospital centers in the world have been implemented, combined with continuous investments in human development management.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2004) | |
| For Profit Organization | |
| Founded in | 2000 |
| Built up area | 26,000 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 245 |
| Number of beds in ICUs | 58 |
| Number of registered doctors | 600 |
| Number of actives employees | 1,500 |
| Number of emergency | 104,601 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 15,600 |
| Number of surgeries per year (except deliveries) | 8,088 |
| Number of deliveries per year | 2,018 |
| Number of tests performed at the Diagnostics and Therapy Unit | 67,589 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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Recife - PE - 50070-480
81 3131-7878 - www.hospitalesperanca.com.br



HOSPITAL ISRAELITA ALBERT EINSTEIN

Brief History of the Organization

Throughout its 60 years of existence, Hospital Israelita Albert Einstein has become a reference in high quality medical and clinical care for physicians, patients and the Brazilian society. The performance model includes massive investments in research, teaching, training and support to improve the public healthcare system, fully developing the Brazilian society. Through this understanding, the hospital maintains in perspective the assumptions that guided its foundation and manifest the gratitude of the Jewish community for the support received when they first came to this country.

Acting in the whole healthcare chain, the Hospital has many services involving promotion, prevention and diagnosis, treatment and rehabilitation. It also holds the main national and international certificates that confirm the quality of healthcare services provided there, in special Joint Commission International (JCI) accreditation, which was granted to the hospital as an organization outside USA for the first time in 1999.

The activities also include technical courses, undergraduate and lato sensu graduate studies, scientific research and support to scientific publications. Einstein also provides consulting and training services to public and private healthcare centers.

Highlights 2012

The year 2012 was marked by the continuation of hospital and outpatient activities, totaling investments of R\$ 178 million. The highlights were: Construction of the new Alphaville unit; expansion of Ibirapuera unit; 12 more beds at Hospital Israelita Albert Einstein; beginning the construction of a new facility for the Oncology and Hematology Institute and a hybrid surgical room, as well as the continuity of the implementation of the new Imaging-Guided Intervention Center. There was also a significant growth of Research and Teaching activities and an increase in Public Partnership Initiatives, especially concerning the Healthcare Complex Paraisópolis. Some achievements and realizations related with management, quality, safety and environmental protection deserve special highlight: The partnership with MD Anderson Cancer Center; the performance of the first Brazilian multivisceral transplant (stomach, duodenum, intestine, pancreas and liver); indexing of Einstein journal by PubMed/MEDLINE; the achievement of Premio SciVal Brasil 2012 in category Citations by Document – Research Institute and Others; the choice made by Revista AméricaEconomía, for the fourth consecutive year, as the best hospital in Latin America; the choice for the 3rd consecutive year as one of the 150 best companies to work in, according to Guia Você S/A Exame; accreditation ONA – Level II of Hospital Municipal Dr. Moysés Deutsch, and accreditation by Foundation for the Accreditation of Cellular Therapy (FACT) for bone marrow transplant.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1971 |
| Built up area | 221,588 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 647 |
| Number of beds in ICUs | 41 |
| Number of registered doctors | 6,081 |
| Number of actives employees | 10,195 |
| Number of emergency | 262,275 |
| Number of emergency visits | 264,657 |
| Number of outpatients visits | 48,881 |
| Number of surgeries per year (except deliveries) | 37,866 |
| Number of deliveries per year | 3,871 |
| Number of tests performed at the Diagnostics and Therapy Unit | 4,778,901 |
| Gross Revenues (in million R\$): | 1,625.6 |



Av. Albert Einstein, 627 - Jd. Leonor
 São Paulo - SP - 05652-900
 11 2151-1233 - www.einstein.br



HOSPITAL MÃE DE DEUS

Brief History of the Organization

Hospital Mãe de Deus, located in Porto Alegre, is a member and leading organization of Sistema de Saúde Mãe de Deus, part of Congregação das Irmãs de São Carlos Borromeo Scalabrini. It was opened on June 1, 1979 and is supported by Associação Educadora São Carlos – AESC, based in Caxias do Sul, RS.

It is a private philanthropic organization acting based on the principles of the Congregation, focused on healthcare needs of the target population in which they operate, with significant activity in social projects, reinvesting the financial results and management competences back into the units of Sistema de Saúde Mãe de Deus, comprising technological update, professional qualification and development of medical clinical processes, based on contemporary corporate governance. Hospital Mãe de Deus has an infrastructure of about 40,000 m², concentrated on state-of-the-art technology, with latest generation equipment, constant technological innovation and highly qualified medical team, comprising about 4,000 physicians and 2,000 employees.

Mãe de Deus was created and is prepared to provide a set of healthcare solutions, with high resolution capacity, comfort, commodity and safety. The main services offered to the population are emergency, ICU, surgical unit, obstetric unit and maternity, inpatient wards and advanced technology diagnostic centers.

Highlights 2012

Hospital Mãe de Deus is currently going through development and organizational growth in many different aspects. Expansion project and growth of its facility; new clinical care model and greater qualification and innovation of its processes and services. New strategies provide innovative clinical care lines, which support new services. The preparation to the World Cup includes Hospital Mãe de Deus as a reference center to the event in Porto Alegre, guiding the expansion and the development of the organization.

During 2012, in August, the Hospital was accredited by Joint Commission International – JCI, and with the Accreditation Level III by ONA, have granted the hospital the qualification and safety in clinical care that meet the needs and expectations of its clients. The strategic plan was also designed for the upcoming years, planning the expansion of the hospital and of its inpatient units, new ICU beds, increase of outpatient services, including the expansion of the emergency department and outpatient care, in partnership with medical care and Clinical Center Mãe de Deus, providing immediate access to all specialties.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1979 |
| Built up area | 50,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI); National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 350 |
| Number of beds in ICUs | 47 |
| Number of registered doctors | 3,700 |
| Number of active employees | 2,050 |
| Number of emergency | 50,640 |
| Number of emergency visits | 80,357 |
| Number of outpatients visits | 16,048 |
| Number of surgeries per year (except deliveries) | 35,532 |
| Number of deliveries per year | 2,323 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,583,701 |
| Gross Revenues (in million R\$): | 297.0 |



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Porto Alegre - RS - 90880-480
51 3230-2000 - www.maedeus.com.br



HOSPITAL MATER DEI

Brief History of the Organization

Hospital Mater Dei has its philosophy to offer differentiated, personalized and humanized clinical care to all its clients. Since its foundation on June 1st, 1980, the Hospital has promoted constant clinical and administrative improvement to provide better medical-hospital services, fulfilling its mission: “Commitment with quality for life”. A hospital that is reference for the community and it is ready to welcome, treat and care for people within the principles of technical quality but with tender care, attention and human touch. These attributes of Hospital Mater Dei throughout its 33 years, plus the constant investment in diagnostic and therapeutic resources and infrastructure, managerial actions, clinical staff management, employee capacity building and focus on clients have contributed to a safe environment and quality care.

Mater Dei was the first hospital in Belo Horizonte to receive accreditation ONA level III (Excellence), in 2004. In 2008, it received ISO 9001/2008 certificate and, in 2009, it finally received the international certificate NIAHO, adopted by the American healthcare model, being the first hospital outside USA to receive it. The hospital currently operates in two buildings, totaling 36,000 m2 of constructed area. In 2012, the Hospital met the criteria set forth by National Surveillance Agency in Brazil (ANVISA) and was accepted in the Sentinel Network of Hospitals in Brazil.

Highlights 2012

Mater Dei will expand the services to the population by opening Unit Contorno in 2014. The expansion will offer to Belo Horizonte an increase in job offers – about 2,000 new jobs – and will contribute to meet the great demand for healthcare services in Minas Gerais capital. There will be more available beds with the same Mater Dei quality. For healthcare professionals, the Hospital will offer physical and technological infrastructure to provide safe and high quality care. Unit Contorno will have 22 floors, 314 beds, 81 ICU beds, 17 operative rooms, one heliport, 878 parking lot spaces and 4,000 m2 modern emergency department, operating with structures and processes compatible with the most modern in the world, capable of seeing 2,000 patients per day.

The works started in 2011, employing modern, innovative and sustainable architecture solutions. The total area to be constructed amounts to 63,400 m2. It is expected to invest over R\$250 million in the construction of the new unit, divided into 50% funding granted by BNDES (Brazilian Economic and Social Development Bank) and 50% from owned resources. The unit will be located on Avenida do Contorno, 9000, a strategic place for easy access to the main avenues and expressways, favoring inflow and commuting.

Characteristics

| | |
|--|--|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1980 |
| Built up area | 35,000 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | National Integrated Accreditation for Healthcare Organization (NIAHO); National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 314 |
| Number of beds in ICUs | 80 |
| Number of registered doctors | 2773 |
| Number of actives employees | 1,457 |
| Number of emergency | 295,895 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 24,918 |
| Number of surgeries per year (except deliveries) | 30,294 |
| Number of deliveries per year | 3,189 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,283,118 |
| Gross Revenues (in million R\$): | 281.0 |



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 Belo Horizonte - MG - 30190-081
 31 3339-9000 - www.materdei.com.br



HOSPITAL E MATERNIDADE BRASIL

Brief History of the Organization

Hospital e Maternidade Brasil is the result of a dream that became reality. In 1966, a group of young physicians trusted they could provide to the local community hospital services that had the same quality standards as the ones placed in large capitals of the country. Thus, what started as a simple idea got in shape and the initial healthcare center became the draft of a large and modern hospital.

The works started in July 1967 and on April 8, 1970, the first part of the hospital was opened, comprising two floors and 30 rooms, two surgical rooms, two delivery rooms, nursery and a recovery center. The original project, however, included six floors that were built throughout the years. At the same time, the founders realized they had to invest in technology and sophisticated diagnostic and therapeutic equipment, in addition to increasing the diversity of medical specialties, promoting specialization of services and expanding their capacity. They have spent years seeking for improving the whole health promotion process. In April 2010, the hospital was acquired by Rede D'Or, which has carried on with the initial ideal of the owners, incorporating new technologies, increasing the hospital capabilities, investing in structural renovation and increasing the number of employees and physicians.

Highlights 2012

As of 2010, Hospital e Maternidade Brasil has increased its capacity with 37 ICU beds, 64 inpatient beds (including the opening of two new units - general and maternity), infrastructure renovation of the rooms, the cath lab and the diagnostic unit, updated with imaging diagnostic devices and a new magnetic resonance device. In 2012, the Smart Track system was implemented, a pioneer in Brazil, providing greater agility to the Emergency department and reducing the waiting time.

But there are still more investments made. Investments directed to providing specialized care to patients have given rise to the Women Diagnostic Center and the new surgical unit, exclusively dedicated to minor surgeries, to be opened in 2013. The hospital intends to become a reference in high performance specialties and to support this idea, the adult, pediatric and neonatal ICUs will be expanded shortly. Aligned with such expansion, the Hospital, which has been accredited for excellence, has applied to the international accreditation, strengthening further the concepts of quality and safety in clinical care.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2004) | |
| For Profit Organization | |
| Founded in | 1970 |
| Built up area | 31,563 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 313 |
| Number of beds in ICUs | 80 |
| Number of registered doctors | 1,279 |
| Number of actives employees | 2,223 |
| Number of emergency | 265,944 |
| Number of emergency visits | 339,570 |
| Number of outpatients visits | 21,842 |
| Number of surgeries per year (except deliveries) | 11,890 |
| Number of deliveries per year | 3,312 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,609,986 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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Santo André - SP - 09020-110
11 2127-6666 - www.hospitalbrasil.com.br



HOSPITAL E MATERNIDADE SANTA JOANA

Brief History of the Organization

Hospital e Maternidade Santa Joana was created in 1948, when a group of young doctors, graduated from Faculdade de Medicina da Santa Casa founded Casa de Saúde Santa Joana. Dr Eduardo Amaro was one of these pioneers and transformed the center into a hospital and maternity that became a reference in treating high risk gestation and low birth weight premature babies. Partner of national and international universities, it has become a reference in obstetric anesthesia and hospital infection control in addition to having the largest private human milk bank in the country. In 2005, it was the first maternity to be accredited as Level III – Excellence, the main level of accreditation granted by the National Accreditation Organization (ONA). In the year 2000, it acquired Maternidade Pró Matre Paulista and in 2009, Perinatal Unidade Barra and Laranjeiras, forming Grupo Santa Joana.

Highlights 2012

In November 2011, Hospital e Maternidade Santa Joana opened the new hospital complex with inpatient wards, obstetric center, modern surgical unit and diagnostic center, expanding by over 18,000 m2 its existing structure, reaching almost 40,000 m2 of constructed area.

Throughout 2012, the organization continued its process of revitalization, executing expansions and renovations in the adult and neonatal ICU, milk bank and milk room, admission and emergency department. The surgical and obstetric units adopted computer-based and integrated systems, with three intelligent rooms designed to perform high complexity procedures, including laminar flow to mitigate risks of infections, monitors with flexible arms for videosurgeries and PACS (Picture Archiving and Communication System) digital radiology, in addition to the central sterilization department located on the same area. It has favored the use of innovative surgical techniques, highlighting the pioneer initiatives of the maternity.

The Hospital has partnerships with the best medical schools in the country and abroad to ensure scientific exchange of information. Safety, imaging diagnosis and humanized hospital processes are also landmarks of the organization.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2002) | |
| For Profit Organization | |
| Founded in | 1948 |
| Built up area | 40,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 347 |
| Number of beds in ICUs | 104 |
| Number of registered doctors | 4,299 |
| Number of actives employees | 1,839 |
| Number of emergency | 48,579 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 26,630 |
| Number of surgeries per year (except deliveries) | 8,098 |
| Number of deliveries per year | 14,819 |
| Number of tests performed at the Diagnostics and Therapy Unit | 62,077 |
| Gross Revenues (in million R\$): | 390.0 |



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 São Paulo - SP - 04103-000
 11 5080-6000 - www.hmsj.com.br



HOSPITAL MEMORIAL SÃO JOSÉ

Brief History of the Organization

Founded on June 2, 1989, hospital complex Memorial São José (HMSJ) opened in Recife with the intention to offer qualified services and technological and high complexity procedures, which used to be performed outside the country, to the state of Pernambuco and Northeast region.

The Hospital is divided into a six-building complex and it is one of the most complete diagnostic centers in Brazil, comprising units Maximagem, Medix, Unigastro, Unicardio, MCor, among others. It offers to the patients five magnetic resonance machines, two CT scans and two angiogram devices, among other advanced technology equipment.

Hospital Memorial São José has 155 beds to offer maximum comfort and safety to its patients. In addition to multidisciplinary urgency, the pediatric emergency recently expanded to provide greater comfort to patients, and adult, pediatric, neonatal and coronary ICU, the complex has three operative units, one of them directed to minor procedures that do not require admission for longer than 12 hours. All investments made in infrastructure and state-of-the-art technology are followed by constant professional improvement of the medical and managerial teams.

Highlights 2012

HMSJ has maintained its Bone Marrow Transplant Program and consolidated the process of International Accreditation, granted to the organization in January/12.

The hospital has continued with the investments in infrastructure and human resources and has developed for some months a detailed program for renegotiation and selection of healthcare plan management companies.

The resizing of the network has gained even more importance in recent years due to the bankruptcy of many healthcare plan operators in the region in 2012/2013.

Characteristics

| | |
|--------------------------------------|--------------------------------------|
| Full Associate Hospital (since 2004) | |
| For Profit Organization | |
| Founded in | 1989 |
| Built up area | 26,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 155 |
| Number of beds in ICUs | 44 |
| Number of registered doctors | 990 |
| Number of actives employees | 808 |
| Number of emergency | 76,904 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 11,368 |
| Number of surgeries per year (except deliveries) | 5,811 |
| Number of deliveries per year | 1,552 |
| Number of tests performed at the Diagnostics and Therapy Unit | 311,759 |
| Gross Revenues (in million R\$): | 100.5 |



HUMANO COMO VOCÊ.

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Recife - PE - 50070-160
81 3216-2222 - www.hospitalmemorial.com.br



HOSPITAL MERIDIONAL

Brief History of the Organization

Constant innovation focusing on quality and safety. The competence of visionary management, regardless of the size of the faced challenge, has never deviated the focus from investments on quality and safety of each service provided, and has transformed the hospital that started with 50 beds in the city of Cariacica, in a high quality and efficacious hospital complex capable of meeting simple to more complex needs of the whole state of Espírito Santo. Always displaying complete solutions that go beyond the hospital complex, encompassing from the first patient visit to home recovery.

The services have always offered high quality, safety and competence. This is how Hospital Meridional has gained national and international recognition, seen today as a reference to be followed by hospitals from North to South of Brazil. Meridional had grown through the purchase of other hospitals in the state of Espírito Santo. There were two in the city of Vila Velha and one more in Cariacica, in addition to the construction of one more hospital, to be completed, also capable of meeting all healthcare complexities, in the city of São Mateus.

Meridional is a top center in heart, liver and kidney transplant, providing highly qualified professionals and a transplant center dedicated to preparation and follow up of patients candidates to transplant, transplanted patients and their family members. It is also a reference in neurology, neurosurgery, oncology and intensive treatment. This is why it has been classified among the best medical centers in the country.

Highlights 2012

The year 2012 was certainly marked by many achievements, successes and acknowledgments for Hospital Meridional. 2012 was the year that Meridional formed its first class of surgeons in the residence program of maxillofacial surgery and trauma. It has also performed an unheard surgery to repair a case of Treacher Collins syndrome, a congenital disease characterized by malformation of the zygoma bone structure. To reconstruct the facial pattern of the patient, biomaterial prostheses were designed by analysis and processing, in 3D, of imaging results. Confirming its high complexity competence, in 2012, Hospital Meridional performed 100% of liver transplants, 100% of heart transplants, more than 60% of total transplants performed in the state of Espírito Santo. In 2012, Meridional has also performed a procedure that represents quite well the marriage between modernization and humanized medicine. The first surgery to implement a heart aorta valve through a catheter, the first one in Espírito Santo, carried out in a 91-year-old patient from the state.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2006) | |
| For Profit Organization | |
| Founded in | 2001 |
| Built up area | 14,783 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 172 |
| Number of beds in ICUs | 62 |
| Number of registered doctors | 588 |
| Number of actives employees | 635 |
| Number of emergency | 86,759 |
| Number of emergency visits | 66,237 |
| Number of outpatients visits | 7,298 |
| Number of surgeries per year (except deliveries) | 8,635 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | not applicable |
| Gross Revenues (in million R\$): | 90.0 |



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Vitória - ES - 29051-920
27 3346-2000 - www.hospitalmeridional.com.br



HOSPITAL MOINHOS DE VENTO

Brief History of the Organization

Counting on 85 years of history, Hospital Moinhos de Vento has built a solid reputation based on ideas of quality and community recognition. Restating its commitment with complete care, its trademark since 1995, it has defined humanization and clinical quality as the pillars that support all activities

Aligned with technological and scientific progression, the healthcare organization ranks among the best in the country, employing the best medical-clinical practices and management strategies to provide to patients an experience that bring together efficacy, safety, welcome and wellbeing.

The organization is one of the six Brazilian hospitals that have been recognized since 2002 as Hospital of Excellence by the Ministry of Health and it is accredited by Joint Commission International (JCI), the agency that assesses and certifies quality standards of healthcare centers in the whole world.

Social responsibility is completely incorporated into the corporate culture, developing a series of projects that try to meet the community demands meeting the same excellence standards as any other activity of the organization.

Highlights 2012

As a result of its expansion plan started in 2011, to be concluded by 2014, Associação Hospitalar Moinhos de Vento is prepared to meet the increased demand for healthcare services, both in private and public arena. The goal is to reach 500 beds in the complex at Moinhos de Vento – to present, the hospital has 354 admission and pre-admission beds – and 135 at Hospital Restinga and Extremo Sul, which is being built in the South area of the city of Porto Alegre, which will be exclusively dedicated to Brazilian Universal Public Healthcare System (SUS). Combining its own resources, and resources obtained through funding and fiscal exemptions, the total investment in the expansion program will be approximately R\$ 320 million, out of which R\$100 million have already been invested. Some important achievements have already been provided to the community, such as the expansion of the emergency department, the new maternity and the orthopedics and trauma centers, and the neurology and neurosurgery center in 2011, and the endoscopy unit in 2012. In 2013, the new surgical center was opened and the dialysis unit is still being prepared. The construction of the hospital building (94 beds), adult and pediatric treatment center (10 and 16 beds, respectively) and the imaging diagnosis unit are at its initial stage, expected to be completed by 2014.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1927 |
| Built up area | 82,412 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 354 |
| Number of beds in ICUs | 72 |
| Number of registered doctors | 2,925 |
| Number of actives employees | 2,854 |
| Number of emergency | 63,677 |
| Number of emergency visits | 143,499 |
| Number of outpatients visits | 25,858 |
| Number of surgeries per year (except deliveries) | 18,226 |
| Number of deliveries per year | 4,490 |
| Number of tests performed at the Diagnostics and Therapy Unit | 764,261 |
| Gross Revenues (in million R\$): | 370.4 |



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Porto Alegre - RS - 90035-001
51 3314-3434 - www.hospitalmoinhos.org.br



HOSPITAL MONTE SINAI

Brief History of the Organization

Since its foundation in 1994, Hospital Monte Sinai has been a reference in pioneer actions for 150 cities in Zona da Mata in Minas Gerais and neighboring states. Relying on qualified clinical staff, it permanently invests in improving its physical infrastructure, in new technologies and high complexity procedures, always focusing on management, quality and healthcare standards.

The efficiency in management and investment in infrastructure are directed to the main objective of the hospital: to become nationally recognized as a center of excellence in healthcare. Due to its management policy founded on the principles of National Quality Foundation (FNQ - Fundação Nacional de Qualidade) started in 2002, Monte Sinai became the first hospital in Minas Gerais to receive the hospital accreditation by National Accreditation Organization ONA, in 2003.

In 2006, it received the Golden award Premio Mineiro de Qualidade. To present, it has applied to reaccreditation to level III ONA, obtained in 2008, and International Accreditation by National Integrated Accreditation for Healthcare Organizations (NIAHO), in 2011.

To maintain its position as reference in the country, Monte Sinai has invested in resources, hospitality and qualification of clinical staff. It will open this year the Monte Sinai Medical Center and invest in its infrastructure to consolidate complete care, always towards achieving excellence in medical hospital care.

Highlights 2012

The opening of the Medical Center will be one of the main landmarks in 2013. Modern architecture and complete integration with the hospital are the main pillars to consolidate Monte Sinai as one of the largest hospital complexes in the country. The new structure will house exclusive clinics and specialists, gathering services and professionals in two buildings that comprise about 40,000 m² of constructed area. Some of the 315 medical offices have already been taken. The Medical Center will also have a commercial mall with 24 convenience stores, fitness center, food court and a congress hall with 250 seats, plus a large 565-car parking facility. There are two towers with air conditioning, sophisticated acoustic isolation and connected to each other and the hospital through skyways.

At the same time, Monte Sinai has invested in urgency and emergency care, by defining state-of-the-art protocols, triage service and restructuring of the specialties, trying to attract more high complexity procedures. Four floors in the main building are going through renovation works and 100 new inpatient beds will be made available this year, in addition to 25 new adult ICU beds and 10 neonatal ICU beds. The surgical center will have improved technology, expanding its capacity to 12 operative rooms. Among the projects started this year, there is the expansion of the oncology and transplant services.

Characteristics

| | |
|--------------------------------------|--|
| Full Associate Hospital (since 2006) | |
| For Profit Organization | |
| Founded in | 1994 |
| Built up area | 72,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation for Healthcare Organization (NIAHO); National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 216 |
| Number of beds in ICUs | 52 |
| Number of registered doctors | 1,096 |
| Number of actives employees | 877 |
| Number of emergency | 26,662 |
| Number of emergency visits | 28,029 |
| Number of outpatients visits | 11,547 |
| Number of surgeries per year (except deliveries) | 11,216 |
| Number of deliveries per year | 804 |
| Number of tests performed at the Diagnostics and Therapy Unit | 455,062 |
| Gross Revenues (in million R\$): | 101.3 |



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 Juiz de Fora - MG - 36033-340
 32 3239-4455 - www.hospitalmontesinai.com.br



HOSPITAL NIPO-BRASILEIRO

Brief History of the Organization

In order to provide post-war immigrants with assistance since the moment they landed with their luggage, offering them a place to rest and stay, Associação de Assistência aos Imigrantes Japoneses was created on January 28, 1959, which was later named Beneficência Nipo-Brasileira de São Paulo, also called Enkyo, supporting entity of Hospital Nipo-Brasileiro.

The supporting pillars of Enkyo are social work and medical care and based on this commitment, a need was observed: The construction of Hospital Nipo-Brasileiro.

Thanks to the donation of a 5,000 m2 land on January 18, 1984 by JAMIC (agency that belongs to the Japanese government), the organization started to plan the construction of the hospital, bringing joint efforts by Enkyo board, the Japanese government and Japanese-Brazilian community.

The hospital has 214 beds and serves as a reference in minimally invasive procedures, adopting video techniques and advanced angioplasty. In order to continuously improve, HNB receives physicians from other countries and sends its teams for training, courses and internships in Brazil and abroad.

Highlights 2012

In 2012, Hospital Nipo-Brasileiro started the expansion works of the cath lab center, which will be housed by a new 600 m2 area on the 6th floor of the main building, where diagnostic and therapeutic procedures will be performed, such as interventional cardiology, electrophysiology, artificial heart stimulation, vascular radiology, diagnostic and therapeutic neuroradiology and interventional radiology. New ultrasound devices have been bought, in addition to latest generation endoscopy devices.

The renovation and expansion of the surgical center will also be scheduled, including the creation of an exclusive area for patient preparation.

It will also include the construction of Hospital São Miguel Arcanjo, conceived to meet the needs of low-income population in the region of Sao Miguel Arcanjo, likely to start operating in 2013.

HNB administration has taken the 7th floor of the main building, bringing together the technical, clinical, administrative, financial and nursing directors, plus the quality office, facilitating communication and interaction between the areas.

Characteristics

| | |
|--------------------------------------|--|
| Full Associate Hospital (since 2008) | |
| Non Profit Organization | |
| Founded in | 1988 |
| Built up area | 22,071 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA II) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 268 |
| Number of beds in ICUs | 50 |
| Number of registered doctors | 1,963 |
| Number of actives employees | 1,547 |
| Number of emergency | 300,789 |
| Number of emergency visits | 269,096 |
| Number of outpatients visits | 15,532 |
| Number of surgeries per year (except deliveries) | 8,367 |
| Number of deliveries per year | 2,895 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,107,506 |
| Gross Revenues (in million R\$): | 218.0 |



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 São Paulo - SP - 02189-000
 11 2633-2200 - www.hospitalnipo.org.com.br



HOSPITAL NOSSA SENHORA DAS GRAÇAS

Brief History of the Organization

In 2013, Hospital Nossa Senhora das Graças is celebrating its 60 anniversary, marked by tradition, experience, study, remodeling and innovation. Founded by Companhia das Filhas da Caridade de São Vicente de Paulo, it is ranked among the largest healthcare centers in the state of Parana. It is a reference in Brazil and abroad for the quality of its clinical and surgical high complexity treatments, such as bone marrow and liver transplantation.

Created by Sister Estanislava Perz, her initial objective was to provide health care to sisters and poor people and still serve as an internship organization for the Nursing School. The hospital name was chosen in honor of Nossa Senhora das Graças, its guardian. During its history, the hospital has brought its essence, the deep and permanent commitment of Vicentine sisters, driven by the charisma that daily guides the organization. After its humble beginning, with 100 beds and a little over 18 physicians, the small hospital at Mercedes district became known as one of the largest hospital centers among the activities performed by the company in the five continents. Such recognition is not a goal in itself, but rather the drive to strengthen the mission of promoting life. Hospital Nossa Senhora das Graças is consolidated every year as an organization of excellence in health services and promotion within the social cultural and moral context within which it operates.

Highlights 2012

Working as an integrated health center, Hospital Nossa Senhora das Graças (HNSG) provides to clients a complete hospital infrastructure, combined with the permanent commitment of providing safety and quality of care. To confirm this fact, the organization has been accredited with Excellence by ONA (National Accreditation Organization). Throughout its 60 years of history, the constant improvement has led to significant acknowledgement and awards that mark the organization's experience of human care. In 2012, HNSG was awarded by Nursing Regional Board as the winner of Prêmio Paranaense de Excelência em Enfermagem (Nursing Excellence Award) in the category Top Private Hospital. It is the second year that the organization is recognized for the quality of care provided to patients. The heart and general ICU of HNSG and the central sterilization and supply department have obtained the award Diamond – maximum award granted by 3M in Brazil, due to the skin damage prevention and the hospital sterilization certificate, respectively.

In recent years, the organization has invested in improving and implementing new services. All rooms at HNSG were renovated; endoscopy, chemotherapy and outpatient medication departments have received a new layout and new treatment centers of epilepsy and imaging tests have completed further the structure.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1950 |
| Built up area | 39,756 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 211 |
| Number of beds in ICUs | 36 |
| Number of registered doctors | 1,175 |
| Number of actives employees | 1,219 |
| Number of emergency | 74,098 |
| Number of emergency visits | 57,871 |
| Number of outpatients visits | 13,460 |
| Number of surgeries per year (except deliveries) | 7,805 |
| Number of deliveries per year | 2,630 |
| Number of tests performed at the Diagnostics and Therapy Unit | 656,832 |
| Gross Revenues (in million R\$): | 92.1 |



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Curitiba - PR - 80810-040
41 3240-6060 - www.hnsg.org.br



HOSPITAL NOVE DE JULHO

Brief History of the Organization

Since its foundation in 1955, Hospital 9 de Julho has been recognized as one of the most important private healthcare organization in the country. Focused on high complexity and minimally invasive procedures, H9J works with multidisciplinary teams gathered in its references centers: Cardiology, spine, diabetes, pain and functional neurosurgery, gastroenterology, sport and exercise medicine, oncology, orthopedics, kidney and urology, and trauma.

Its open clinical staff is formed by over 4,000 professionals, supported by a team of 1,500 employees. Capable of performing 14 surgeries simultaneously, the Hospital has 294 beds, 70 of which are intensive care unit beds.

Highlights 2011 and 2012

Being awarded the accreditation by Joint Commission International (JCI) made the year 2012 really special for Hospital 9 de Julho. It is the international recognition for the work that had started before 2008, when the hospital was awarded Excellence Center by ONA, the National Accreditation Organization, strengthened further by the experience acquired with the certification by the Canadian Council for Health Services Accreditation (CCHSA), in 2010.

Counting on management focused on strategic planning that intends to maintain the organization within the top private healthcare centers in the country, the hospital has invested US\$ 8 million in technology directed to minimally invasive procedures, especially 3D technology for the cath lab and Da Vinci robotic system, which can be found in only six organizations in Brazil.

The investment made in infrastructure has also gained more attention in 2012 when 14 floors of the Specialized Medical Center started to operate so that the professionals in the reference centers could have complete facilities, with rooms for small procedures, beds for day hospital, infusion center, outpatient chemotherapy and space for rehabilitation and tests.

For future years, the organization intends to keep on investing in high technology and wants to deliver until the beginning of 2015 a new LEED (Leadership in Energy and Environmental Design) certified building, expanding the number of beds to 430.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1955 |
| Built up area | 27,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI); Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 294 |
| Number of beds in ICUs | 70 |
| Number of registered doctors | 4,153 |
| Number of actives employees | 1,722 |
| Number of emergency | 108,736 |
| Number of emergency visits | 44,000 |
| Number of outpatients visits | 17,504 |
| Number of surgeries per year (except deliveries) | 13,836 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,335,113 |
| Gross Revenues (in million R\$): | 383.9 |



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 São Paulo - SP - 01409-902
 11 3147-9999 - www.hospital9dejulho.com.br



HOSPITAL PORTO DIAS

Brief History of the Organization

Porto Dias started its activities in June 1995 as an orthopedic emergency department located at Avenida Almirante Barroso, the main avenue in Belém. Having the proposal of offering differentiated and humanized services to clients, the hospital soon became a reference in different specialties, such as orthopedics, neurosurgery and renal surgery. It has received many awards as the best hospital in the region, according to opinion surveys, and was the first hospital in the North region to be accredited by ONA.

Always in the forefront of medicine in Para, it opened the first elevated heliport of the city in 2002. Likewise, Porto Dias offers 257 operational beds, being 51 in ICU and 10 surgical rooms, all equipped with laminar flow air system. The emergency department, housed in 1,000 m², is a reference in trauma and severe patients. During its 17 years of history, the organization has invested continuously in imaging diagnostic devices, having the largest installed capacity in the region.

Having strong vocation to trauma and orthopedics, the hospital has a medical residence program credentialed by the Brazilian Society of Orthopedics and Trauma (SBOT).

Highlights 2012

Hospital Porto Dias has developed throughout 2011 and 2012 a solid basis of projects directed to best practices focusing on patient safety. There has been an update of the strategic planning and all institutional protocols developed in the year were directed to the business areas focused on it. The managed protocols of sepsis, femur proximal fracture in elderly and videolaparoscopic bariatric surgery were initiated.

There has been implementation and management of bundles for prevention of infection associated with invasive procedures (mechanical ventilation, central venous catheters and urinary tube). The first implemented bundle (mechanical ventilation) showed effectiveness rate of 99%.

Activities directed to dissemination of institutional strategy, as well as the involvement of patients and family in care, comprising employees and external clients in order to expand the safety culture.

These and many other activities developed in 2012 have brought recognition to Hospital Porto Dias, which was accredited with Excellence as ONA III.

The main highlight of new services in 2012 was the installation of the PET SCAN. Moreover, in 2013, the radiotherapy service will be in full operation.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2013) | |
| For Profit Organization | |
| Founded in | 1995 |
| Built up area | 51,122 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 257 |
| Number of beds in ICUs | 51 |
| Number of registered doctors | 389 |
| Number of actives employees | 1,588 |
| Number of emergency | 122,240 |
| Number of emergency visits | 132,494 |
| Number of outpatients visits | 18,027 |
| Number of surgeries per year (except deliveries) | 6,845 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 210,743 |
| Gross Revenues (in million R\$): | undisclosed |



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Belém - PA - 66020-093
91 3184-9999 - www.hpd.com.br



HOSPITAL PORTUGUÊS

Brief History of the Organization

The origin of Hospital Português is connected with the merger of Sociedades Dezesesseis de Setembro e Portuguesa de Beneficência – both founded in the second half of 19th century, more precisely in 1857, to support Portuguese immigrants that had move to Brazil. To carry on with this humanitarian proposal, the organization Real Sociedade Portuguesa de Beneficência Dezesesseis de Setembro was created on August 14, 1859, which received the title Royal by Portuguese monarchy.

Developed by its members, Real Sociedade opened its first building on September 16, 1866 at Alto do Bonfim. After 61 years of activities provided to Portuguese people, their spouses and children, the Hospital opened its doors to other nationalities. The expansion of care to the whole population, including the most needy, led to its recognition as Public Utility Organization by municipal, state and federal decrees, fact that motivated its transfer to Barra Avenida, more centralized and developing region in the city.

After 156 years of operation, HP stands out in different medical specialties owing to the modern, minimally invasive and high complexity procedures that it performs. The organization is also known for its state-of-the-art infrastructure, with experienced and qualified professionals, modern resources and interconnected units (Maternidade Santamaria, Day Hospital and Medical Center HP).

Highlights 2012

Enhanced safety to patients, accompanying people, healthcare professionals, suppliers and other people who come to Hospital Português. This is the main assurance of the quality seal awarded to the philanthropic organization by ONA – National Accreditation Organization, on November 28, 2012, a result obtained thanks to the commitment and the integrated actions of the clinical and administrative teams and the executive office.

Before receiving this certificate, the Hospital was visited by auditors of Instituto Qualisa de Gestão, the certifying agency for ONA. During this period, the whole structure was assessed – clinical staff, provided services, management style, protocols, etc. In the end of the inspection, there was the confirmation of risk reduction and hospital safety in all dimensions advocated by the Brazilian Manual of Accreditation.

By reaching Level II of Hospital Accreditation, Hospital Português is now part of the small group of Brazilian hospitals (about 2%) that have a confirmed systemic vision of health. The certification of best practices and the standardization of processes and quality of services add value to the centennial reliability of the hospital, to be used as a market differential to guide users' choice of healthcare centers, such as is observed in Europe, the United States and Canada.

Characteristics

| | |
|--------------------------------------|--|
| Full Associate Hospital (since 2002) | |
| Non Profit Organization | |
| Founded in | 1857 |
| Built up area | 34,990 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA II) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 371 |
| Number of beds in ICUs | 122 |
| Number of registered doctors | 2,906 |
| Number of actives employees | 2,873 |
| Number of emergency | 44,263 |
| Number of emergency visits | 47,813 |
| Number of outpatients visits | 20,678 |
| Number of surgeries per year (except deliveries) | 32,406 |
| Number of deliveries per year | 3,201 |
| Number of tests performed at the Diagnostics and Therapy Unit | 963,584 |
| Gross Revenues (in million R\$): | 277.1 |



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 Salvador - BA - 40140-901
 71 3203-5555 - www.hportugues.com.br



HOSPITAL PRÓ-CARDÍACO

Brief History of the Organization

Hospital Pró-Cardíaco, one of the most modern high complexity centers in the world, was founded on November 9, 1959 as Cardiology Emergency Department Pró-Cardíaco, transforming into reality the dream of cardiologist Dr Onaldo Pereira to have urgency cardiology home care in Rio de Janeiro.

First coronary unit and first cath lab in a private hospital, respectively in 1968 and 1980; operative unit also in 1988, together with the ICU, which offered the organization the opportunity to provide complete care to patients with acute coronary disease; first heart surgery in 1988. The Hospital was also a pioneer in using transesophageal echocardiogram during surgeries; first chest pain unit in the country, in 1995; pioneer in stem cell investigations in ischemic cardiopathy, in 2003, in partnership with the Texas Heart Institute and UFRJ. Two years later, the study was published in the prestigious scientific journal Circulation.

In 2007, Pró-Cardíaco confirmed the national excellence level by being accredited by National Accreditation Organization – ONA III, a seal to the best models of management and safe healthcare practice. In 2008, the Hospital was awarded Merito em Ciencia and Tecnologia (Merit in Science and Technology), by Sociedade Brasileira de Cardiologia-SBC (Brazilian Society of Cardiology), a sign of the important scientific contributions of the clinical staff and the researchers from the organization.

Highlights 2012

The years 2011 and 2012 were periods of transformation that have revolutionized Pró-Cardíaco with the following facts: A new model of shared management based on indicators, leading to a profound management evolution; reinforcement of the development of quality, safety, sustainability and communication actions; restructuring of hospitality, teaching and research; renovation and expansion of different sectors; creation of new spaces and exclusive services for physicians and family members as part of the effective humanization policy; renovation of the technology, acquiring best equipment for Nuclear Medicine, Cath Lab and Arrhythmia areas. The certification by Accreditation Canada International, in March 2012, was a major achievement for the Hospital in this period. Pró-Cardíaco went through a very strict and broad accreditation process, which aligns the dimensions of quality of healthcare through outcome indicators in the areas of technical efficiency, clinical effectiveness and patient satisfaction. It has also become the third hospital in the world outside Canada and the first one in Brazil to receive the “Canada Distinction for CVA Patient Care”, a landmark to our organization. In 2012, the hospital was recertified by ONA III Excellence.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1959 |
| Built up area | 14,515 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 98 |
| Number of beds in ICUs | 34 |
| Number of registered doctors | 1,253 |
| Number of actives employees | 862 |
| Number of emergency | 9,588 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 4,465 |
| Number of surgeries per year (except deliveries) | 1,732 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 32,688 |
| Gross Revenues (in million R\$): | 184.0 |



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Rio de Janeiro - RJ - 22280-020
21 2131-1442 - www.procardiaco.com.br



HOSPITAL QUINTA D'OR

Brief History of the Organization

Founded in September 2001, Quinta D'Or stemmed from the renovation of old Hospital São Francisco de Paula. The spaces of the historic building were completely renovated and the whole structure was modernized, preserving the large apartments facing Quinta da Boa Vista, one of the largest and most beautiful parks in Rio de Janeiro, and the natural lighting of the corridors in a cozy and humanized environment.

Throughout these 10 years of operation, the organization has been consolidated as a center that provides care to severely ill patients, in a workplace that is harmonious and cooperative, with highly qualified multidisciplinary team, being awarded ONA Level III and the international accreditation by Accreditation Canada.

Quinta D'Or has become a reference in the densely populated region for clinical and surgical emergencies, with high resolution capability and technological resources widely recognized by the medical society in Rio de Janeiro. The hospital complex has 300 beds distributed into inpatient wards, ICU, step-down, pediatrics, neonatal ICU, ventilation unit and liver unit. The 16,000 m2 area next to the hospital offers a large parking facility and the possibility to expand the constructed area.

Highlights 2012 and 2013

In 2012, Quinta D'Or celebrated 11 years. In May 2012, the check-up program was initiated, with employees from Caixa Econômica Federal. The main purpose of the program is to provide to Caixa a check-up service to its employees – they simply have to call and schedule a date. In 2013, Quinta D'Or intends to expand the number of partnering companies.

In May 2012 a Scheduling Center was created. This project was developed to speed up and facilitate the scheduling of surgeries at the hospital. Using the Scheduling Center, the surgical teams can schedule their elective surgeries.

In June 2012, the oncology clinic was opened, offering tests and diagnosis. Now the clinic also provides chemotherapy and radiotherapy in addition to the whole necessary structure, such as oncologists, surgeons and radiologists in one single site. In August 2012, the obesity treatment center started to gain life. The hospital is totally equipped to receive obese patients. The idea of the project is to provide one-stop services. In addition to the surgical team, the patient can count on the support of dietitians, psychologists and presentations about the topic. The project will be implemented in 2013.

The hospital has also opened the Smart Track system in the adult ED, which was implemented in Hospitals of Rede D'Or São Luiz in 2012.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2010) | |
| For Profit Organization | |
| Founded in | 2001 |
| Built up area | 26,587 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 323 |
| Number of beds in ICUs | 115 |
| Number of registered doctors | 341 |
| Number of actives employees | 2,828 |
| Number of emergency | 110,856 |
| Number of emergency visits | 14,950 |
| Number of outpatients visits | 13,567 |
| Number of surgeries per year (except deliveries) | 9,558 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 8,822 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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Rio de Janeiro - RJ - 20941-150
21 3461-3600 - www.rededor.com.br/quintador



HOSPITAL SAMARITANO

Brief History of the Organization

Hospital Samaritano is located in São Paulo, main Brazilian city and one of the most important financial hubs in the world. It is one of the main healthcare centers of excellence in the country, recognized by the Ministry of Health for its quality of care and services provided in the area of social responsibility, especially the programs directed to the development of the Public Universal Healthcare System (SUS).

Counting on 119 years of history, it has excellent infrastructure, state-of-the-art technology and highly specialized clinical staff in clinical and surgical areas, comprising general surgery, cardiology, neurology, orthopedics, oncology, gastroenterology, fetal/perinatal medicine and urology/ nephrology.

Since 2004 Hospital Samaritano Sao Paulo has been accredited by Joint Commission International (JCI), one of the most important accreditation agencies of hospital quality standards in the world. Being awarded the accreditation has consolidated its position as a hospital center of excellence. In 2011 and 2012, Hospital Samaritano ranked 2nd in Brazil in the Ranking of the Best Hospitals and Clinics in Latin America, according to magazine AméricaEconomía Intelligence.

The hospital complex has 19 floors, 313 inpatient beds and neonatal, pediatric and adult intensive care units, two surgical centers with 21 operative rooms to perform high complexity procedures, adult and pediatric emergency department, complete and modern diagnostic medicine center, gastronomy and nutrition, atrium with services and convenience stores, in addition to other amenities.

Highlights 2012

In order to offer to patients specialized medical services, since 2012 Hospital Samaritano has been investing and implementing centers of specialties, focusing on cardiology, orthopedics, oncology, gastroenterology, urology / nephrology, neurology and fetal/ perinatal medicine, in addition to the creation of a transplant center, head trauma care and rehabilitation, memory center and others.

Supported by highly specialized clinical staff, the units are focused on complete and integrated care of patients, comprising all steps of treatment. Moreover, these centers have the modern infrastructure of Hospital Samaritano, including modern surgical center, with the most advanced technologies for high complexity procedures and complete Diagnostic and Therapeutic Center, staffed with specialists that can perform imaging tests for more precise diagnosis, in addition to an emergency department.

The implementation of these services led to the performance of three innovative procedures in the country in 2013. The Hospital was the second organization in the world to perform intra-uterine endoscopic procedure to repair spina bifida, a malformation that affects the structure that protects the baby's marrow. The surgery corrects the lesion, reducing the neurological damage in the fetus and the risk of hydrocephalus. The technique was performed by minor incisions, offering lower risks to the pregnant mother. Another unique procedure was the transplant known as incompatible ABO, in which donor and recipient do not have the same blood type. This surgery may be a great hope to patients who are waiting for a kidney to be transplanted. In addition to these unique and innovative procedures, Hospital Samaritano successfully performed an artificial heart implant surgery.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1894 |
| Built up area | 60,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 275 |
| Number of beds in ICUs | 74 |
| Number of registered doctors | 3,681 |
| Number of actives employees | 2,089 |
| Number of emergency | 144,619 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 18,950 |
| Number of surgeries per year (except deliveries) | 11,835 |
| Number of deliveries per year | 369 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,923.643 |
| Gross Revenues (in million R\$): | 389.0 |



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 São Paulo - SP - 01232-010
 11 3821-5300 - www.samaritano.org.br

HOSPITAL SANTA CATARINA

Brief History of the Organization

For over one hundred years, Hospital Santa Catarina (HSC) has provided safe and humanized service of excellence. Reference of quality in healthcare services in Brazil, HSC is considered one of the best and most prepared organizations to perform high complexity procedures in orthopedics, neurology, cardiology and oncology.

Counting on a modern infrastructure, state-of-the-art equipment and highly qualified professionals, the hospital has 327 beds, 20 operative rooms, five ICUs (neurology, cardiology, pediatric, neonatal and general) and 24-hour emergency department. Moreover, it provides services of quality, performing from minor procedures to high complexity surgeries.

Hospital Santa Catarina is a philanthropic organization that is part of Associação Congregação de Santa Catarina, which is part of a social network that works in healthcare, education and social services. It gathers more than 12,000 employees distributed into different social initiatives and support programs in seven Brazilian states.

Highlights 2011 e 2012

In 2012, Hospital Santa Catarina renovated its emergency department Counting on total investment of R\$ 9.3 million, the facility became much more spacious and modern, with comfortable furniture, individual spaces, pharmacy and cubicles for care with ICU equipment for more emergent cases. In addition to these modifications, the emergency department was integrated with the chest pain unit and the encephalic vascular accident, favoring access of emergency cases.

Another highlight was the hiring of a new Executive Director. Larry Meagher, North-American executive with over 40 years of experience in the hospital area, came in with the mission to improve the management process of Hospital Santa Catarina as a whole. To reach such objective, the buzz word for the new Executive Office is efficiency. The proposals for 2013 are: Innovate and increment the existing services and improve processes, such as for example, the reduction of length of stay. The main purpose is to ensure even greater safety and quality in care provided to the patients of the organization.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1906 |
| Built up area | 61,513 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 233 |
| Number of beds in ICUs | 94 |
| Number of registered doctors | 7,332 |
| Number of actives employees | 2,227 |
| Number of emergency | 192,321 |
| Number of emergency visits | 22,140 |
| Number of outpatients visits | 13,708 |
| Number of surgeries per year (except deliveries) | 14,508 |
| Number of deliveries per year | 3,640 |
| Number of tests performed at the Diagnostics and Therapy Unit | 199,812 |
| Gross Revenues (in million R\$): | 446.1 |



HOSPITAL SANTA GENOVEVA

Brief History of the Organization

Founded 43 years ago and constructed within 48,000 m² of native wood area, Hospital Santa Geneveva, accredited by ONA, has 11,300 m² of built up area, offering 133 beds divided into rooms, wards, ICUs, day clinic and 24-hour emergency department. There is an operative center with six rooms and diagnostic centers including: Cath lab, radiology, CT scan, ultrasound, endoscopy, colonoscopy, stress test, echography, holter, mapping and clinical analysis, in addition to parking facility that can have up to 250 cars.

The hospital is one of the most traditional private healthcare centers in Goiás, classified as a general hospital. It is a reference in heart surgery, bariatric surgery, general surgery, neurology, orthopedics, heart, kidney and pancreas-kidney transplant (the only private hospital in Goiás that performs transplants). Hospital Santa Geneveva offers medical residency programs authorized by Ministry of Education on cardiology, general surgery, general practice and anesthesiology. Promoting life in all its values, founded on knowledge, technology and sustainable management, with social and environmental responsibility, are the reasons for being of the hospital, dedicated to its inpatients and outpatients.

Highlights 2012

Hospital Santa Geneveva has consolidated its management model on decision making, pursuing commitment and engagement of the whole multidisciplinary team, aligned with strategic management and in compliance with risk management. Thanks to continuous improvement to meet clients' needs, it has carried on with renovation and revitalization of hospitality.

There was the renovation and revamping of the cardiology diagnostic centers (holter, mapping, echocardiogram). The hospital has acquired a new high definition imaging CT scan, respirators and the latest generation monitors to ICU, cath lab, operative rooms and emergency department. It has expanded the hemodialysis services to transplanted patients seen in the ICU by acquiring hemodialysis devices for reverse osmosis.

The organization has maintained its investments in courses, graduate studies and capacity building of employees, emphasizing continuing education. The hospital has also enhanced its social-environmental friendly profile by following up actions to promote chemical and biological hazardous waste management, according to the waste management model.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1970 |
| Built up area | 11,300 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA I) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 121 |
| Number of beds in ICUs | 20 |
| Number of registered doctors | 115 |
| Number of actives employees | 328 |
| Number of emergency | 18,136 |
| Number of emergency visits | 45,600 |
| Number of outpatients visits | 5,049 |
| Number of surgeries per year (except deliveries) | 2,067 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 21,408 |
| Gross Revenues (in million R\$): | 33.5 |



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 62 3264-9032 - www.santagenoveva.com.br



HOSPITAL SANTA JOANA

Brief History of the Organization

In the end of the 70's, with a modern and elegant architectural plan and a layout created based on the most advanced hospitality concepts, Hospital Santa Joana was opened to provide safety and excellent quality in healthcare.

Three decades later, recognition and prestige by the patients and the physicians confirm that the boldness and determination to break paradigms and implement new concepts of private healthcare management in Brazil were initiatives that enriched hospital medicine in the country. Innovation and technological breakthroughs and new hospital management concepts have been constantly incorporated by the organization.

Throughout its history, Hospital Santa Joana has been recognized by its pioneer actions and development of a permanent investment policy on state-of-the-art technology and improvement of human resources, providing to physicians and patients high quality standards. As a result of this philosophy, in November 2012 the organization was accredited by Joint Commission International (JCI), becoming a highlight in the North and Northeast of Brazil.

Hospital Santa Joana has one of the largest private emergency departments in the state, comprising eight in-house specialties to receive about 7,000 patients per month, becoming a reference center for multiple trauma patients. It is recognized as one of the main hospital complexes in the region offering many specialized and high complexity services, such as neurosurgery, trauma and orthopedics, urology, oncology, angiography and cath lab, preventive and diagnostic medicine, among others.

Highlights 2012

Since its foundation, Hospital Santa Joana has developed actions and investments focused on constantly improving the services, consolidating its position among the most modern hospital centers in the country. Some points in the year have to be highlighted, such as the expansion of activities by increasing the multiple emergency area and doubling the capacity to receive adult patients; opening of a new and modern Central Sterilization and Supplies Department, and a new ICU, comprising a whole floor of the main building distributed onto 750 m2. Moreover, a new building was constructed to see clinical and surgical cases – Clinical-Surgical Unit.

In 2012, Hospital Santa Joana consolidated the processes that define the best clinical practices and strengthened its quality standard and excellence in care. Always ahead of the competition, the hospital started 2013 to celebrate 34 years of history in Pernambuco, known as a national and international reference and accredited by Joint Commission International (JCI).

Following its plan of evolution, there is a new Bone Marrow Transplant Unit opened to the public, a Chest Pain Unit about to be completed, and the expansion of the emergency department and the operative unit, expected to be completed in the second half of the year. Everything intends to provide greater comfort, quality and safety to patients.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1979 |
| Built up area | 17,835 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 165 |
| Number of beds in ICUs | 54 |
| Number of registered doctors | 1,300 |
| Number of actives employees | 1,449 |
| Number of emergency | 79,367 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 11,181 |
| Number of surgeries per year (except deliveries) | 6,951 |
| Number of deliveries per year | 1,485 |
| Number of tests performed at the Diagnostics and Therapy Unit | 83,937 |
| Gross Revenues (in million R\$): | 125.8 |

HOSPITAL SANTA JOANA
A CIDADE EM BOAS MÃOS

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81 3216-6666 - www.santajoana.pe.com.br



HOSPITAL SANTA LUZIA

Brief History of the Organization

Founded in 1969, Hospital Santa Luzia has become a high complexity general hospital and throughout the years it has been consolidated as a reference in medical hospital care in the Federal Capital and its neighboring cities.

Located in Hospital Sector Local South, a reference area for medical-hospital care in Brasilia, the hospital has infrastructure with all human and technological resources that a top quality hospital should have.

Divided into six floors, Santa Luzia has 172 beds in operation: 100 inpatient beds for clinical, medical and specialty admissions, 23 maternity beds with rooming in, 40 ICU beds for adults and 9 pediatric and neonatal ICU beds. There is still a surgical center with eight operative rooms and four obstetric rooms, emergency department, outpatient clinic, imaging diagnostic center and laboratory.

Highlights 2012

In February 2012, two intelligent surgical rooms with the latest generation devices were opened, enabling the performance of high complexity procedures with enhanced safety both for the patient and the clinical staff.

In March 2012, 14 new inpatient beds were opened, built within the most modern concepts of quality care with humanization.

In May 2012, Hospital Santa Luzia was acquired by Rede D'Or São Luiz, the largest private hospital network in the country. With the arrival of Rede D'Or, the hospital has gained drift to trigger a modernization process. It has started by launching an internal campaign to improve quality standards by implementing new clinical care protocols, and investing approximately R\$ 36 million in expansion and modernization works and acquisition of new devices.

In 2013, 30 new inpatient beds are expected, plus 16 new adult ICU beds, 7 new Mixed ICU beds (Pediatric and Neonatal), modernization of the surgical area with private preoperative cubicles, and expansion of post-anesthetic and post-delivery recovery.

Characteristics

| | |
|--|--|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1969 |
| Built up area | 14,221 m ² |
| Clinical staff organization | opened |
| Hospital Accreditation | National Accreditation Organization (ONA II) |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 174 |
| Number of beds in ICUs | 53 |
| Number of registered doctors | 711 |
| Number of actives employees | 1,330 |
| Number of emergency | 135,000 |
| Number of emergency visits | 70,000 |
| Number of outpatients visits | 17,000 |
| Number of surgeries per year (except deliveries) | 9,000 |
| Number of deliveries per year | 2,400 |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,000,000 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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 Brasilia - DF - 70390-903
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HOSPITAL SANTA ROSA

Brief History of the Organization

Santa Rosa Hospital, located in the state of Mato Grosso, a region in clear expansion in Brazilian Western area, has been following the development of the state and the capital city Cuiaba, showing itself as an innovative and technological project for healthcare.

In 2012, the Hospital celebrated 15 years of operation, marked by pioneer actions and entrepreneurial management, which make the organization be seen as a reference in the state due to investments made in technology, specialized medicine, humanization of hospital environment and comfort provided to patients. The Santa Rosa Hospital is a complex that occupies two buildings in an upscale area of the city, enabling quick access to patients, even those coming from other states such as Rondonia and Acre.

The Hospital has the mission of providing complete health care. The vision, defined until 2016, is to make the hospital become recognized as a reference in high complexity, quality, generation of knowledge, humanization and social responsibility.

Highlights 2012

Following the national trend adopted by large hospitals in Brazil, Santa Rosa Hospital has opened a day clinic for short term stay.

It has also opened a new coronary unit with 23 beds, presenting modern and humanized structure, totaling 54 ICU beds.

It has also made a partnership with Consulting and Management Institute of Hospital Israelita Albert Einstein to implement a clinical staff management system. The main objective is to organize care by using protocols and integrated programs focused on strategic specialties, placing Santa Rosa as a model hospital in the state of Mato Grosso.

Another partnership was made with Fundação Dom Cabral in the program Parceiros para Excelência (PAEX – Partners for excellence), towards continuously improving management and organizational results.

The concepts of modernity and differentiated and high quality care in one of the most beautiful areas in the capital city of the state has granted to the hospital for the sixth time the award Top Of Mind as the most frequently recalled hospital in the state.

In the end of 2012, the hospital received accreditation Level III – Excellence by National Accreditation Organization – ONA, being the only hospital to hold this title in Mato Grosso.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2003) | |
| For Profit Organization | |
| Founded in | 1997 |
| Built up area | 13,937 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 136 |
| Number of beds in ICUs | 54 |
| Number of registered doctors | 883 |
| Number of actives employees | 660 |
| Number of emergency | 73,896 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 6,511 |
| Number of surgeries per year (except deliveries) | 7,827 |
| Number of deliveries per year | 413 |
| Number of tests performed at the Diagnostics and Therapy Unit | 537,711 |
| Gross Revenues (in million R\$): | 51.6 |



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65 3618-8000 - www.hospitalsantarosa.com.br

HOSPITAL SÃO CAMILO POMPEIA

Brief History of the Organization

São Camilo Pompeia Hospital is a philanthropic organization that belongs to the São Camilo Group, whose main purpose is to contribute for the maintenance of other 33 hospitals of Sociedade Beneficente São Camilo (SBSC), distributed all over the country and providing care through the Universal Public Healthcare System (SUS) to low income populations.

Located in the west area of São Paulo, Unit Pompeia is a general hospital that can provide elective and emergency care, transplanted and other high complexity surgeries. Counting on a modern and safe infrastructure, the Unit has 273 beds and a clinical staff of about 4,000 highly qualified credentialed physicians, providing care to about 1 million people every year.

The history of the hospital paved the arrival of Provincia Camiliana into Brazil. Idealized by Father Inocente Radrizzani, Policlínica São Camilo opened in 1928 and it was the cornerstone for the construction of the currently existing modern and large hospital complex. After going through a number of renovations and expansions, Policlínica was renamed Hospital São Camilo Pompeia on January 23, 1960.

In addition to Unit Pompeia, the network São Camilo has two units - Santana (230 beds) and Ipiranga (162 beds).

Highlights 2012

Hospital São Camilo Pompeia started the year 2013 with a number of achievements, major projects and good news. A new building is being constructed at the area that used to house the administrative operations of the Hospital. There will be a total of 10 floors, five underground floors, about 90 beds, new surgical rooms and more adult ICU beds.

The new construction is part of the hospital expansion plan, started in 2003, which is expected to be executed into three steps. The first one included the construction of a 34,000 m² building, opened in 2005. The second one was concluded in 2010 and the third step will be concluded by 2014. As a result of this expansion, the unit will have 400 beds. Moreover, the hospital will do a revitalization, conveying a more modern look to the Hospital.

After celebrating the success of the I International Congress on Realistic Simulation held in 2012 for over 150 participants, the Teaching and Research Institute of Hospital Network São Camilo will organize, in 2013, the III International Congress about the topics of urgency, emergency and patient safety.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2003) | |
| Non Profit Organization | |
| Founded in | 1960 |
| Built up area | 38,772 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI); Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 273 |
| Number of beds in ICUs | 65 |
| Number of registered doctors | 3,700 |
| Number of active employees | 1,742 |
| Number of emergency | 17,483 |
| Number of emergency visits | 6,674 |
| Number of outpatients visits | 14,466 |
| Number of surgeries per year (except deliveries) | 10,619 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,154,790 |
| Gross Revenues (in million R\$): | 368.0 |



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São Paulo - SP - 05022-000
11 3677-4444 - www.saocamilo.com

HOSPITAL SÃO JOSÉ

Brief History of the Organization

Designed to provide humanized and personalized care through a complete clinical and technological structure, Hospital São José opened on November 27, 2007 by Beneficência Portuguesa de São Paulo, one of the largest hospital complexes in Latin America.

The hospital is an oncology reference in Brazil. Its clinical staff is formed by well-known specialists who work together with other healthcare professionals to provide patients with multidisciplinary care within international standards. Counting on over 23,000 m², the organization has a Teaching and Research Center recognized for its technical and scientific knowledge continuously generated by their professionals. In December 2010, Hospital São José was accredited by Joint Commission International (JCI) after the implementation of a project directed to quality improvement and patient safety. The organization continues with periodic improvement actions, towards reaching even more satisfactory medical and clinical outcomes.

Highlights 2012

In 2011, Hospital São José opened its Advanced Oncology Center. The project required R\$ 3 million in investments and has placed the organization among the main cancer treatment reference centers in Brazil.

In addition to modern hospital infrastructure, the Advanced Oncology Center has a highly qualified clinical team, led by oncologist Antonio Carlos Buzaid. The following are also coordinators of the medical centers: Fernando Cotait Maluf, head of Clinical Oncology, Riad Younes, head of Surgical Oncology, and Phillip Scheinberg, head of Hematology Services.

In 2012, the hospital invested even further in consolidating its brand by hiring well known physicians to join the clinical staff of the hospital, such as Ben Hur Ferraz Neto, director of Liver Institute, who used to work for Hospital Israelita Albert Einstein.

Investments in technology were made to improve even further the diagnosis and treatment of patients. Devices such as Liver and Nuclear Medicine GPS were incorporated by the Diagnostic Center of the Hospital.

Characteristics

| | |
|--------------------------------------|--------------------------------------|
| Full Associate Hospital (since 2012) | |
| Non Profit Organization | |
| Founded in | 2007 |
| Built up area | 29,761 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 65 |
| Number of beds in ICUs | 14 |
| Number of registered doctors | 2,500 |
| Number of actives employees | 657 |
| Number of emergency | not applicable |
| Number of emergency visits | 9,794 |
| Number of outpatients visits | 2,897 |
| Number of surgeries per year (except deliveries) | 2,575 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 287,110 |
| Gross Revenues (in million R\$): | 134.2 |



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11 3505-6000 - www.bpsp.org.br



HOSPITAL SÃO LUCAS

Brief History of the Organization

Founded in January 1969 in the countryside of the State of São Paulo, in the city of Ribeirão Preto, by the Association of Professors and Physicians from the Medical School of University of Sao Paulo (USP), Hospital São Lucas S/A is recognized as one of the main providers of high quality and safe medical and hospital services and excellent neurological care – with 24-hour emergency care, cardiology and gastroenterology care. Our hospital is also a pioneer in bone marrow transplantation in the private healthcare system in Ribeirão Preto and neighboring areas.

Sao Lucas is the first hospital in the countryside of Brazil and the seventh hospital in Brazil to be certified by the National Accreditation Organization (ONA). The success of São Lucas Group, which also owns Hospital Ribeirânia, RD Diagnosticos, Multilav Lavanderia Industrial and Multilav Esterilizações, arises from many years providing high quality and safe services with a focus on the client's satisfaction and the concept of "people taking care of people." These values have always guided Hospital São Lucas' actions and ensured the fulfillment of its commitments.

2012 Highlight

Reaching excellence in patient safety and healthcare quality are the main aims of Sao Lucas Group and were the same criteria which enabled the Hospital, in August 2012, to be granted a Level III Excellence Certificate by ONA, becoming the only hospital in the region to have achieved a quality certificate of this level.

New rooms have been opened and the refurbishment of all the other rooms is in the final stage, showing the hospital's concern for the comfort and safety of its clients and their relatives.

2013 challenges: to implement new technologies, increase the number of ICU beds, become a center of excellence in gastric bypass surgery, achieve the specific stroke protocol certificate "Stroke Services Distinction Information Package" from Accreditation Canada, and prepare the hospital to earn international certificates.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2002) | |
| For Profit Organization | |
| Founded in | 1969 |
| Built up area | 8,592 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 87 |
| Number of beds in ICUs | 22 |
| Number of registered doctors | 1,438 |
| Number of actives employees | 470 |
| Number of emergency | 48,943 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 5,563 |
| Number of surgeries per year (except deliveries) | 8,997 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 247,900 |
| Gross Revenues (in million R\$): | 64.3 |



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Ribeirão Preto - SP - 14015-130
16 4009-0020 - www.gruposaoLucas.com.br



HOSPITAL SÃO LUCAS DE ARACAJÚ

Brief History of the Organization

Clinica e Hospital São Lucas was founded on October 18, 1969, Physicians' Day, by a cardiologist and a pneumologist – brothers in law and friends – both professors at Medical School of Federal University of Sergipe. Since the beginning, the organization has stood out owing to its concern about quality, trying to attract good physicians, well trained nursing team and high quality devices.

For over 40 years, it has been a reference in hospital care in the state and North and Northeast regions, having as its main focus cardiology, neurology, vascular medicine, geriatrics and complex surgeries, among others.

The organization performs renal transplantation, heart surgery, bariatric surgery, endovascular procedures in the cath lab and has a wide range of diagnostic tests provided to inpatients and outpatients.

To fulfill its mission, which in addition to providing care includes teaching and researching, it has created Fundação São Lucas (FSL) on October 2, 1986, which operates independently from the hospital and manages a day care center opened to the community and a school of health-related technical courses, considered to be the best in the area. The organization has also actively participated in many Brazilian and international multicenter studies through its Teaching and Research Center (CEPFSL).

Highlights 2012

In the end of 2011, the Hospital was invited to join the process for Accreditation Canada. In November 2012, the certificate was awarded after less than one year of observation, added up to ONA certificate. It was a process that engaged deeply the whole organization at all levels and all professional categories.

Another highlight was having a free choice healthcare plan for employees so that they could be entitled to use the hospital. As of 2012, those who provide care at Hospital São Lucas can also be taken care of here, with no restrictions. It has been a major achievement, aligned with the principles and human values of the organization.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2012) | |
| For Profit Organization | |
| Founded in | 1969 |
| Built up area | undisclosed |
| Clinical staff organization | mixed |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 158 |
| Number of beds in ICUs | 30 |
| Number of registered doctors | 715 |
| Number of actives employees | 1,018 |
| Number of emergency | 65,428 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 10,153 |
| Number of surgeries per year (except deliveries) | 8,743 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 937,511 |
| Gross Revenues (in million R\$): | undisclosed |



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Aracajú - SE - 49015-400
79 2107-1000 - www.saolucas-se.com.br



HOSPITAL SÃO LUIZ ITAIM

Brief History of the Organization

Considered one of the largest private hospitals in the country, Hospital São Luiz was established in 1938 as an outpatient department with 12 beds in the neighborhood of Itaim Bibi, in São Paulo, Brazil. Two years later, it became the first private emergency room in São Paulo. It was just a matter of time to construct the hospital building with 80 beds in 1963. In 1983, its maternity unit was established introducing an innovative concept of hospitality in the healthcare market in Brazil by providing patients with comfort and humane and caring service and employing reference practices in maternity care and neonatal ICU.

In 1994, a modern diagnostic unit became part of the hospital complex capable of performing the latest medical examinations with the support of specialized teams. In 2010, São Luiz Hospital merged with Rede D'Or and became part of the largest private hospital chain in Brazil. São Luiz Hospital gathers highly qualified medical teams, strives for excellence in healthcare and uses high-tech equipment, in addition to providing healthcare in more than 40 medical specialties. São Luiz Hospital is a reference in gynecologic, urologic, neurological, heart and orthopedic surgeries. Its technology department, established in 2005, provides the society with innovation and safety in operating rooms, labor delivery rooms and adult and neonatal ICUs. According to its tradition in pursuing excellence and fostering continuous development for the best healthcare practices, Hospital e Maternidade São Luiz has been the official hospital for the Formula One Brazil Grand Prix for 13 years.

Highlight 2012

The year 2012 was marked with great achievements by establishing partnership with brand Fleury, which added great value to technical quality, as well as with 39 new rooms on the first, second and third floors with the highest standards and latest infrastructure. This consolidated the expansion of the unit for the year 2012 and there was a significant improvement in technical quality in the emergency room by implementing the Smart Track tool.

Among the large-scale projects for the year 2013 in technology, there will be investments in the radiology department with the installation of a second tomography (64 channels) and of a new hemodynamic device. Still in 2013, the implementation of the Tasy system will be concluded, resulting in significant improvement in hospital management. As for infrastructure, the building of new facilities will go on with the institution expansion project.

Another important mark is pursuing the Joint Commission International (JCI) accreditation.

Characteristics

| | |
|--------------------------------------|-----------------------|
| Full Associate Hospital (since 2003) | |
| For Profit Organization | |
| Founded in | 1938 |
| Built up area | 35,745 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | in progress |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 369 |
| Number of beds in ICUs | 96 |
| Number of registered doctors | 10,573 |
| Number of active employees | 2,110 |
| Number of emergency | 137,946 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 31,742 |
| Number of surgeries per year (except deliveries) | 18,246 |
| Number of deliveries per year | 8,236 |
| Number of tests performed at the Diagnostics and Therapy Unit | 887,925 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



Rua Dr. Alceu de Campos Rodrigues, 95
Vila Nova Conceição - São Paulo SP - 04544-000
11 3040-1100 - www.saoluiz.com.br



HOSPITAL SÃO LUIZ JABAQUARA

Brief History of the Organization

Located in Jabaquara, South of the city of São Paulo, Nossa Senhora de Lourdes Hospital was founded in 1958, later becoming a reference health center in the region. In 1998, the Children's Hospital was opened, comprising a pediatric specialized center capable of providing complete care with comfort, tenderness and safety.

Recently, in April 2012, Hospital Nossa Senhora de Lourdes and the Children's Hospital were acquired by Rede D'Or São Luiz. As of November 2012, Hospital Nossa Senhora de Lourdes received the name Hospital São Luiz Jabaquara and started to operate based on the new emergency system of the network: Smart track.

Highlights 2012

In November 2012, Rede D'Or São Luiz announced the change of brand Nossa Senhora de Lourdes to Hospital São Luiz Unit Jabaquara, becoming the fourth unit to use São Luiz name in São Paulo. The new owner took over the unit located in Jabaquara, south of São Paulo, including also the Children's Hospital. The group has already invested R\$ 100 million and expects to grow 20% in revenues within the first year of operation.

According to the growth plan and the commitment with development of the private healthcare market in Brazil of Rede D'Or São Luiz, Nossa Senhora de Lourdes Hospital has gone through a number of structural changes. As a result of the change in management, it now provides the same standard and excellence of care of other units under the same brand. Among the improvements we can mention the expansion of the ICU, opening of important areas that were not in operation, and increased efficiency in the emergency department with the implementation of smart track, a new methodology to reduce the maximum waiting time in the first visit to about 20 minutes in less severe cases.

Characteristics

| | |
|--------------------------------------|-----------------------|
| Full Associate Hospital (since 2004) | |
| For Profit Organization | |
| Founded in | 1958 |
| Built up area | 32,800 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | in progress |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 150 |
| Number of beds in ICUs | 31 |
| Number of registered doctors | 1,060 |
| Number of actives employees | 940 |
| Number of emergency | 130,000 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 9,000 |
| Number of surgeries per year (except deliveries) | 5,000 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 141,000 |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



Rua das Perobas, 344 - Jabaquara
 São Paulo - SP - 04321-120
 11 5018-4000 - www.saoluiz.com.br



HOSPITAL SÃO RAFAEL

Brief History of the Organization

Founded by physician Luigi Verze, Hospital São Rafael is a non-profit medical-hospital complex operating in Salvador and in various countryside cities of Bahia supported by Monte Tabor – Italian-Brazilian Center for Health Promotion. With focus on human-beings and on the mission “Go, Teach and Heal,” Hospital São Rafael is one of the most renowned healthcare institutions in Bahia and one of the most important ones in the country following the concept of the uniqueness of the person – being biopsychospiritual.

Hospital São Rafael provides approximately 2,000 patients with care on a daily basis. The institution has 304 beds, including 42 ICU beds (general, pediatric and cardiology) and 28 step-down beds, in addition to an outpatient department with 77 physician’s offices, emergency room, hemodialysis, the latest imaging equipment, operating room, pathological anatomy, clinical analysis laboratory, day hospital and computerized blood bank. Medical residence, corporate university and research efforts have become part of this scenario recognized by the National Accreditation Organization with Level III (Excellence).

Highlight 2012

At Hospital São Rafael, care, teaching and research become part of an innovative environment in healthcare. In 2012, the institution stood out at national and international levels due to research on stem cells – carried out through the Center of Biotechnology and Cell Therapy (CBTC) with the support of FINEP (Brazilian Agency of Innovation), FIOCRUZ (Oswaldo Cruz Foundation) and FAPESB (Bahia State Research Support Foundation). Also, the institution became part of the National Network for Clinical Research and University Telemedicine Network. In addition, Hospital São Rafael earned the certificate “Accredited with Excellence – Level III” awarded by the National Accreditation Organization, as well as signed the “Corporate Agreement for Integrity and Against Corruption” promoted by Instituto Ethos.

In order to maintain the healthcare quality and increase the number of services provided by Hospital São Rafael, a new building is being constructed with 10 floors and 13,000 square meters of constructed area. This expansion will enable the provision of new beds and benefit departments, including emergency, oncology and BMT (Bone Marrow Transplant). The Corporate Governance implemented an automation process through the Interact system to compile indicators, always promoting management transparency and financial sustainability.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2013) | |
| Non Profit Organization | |
| Founded in | 1974 |
| Built up area | 40,000 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 304 |
| Number of beds in ICUs | 42 |
| Number of registered doctors | 871 |
| Number of actives employees | 2,953 |
| Number of emergency | 81,727 |
| Number of emergency visits | 505,597 |
| Number of outpatients visits | 19,945 |
| Number of surgeries per year (except deliveries) | 13,508 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 2,049,087 |
| Gross Revenues (in million R\$): | 349.3 |



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 Salvador - BA - 41253-190
 71 3281-6265 - www.hsr.com.br



HOSPITAL SAÚDE DA MULHER

Brief History of the Organization

Hospital Saúde da Mulher was founded on November 29th, 1991 with an initial focus on adult female and child healthcare performing minor and major surgeries. For the past 21 years, Hospital Saúde da Mulher has broadened its horizons and started to service men and women of all ages, becoming a high complexity hospital with the highest number of ICU beds in the state of Para and the first private hospital in the north of Brazil to provide patients with the latest healthcare services. With the aim to become a reference in oncology in the North region, Hospital Saúde da Mulher stands out for being the first and unique private hospital in the state of Para to perform all diagnostic exams and treatment in nuclear medicine, radiotherapy and brachytherapy.

Currently, Hospital Saúde da Mulher has five buildings, including the hospital itself and the diagnostic unit. It has 177 beds, 50 ICU beds and 13 operating rooms. The diagnostic unit has the latest imaging equipment collection aligned with a comfortable structure to perform medical examinations and schedule medical appointments, which provides greater safety and reliability for patients' healthcare.

Highlight 2012

In 2012, Hospital Saúde da Mulher invested even more in high-tech equipment to fight cancer. Varian Trilogy and PET-CT (Pet Scan) of 64 channels were installed – pieces of equipment that represent a new stage in oncology diagnosis and treatment. With Varian Trilogy, Hospital Saúde da Mulher performed the first radiosurgery in the North of Brazil, leaving Belem in the select group of capitals that carries out this procedure.

Other highlights in the year 2012 include earning the certificate in excellence level by National Accreditation Organization– the most important one in the healthcare market in Brazil, and the certificate “Accreditation Program of Clinical Analysis Laboratories” (PALC) – the most relevant one in Latin America – awarded by the Brazilian Society of Clinical Pathology and Laboratory Medicine (SBPC/ML). These certificates validate quality, safety, accuracy and reliability in laboratory examination results for patients, physicians and healthcare operators. In 2012, Hospital Saúde da Mulher also became member of the Canadian Accreditation.

In 2013, Hospital Saúde da Mulher will open the doors of its new building, which reaffirms its commitment to always improve healthcare by expanding its structure with new beds, new operating rooms, new ICUs and a heliport.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2012) | |
| For Profit Organization | |
| Founded in | 1991 |
| Built up area | undisclosed |
| Clinical staff organization | mixed |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 177 |
| Number of beds in ICUs | 50 |
| Number of registered doctors | 230 |
| Number of actives employees | 1,541 |
| Number of emergency | 77,068 |
| Number of emergency visits | 307,810 |
| Number of outpatients visits | 11,346 |
| Number of surgeries per year (except deliveries) | 8,909 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 305,790 |
| Gross Revenues (in million R\$): | undisclosed |



Travessa Humaita, 1598 - Marco
 Belém - PA- 66085-220
 91 3181-7000 - www.hsmdiagnostico.com.br

Hospital Sírio Libanês

HOSPITAL SÍRIO-LIBANÊS

Brief History of the Organization

Sociedade Beneficente de Senhoras Hospital Sírio-Libanês (SBSHSL) is a philanthropic institution and an International reference in healthcare. Founded in 1921, SBSHSL is based on three pillars, including Hospital Sírio-Libanês (HSL), Sírio-Libanês Teaching and Research Institute (IEP) and Philanthropy.

As its main characteristic, SBSHSL brings together medical and technological excellence and humanized care provided to Brazilian and international patients who seek the hospital for diagnostic and treatment purposes in more than 60 medical specialties. This is achieved through regular investments in modernizing the hospital infrastructure, training its professionals and valuing the clinical staff formed by renowned physicians in Brazil.

Through the IEP, SBSHSL has as its mission to acquire and spread knowledge and build the capacity of its professionals, while contributing to attain excellence in healthcare, in addition to developing and implementing new technologies in laboratories and training centers.

SBSHSL is also a partner of the Ministry of Health in projects aimed to develop SUS (Universal Public Healthcare System) by implementing the best management practices and providing quality medicine to an increasing number of Brazilian citizens.

Highlights 2012

Hospital Sírio-Libanês continued to make investments totaling R\$ 227 million in its expansion and modernization project. In the teaching field, IEP concluded various activities that fostered knowledge and strengthened even more existing partnerships, including the CMIRA project – A New Look at the Assessment of Medical Skills. As for stricto sensu graduate courses, IEP implemented a Master's in Technology Management and Innovation in Healthcare in partnership with Fundação Dom Cabral (FDC).

IEP senior management took an important step to carry out three clinical trials in obesity, diabetes, Parkinson's disease and head and neck cancer with approximately 100 patients in the triennium 2012-2013-2014. The HSL Molecular Oncology Center in partnership with Ludwig Cancer Research Institute started its activities in January 2012, enabling the participation of new researchers and post-graduate students. As for philanthropy, the year was marked by the beginning of projects for the new triennium (2012-2013-2014). In total, 18 projects were approved by the Ministry of Health, including 11 new projects and seven ongoing projects.

This process is important as it establishes a synergic relation in carrying out collective actions, where real needs arise from the society. For this, HSL's concern in taking advantage of all acquired and spread knowledge was shared with the management of Ministry of Health.

Characteristics

| | |
|--|--------------------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1921 |
| Built up area | 99,989 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Joint Commission International (JCI) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 367 |
| Number of beds in ICUs | 44 |
| Number of registered doctors | 3,792 |
| Number of actives employees | 4,498 |
| Number of emergency | 81,671 |
| Number of emergency visits | 61,402 |
| Number of outpatients visits | 18,677 |
| Number of surgeries per year (except deliveries) | 20,442 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 3,678,892 |
| Gross Revenues (in million R\$): | 1,085.3 |



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São Paulo - SP - 01308-050

11 3155-0200 - www.hospitalsiriolibanes.org.br



HOSPITAL VERA CRUZ

Brief History of the Organization

Created after the Second World War, in the end of the 40's, by Minas Gerais traditional families Rabello and Starling, Hospital Vera Cruz has specialized services, including obstetric and maternity, cardiology and heart and vascular surgery, neurology, general surgery and orthopedics. It used to take care of patients for the Universal Public HealthCare System in Brazil (former INPS, currently SUS), carrying out high complexity surgeries, especially in pediatric cardiology.

In the 90's, SUS services were suspended. Since then, the Hospital started to work primarily with the private healthcare sector. Thanks to distinguished physicians, such as Sebastião Correa Rabello (heart surgery), Ilanio Starling (general surgery), Francisco Rocha (neurology), Luis Fabio Rocha (cardiology) and other well-known professionals, HVC became a reference in its key service offers for the past 20 years.

The hospital is celebrating 64 years in 2013, standing out in high complexity medicine in Minas Gerais. The company is now managed by the third generation and collects the benefits of its tradition, facing the challenges of modern competitive management in a complex segment, going through the turmoil of a modern society in transition.

Highlights 2012

During the year 2012, many actions have been adopted to provide greater corporate stability and implementation of a governance model, trying to reach better technical and economic results. The main highlights are the services of oncology, pain and neurology, in addition to the traditional services of heart surgery, cath lab, general surgery, neurology and orthopedics, among others. The Hospital has developed better relationship with the healthcare operators and improved contract negotiations, in addition to adopting the lean methodology, bed management, clinical staff and supply chain management strategies, focusing on information management by Tasy web-based system to support decision making. The Hospital has been accredited with Excellence by National Accreditation Organization (ONA III) and it is one of the few hospitals in the state of Minas Gerais to be an associate member of Anahp.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2011) | |
| For Profit Organization | |
| Founded in | 1949 |
| Built up area | 5,433 m ² |
| Clinical staff organization | closed |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 111 |
| Number of beds in ICUs | 44 |
| Number of registered doctors | 622 |
| Number of actives employees | 765 |
| Number of emergency | 105,191 |
| Number of emergency visits | 61,342 |
| Number of outpatients visits | 9,164 |
| Number of surgeries per year (except deliveries) | 8,469 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 88,952 |
| Gross Revenues (in million R\$): | 75.5 |



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 Belo Horizonte - MG - 30190-130
 31 3290-1000 - www.hvc.com.br



HOSPITAL VITA BATEL

Brief History of the Organization

Hospital VITA Batel was opened in December 2004, in one of most upscale neighborhoods in Curitiba, to provide high-quality distinguished services and safety in healthcare to its customers.

The Hospital's history of eight years dedicated to patients led it to obtain a level III Certificate of Excellence by the National Accreditation Organization (ONA III). More recently it was also awarded the Accreditation Canada.

The hospital has an open clinical staff and a high demand for medium and high complexity healthcare, chiefly in the areas of cardiology, neurology, orthopedics, general surgery and urology. It is currently a benchmark in bariatric surgery, both in Brazil and abroad. The hospital has 80 beds, 57 rooms, 23 ICU beds (general and cardiology) and 7 operating rooms.

The institution has developed health promotion and disease prevention plans as part of Viver Mais, a VITA program dedicated to the elderly, supported by its partnership with health plans operators.

The alliance with Hospital do Coração in Curitiba, dating back to 2009, made Hospital VITA Batel also a benchmark in cardiac healthcare.

Highlights 2012

2012 was a year of important accomplishments to Hospital VITA Batel. After eight years of efforts and dedication Hospital Vita Batel obtained excellence level accreditation by ONA and the Accreditation Canada. During 2012 the hospital also celebrated the achievement of the Bariatric Accreditation by the Surgical Review. Other facts worth mentioning are:

- 3M Diamond Certification for Skin Injury Prevention;
- Improvements in the surgical center with a major renovation in the main operating room, purchasing of a new surgical arch, exclusive elevator to the operating room, VITA TV – a Communication channel of with the clinical staff, and a new oxygen peroxide autoclave;
- Creation and implementation of the 8 steps for healthcare safety;
- Eric Roger Wroclawski award, given by Einstein Scientific Journal, the article "Biocompatibility of castor oil polymer (Pm) compared to titanium (Ti), aimed at use in circulatory assist device (K-Pump);
- New Laboratory of Motility and Digestive Physiology;
- Drill of Multiple Victims Care performed (AMUV);
- Partnership with the Fukuoka Foundation to accomplish Zero Waste Program;
- Creation of VITA Institute of Education and Research;
- Focus Group with health insurance companies;
- Medical Specialization in bariatric and metabolic surgery.

Characteristics

| | |
|--------------------------------------|--|
| Full Associate Hospital (since 2010) | |
| For Profit Organization | |
| Founded in | 2004 |
| Built up area | 7,005 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 65 |
| Number of beds in ICUs | 23 |
| Number of registered doctors | 978 |
| Number of actives employees | 375 |
| Number of emergency | 64,460 |
| Number of emergency visits | 5,525 |
| Number of outpatients visits | 7,803 |
| Number of surgeries per year (except deliveries) | 6,081 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 269,307 |
| Gross Revenues (in million R\$): | 57.2 |



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Curitiba - PR - 80420-160
41 3883-8406 - www.hospitalvita.com.br



HOSPITAL VITA CURITIBA

Brief History of the Organization

Hospital VITA Curitiba opened in March 1996, and was acquired by VITA Participações in June 2000. The built up area of the hospital is 18,000 m² on a plot area of 102,000 m². It currently has 153 beds and around 560 employees. On average, it receives 11,000 emergency visits, 900 hospitalizations and 600 surgeries. It is a general hospital, with an open clinical staff, covering different specialization areas. VITA Curitiba is one of the most modern hospital complexes in Brazil and the most important one in Paraná, characterized by high-complexity care.

Over 17 years of existence and dedication to its patients, it has been recognized in Brazil and abroad for its accreditations: Accreditation with Excellence seal (ONA III) and International Accreditation Canada. The hospital has five perfectly structured vocational areas: cardiology, neurology, orthopedics, pediatrics and emergency medicine. The hospital's structures offer the following services: inpatient unit, general ICU, coronary ICU, Pediatric ICU, neurological ICU, one-day hospital, surgical center, 24-hour emergency service, medical offices center, diagnosis and therapeutic services' support.

Highlights 2012

The highlights for 2012 are:

- Conducting the Second Focus Group with Health Operators - The Focus Group consists of a working group made up of representatives from the Hospital and from major health insurance companies, with the aim of discussing issues related to the quality and safety of care, promoting the integration of processes to create value for the patient;
- Consolidation of communication channels with the community, providing public interest information through social networks;
- Performance of SULBRAFIX, a series of courses focusing on planning for deformity correction and bone lengthening, with the presence of national and international speakers and students;
- 3M Diamond Certification for Skin Injury Prevention;
- Creation and implementation of the 8 steps for healthcare safety - the project aimed to engage patients and caregivers in their treatment providing an additional guarantee of healthcare quality and safety;
- Expansion of Sports Medicine Offices;

At the end of 2012 were initiated three major projects with prospects for completion in early 2013:

- Restructuring the center for image diagnostic, with the acquisition leading-edge equipment for computerized tomography and magnetic resonance imaging, acquisition of digital X-ray equipment, equipment for scanning images and technological upgrading of the PACS system.
- Creation of Instituto VITA de Ensino e Pesquisa, dedicated to education and research;
- Expansion and restructuring of the Medical Center.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1996 |
| Built up area | 18,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | Accreditation Canada; National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 153 |
| Number of beds in ICUs | 42 |
| Number of registered doctors | 2,152 |
| Number of active employees | 563 |
| Number of emergency | 128,755 |
| Number of emergency visits | 27,492 |
| Number of outpatients visits | 10,272 |
| Number of surgeries per year (except deliveries) | 6,709 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 450,156 |
| Gross Revenues (in million R\$): | 80.3 |



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Curitiba - PR - 82590-100
41 3315-1900 - www.hospitalvita.com.br



HOSPITAL VITA VOLTA REDONDA

Brief History of the Organization

Since its inauguration, in 1953, when it belonged to Companhia Siderurgica Nacional (CSN), Hospital Vita Volta Redonda has always been recognized as a benchmark in healthcare in the South of Rio de Janeiro.

The foundation of the hospital's mission is to adopt best practices and achieve excellence in quality of service through continuous improvement practices.

The Hospital's commitment to excellence leads it to engage in quality-assurance processes, which resulted in an important milestone: it was the first hospital accredited as excellence-level in the State of Rio de Janeiro, and the fifth in Brazil, by the National Accreditation Organization (ONA). Additionally, it is a member of the Canadian Council on Health Services Accreditation (CCHSA).

VITA Hospital is a founding member of Anahp.

The Hospital focuses on high and medium surgical complexity service, supported by structured intensive care therapies - adult ICU, neonatal and cardiology ICU, and Diagnostics and Therapy Unit with services that contribute to the quality of results achieved.

Highlights 2012

In 2012, Hospital VITA Volta Redonda started a project to revitalize its Specialties Medical Center.

Investments of R\$ 2 million, provided for a wide range of service improvements, expanding the areas of specialty and the number of visits.

The project defines a new space for orthopedics care, more convenience for patients, a unique diagnostic imaging service and a substantial increase in the number of doctors' offices.

At the end of 2013, the Medical Center will feature a three-story structure, panoramic elevator and more clinical offices to ensure safety and well-being of its customers.

The strategies for 2013/2014 call for more investments, ensuring a complex restructuring at build and logistic levels both for adult and pediatric emergency services, aiming at streamlining the entire image service and implementing a new computerized management system, employing technologies used in several European countries. This new system will update administrative and healthcare processes.

Characteristics

| | |
|--|---|
| Full Associate Hospital Founder (since 2001) | |
| For Profit Organization | |
| Founded in | 1953 |
| Built up area | 11,000 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|---------|
| Total number of available beds | 127 |
| Number of beds in ICUs | 51 |
| Number of registered doctors | 558 |
| Number of actives employees | 357 |
| Number of emergency | 110,643 |
| Number of emergency visits | 76,826 |
| Number of outpatients visits | 9,428 |
| Number of surgeries per year (except deliveries) | 4,491 |
| Number of deliveries per year | 430 |
| Number of tests performed at the Diagnostics and Therapy Unit | 172,802 |
| Gross Revenues (in million R\$): | 65.6 |



Rua Lions Club, 160 - Vila Santa Cecilia
Volta Redonda - RJ - 27255-430
21 2102-0001 - www.hospitalvita.com.br



HOSPITAL VIVALLE

Brief History of the Organization

Hospital viValle started its activities in 1980 as a Gastro Clinic and was turned into a Hospital in 2000. In 2006, its name changed to Hospital viValle. The infrastructure features 24-hour clinical and orthopedic healthcare, oncology center, highly equipped surgical center, ICU, center for sterile materials with high-tech equipment for hospital infection control, hemodynamics and diagnostic center imaging.

To ensure first-class treatment, Hospital viValle offers the comfort and convenience of a hotel, from the facilities to the food offered – adopting the concept of Hospital Gastronomy.

The same professionalism and humanization is also a hallmark of Centro Médico viValle, which provides outstanding services in consultations and treatments in various specialties. The institution also offers viValle check-up services, and an occupational medicine product named Pro-Saude, catering to companies in managing the health of their employees.

In December 2011, the Hospital became part of Rede D’Or São Luiz, one of the largest healthcare groups in Brazil, in a movement of empowerment investment for medical excellence.

Highlights 2012

In 2012, Hospital viValle was awarded ONA III Accreditation, the National Accreditation Organization seal confirming the excellence of hospital services.

New sectors were inaugurated in the hospital, as for example hemodynamics, and the ICU area was expanded and now has 16 beds.

Rede D’Or São Luiz acquired a majority share of URC Medical Diagnostics, a company which will be administered by Hospital viValle. URC meets high-tech equipment for Image exams.

In 2013 Hospital viValle will begin the deployment of smart track, a modern methodology of care for emergency treatment, developed to decrease the waiting time of patients and promote the rational use of resources.

But that is not all, the works continue: viValle will go from the current 4,500 m² to 14,000 m², an extension not only in terms of area but involving the entire structure, which will have approximately 130 beds, an increase of over 150%.

To continue to meet the quality standards it is already known for, in 2013 viValle intends to obtain the Accreditation Canada, a process it has already started.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2004) | |
| For Profit Organization | |
| Founded in | 2000 |
| Built up area | 4,615 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 62 |
| Number of beds in ICUs | 16 |
| Number of registered doctors | 1,353 |
| Number of actives employees | 367 |
| Number of emergency | 69,693 |
| Number of emergency visits | 19,356 |
| Number of outpatients visits | 3,557 |
| Number of surgeries per year (except deliveries) | 5,125 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | undisclosed |
| Gross Revenues (in million R\$): | 2,300.0 |

*Consolidated Group - Anahp Members



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REAL HOSPITAL PORTUGUÊS

Brief History of the Organization

Real Hospital Português de Beneficência em Pernambuco was founded in 1855 as a resistance center for victims of the cholera outbreak that swept the country. Its founder was Portuguese physician Jose D’Almeida Soares Lima Bastos, at the time Chairman of Portuguese Reading Office in Recife.

Thanks to an authorization passed on July 1856, to show the support of the Portuguese nation to the institution, The King of Portugal placed the hospital under his special protection, an honor confirmed in 1862. Later, on an official communication dated November 7, 1907, granted by Don Carlos I, the hospital was named Royal - Real Hospital Português de Beneficência de Pernambuco.

Currently, RHP is considered the most complete medical center of excellence in the North and Northeast of Brazil, the most complex and best equipped in these regions. The following form the hospital complex: Building São João de Deus (oncology), Real Hospital do Coração (RHC), Building Egas Moniz (general emergency department – Real Vida and admissions), Real Mater (maternity), Infante (Pediatric unit), Building Arnobio Marques (outpatient offices), Building José Maria Matos (parking lot, outpatient offices and management), Social Outpatient center Maria Fernanda and Advanced Unit Boa Viagem. Moreover, there are within RHP over 50 specialized clinics and three laboratories.

Highlights 2012

The first highlight in 2012 was the opening of the vascular surgery unit credentialed by Universal Public Healthcare System (SUS), to reduce the major public emergencies in the state of Pernambuco. The Medical Residence Program was expanded and had credentialing of the areas of trauma and orthopedics, general medical practice and nephrology.

In the area of medical technology, there was a highlight for acquisition of stress test devices, which provides complete analysis of heart and lung functions in one single test, and pletysmography, indicated for the diagnosis of functional respiratory diseases. The Imaging diagnosis center was renovated and had three new 128-channel CT machines and 3T MRI machine bought, the latter the first one of its kind in Pernambuco.

RHP has been awarded, once again, with Marcas que eu Gosto and Recall de Marcas as the most widely recalled private hospital in Recife. In 2013, investments will be made in the new sterilization unit, the expansion of the unit Hospital Português in Boa Viagem by implementing an elective imaging diagnosis unit and the renovation of the building Egas Moniz, which houses the general emergency department.

Characteristics

| | |
|--|------------------------|
| Full Associate Hospital Founder (since 2001) | |
| Non Profit Organization | |
| Founded in | 1855 |
| Built up area | 117,736 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | in progress |

Main Indicators (2012)

| | |
|---|-----------|
| Total number of available beds | 720 |
| Number of beds in ICUs | 158 |
| Number of registered doctors | 1,954 |
| Number of actives employees | 4,628 |
| Number of emergency | 237,618 |
| Number of emergency visits | 55,542 |
| Number of outpatients visits | 27,868 |
| Number of surgeries per year (except deliveries) | 25,293 |
| Number of deliveries per year | 2,382 |
| Number of tests performed at the Diagnostics and Therapy Unit | 2,444,284 |
| Gross Revenues (in million R\$): | 424.9 |



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VITÓRIA APART HOSPITAL

Brief History of the Organization

Vitória Apart Hospital was established in 2001, a dream come true for a group of medical entrepreneurs, who faced the challenge to create a large medical complex in Vitória's Metropolitan Area, to provide healthcare for all specialties within a single venue. The result was a hospital with modern facilities, segregated structures, oriented flow and simultaneous care for hospitalized patients and outpatients, equipped with leading-edge resources and specific medical units, as for example general, cardiology, pediatric and neonatal ICU beds.

The complex surgical blocks also features a burn treatment center, hyperbaric medicine, nephrology service and hemodialysis, transplant services, emergency department with operating room, and a large support for a tertiary hospital.

In just over 11 years of existence, the Vitória Apart Hospital has established itself as a benchmark in high-complexity care in , with an infrastructure and technical expertise on a par with the best healthcare centers in Brazil. Characterized by its highly qualified medical staff, high-tech facilities and modern architecture, in addition to the humane, safe healthcare it provides, Vitória Apart Hospital is fully equipped to provide excellence in services.

Highlights 2012

In 2012, Vitória Apart Hospital expanded the emergency department's floor space and opened up an obstetric emergency department, a 24-hour service dedicated to providing health care to pregnant women in ob-gyn emergencies. The clinical area was also expanded to include a clinical pharmacy, catering to all ICUs in the hospital.

The Hospital has expanded the number of institutional protocols. Clinical nutrition service to patients was also upgraded in its healthcare coverage to include all hospitalized patients. R\$ 1.5 million were invested to complete a Power Generation Project, enabling the hospital to generate its own energy during peak hours.

In 2012, the Instituto de Saúde e Cidadania Vitória Apart Hospital provided healthcare to over 5 thousand people from needy communities, via two Clínicas Comunitárias de Saúde Solidária (CLICS). These clinics, were staffed by volunteers, physicians and other health professionals, with the support of various educational institutions, departments of health (Secretarias de Saúde do Município da Serra e do Estado - Sesa), federations and trade unions.

The Hospital conducted a statewide campaign to raise awareness about the dangers of self-medication and inappropriate disposal of medicines. It also expanded its operations through the creation of the Department of Medical Technology and Robotics and Transplantation of Organs and Tissues.

2012 was also a year of important achievements, with the receipt of the trophy Marcas de Valor, awarded to companies that are most valued by consumers in Espírito Santo in their industry.

Characteristics

| | |
|--------------------------------------|---|
| Full Associate Hospital (since 2006) | |
| For Profit Organization | |
| Founded in | 2001 |
| Built up area | 35,342 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | National Accreditation Organization (ONA III) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 216 |
| Number of beds in ICUs | 48 |
| Number of registered doctors | 750 |
| Number of actives employees | 1,130 |
| Number of emergency | 87,566 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 10,883 |
| Number of surgeries per year (except deliveries) | 14,848 |
| Number of deliveries per year | 887 |
| Number of tests performed at the Diagnostics and Therapy Unit | not applicable |
| Gross Revenues (in million R\$): | 83.5 |



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Anahp creates a new category for member hospitals: Affiliated hospital.

The initiative intends to encourage hospitals to search for continuous medical-hospital care quality in Brazil

In order to raise awareness and encourage hospitals and other entities in the industry to search for hospital accreditation as a means to increase patient safety and healthcare quality, in 2013 Anahp has launched the Qualification Incentive Program, which consists on the creation of new category for member hospitals: affiliated hospital.

As of 2013, hospitals which are still not accredited, a requirement for any hospital to join Anahp, will be accepted as affiliated hospitals.

However, new applicants will have to show the potential to obtain the quality awards by organizations that attest quality standards. The Association will share best clinical practices and quality indicators so as to encourage affiliated hospitals to apply for accreditation processes.

This initiative of the organization is in agreement with the objectives that guide the existence of Anahp – to promote continuous quality improvement in services, creating the conditions for certification, in addition to bringing to Brazilian culture the concept of health as a major value.

The new affiliated hospitals will have four years to complete the accreditation processes that will grant them the category of associated hospital.

Hospitals that apply as associated or affiliated hospitals should be private, for or not for profit, holders of the best quality standards in providing medical-hospital services, whose gross revenues is at least 60% from private healthcare plans or private patients, meaning that directly or indirectly companies controlled by healthcare plans cannot apply.



HOSPITAL MARCELINO CHAMPAGNAT

Brief History of the Organization

Opened on November 17, 2011, Hospital Marcelino Champagnat, member of healthcare area of Grupo Marista, represented the major investment in healthcare made in the last 10 years in the south of Brazil.

In order to place Curitiba among the main healthcare centers in the country, R\$65 million were invested in the project, mostly directed to acquisition of equipment and implementation of advanced technology.

Hospital Marcelino Champagnat works within international standards of care and intends to provide service excellence in clinical and surgical areas, comprising medium and high complexity care for adult patients.

The project was conceived based on quality and safety recognized standards, in order to reach international accreditation. Hospital Marcelino Champagnat was supported by the consulting services of Consórcio Brasileiro de Acreditação (CBA) since the inception of the project.

The focus is satisfaction and absolute confidence of the patient, with high performance and safety. Since its creation, the Hospital has had the commitment to provide humanized care, which means to have more humane and closer care, generating a new relationship between healthcare professionals and patients.

Highlights 2012

Hospital Marcelino Champagnat has celebrated its first year of activities reaching significant figures. Between November 2011 and November 2012, there were over 37,000 care visits provided to patients and about 5,000 surgeries. Figures have shown that the hospital, within little time, has become a reference in medium and high complexity care in the capital of Paraná.

In 2013, the opening of the cardiovascular ICU is expected. There will be ten beds directed to specialized and integrated care of patients who have had heart and neurological problems, especially acute myocardial infarction (AMI) and cerebral vascular accident (CVA).

Structuring of the Management Support Center – Responsible for implementing a new evidence-based model, focusing on the prospective compensation model advocated by the National Healthcare Agency.

Implementation of Variable Compensation – Variable compensation to all employees, based on safety and quality perspectives, patient satisfaction, good administrative practices, continuous development of employees and economic-financial perspective.

Structuring and implementation of the Medical Governance Program – The Medical Governance Program includes the creation and follow up of clinical staff performance indicators.

Characteristics

| | |
|----------------------------------|-----------------------|
| Affiliated Hospital (since 2013) | |
| Non Profit Organization | |
| Founded in | 2011 |
| Built up area | 27,434 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | in progress |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 107 |
| Number of beds in ICUs | 20 |
| Number of registered doctors | 557 |
| Number of actives employees | 375 |
| Number of emergency | 37,800 |
| Number of emergency visits | not applicable |
| Number of outpatients visits | 6,532 |
| Number of surgeries per year (except deliveries) | 5,404 |
| Number of deliveries per year | not applicable |
| Number of tests performed at the Diagnostics and Therapy Unit | 213,401 |
| Gross Revenues (in million R\$): | 42.2 |



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HOSPITAL METROPOLITANO

Brief History of the Organization

Hospital Metropolitano was the first private healthcare organization in the state of Espírito Santo, founded by physicians in 1996. The organization is located in the city of Serra, referred by the Brazilian Institute of Geography and Statistics (IBGE) as the one that grows the most in the state, the fourth in the country.

The decision to invest in the city was quite innovative, given that at that time, most initiatives in the sector were concentrated in the capital Vitória. The organization was also a pioneer in the state because it has invested in professional management. The organization's mission is to innovate in healthcare solutions with social commitment and its vision is to have a center of excellence in healthcare solutions. Having this as a focus, the hospital is positioned with some competitive differentials in the market: to be a reference in intensive care services, cardiology care, general clinical practice and infectology and introducing dedicated care to geriatric patients, with the work directed to patient quality and safety. The hospital is also the only one in the private sector in Espírito Santo structured to treat children with cancer and hematology diseases.

The organization adopts a merit-focused management and largely uses information technology to develop its clinical staff, employees and to ensure company sustainability.

Highlights 2012

In 2012, the Hospital was certified by the National Accreditation Organization (ONA) as Level II and has maintained the ISO 9001 certification, obtained in 2009, by means of a certifying audit made by Det Norsk Veritas (DNV).

For years 2013/2015, the strategic planning of Hospital Metropolitano is to reach Level III ONA certification and expand the hospital, doubling its installed capacity. Following the increasing demand and elevating the quality standards of the services provided to the society are the main expansion objectives of the organization.

Once the investments in infrastructure are completed, they will enable the hospital to provide care to 400,000 patients on average every year, including outpatient, urgency and emergency care, surgery and hospital admissions. The beds will increase to about 220, out of which 70 in ICU.

As a result of the expansion, the number of surgeries will reach 20,000 per year. The constructed area will increase from 10,500 to 30,000 m². The expected investment is about R\$ 60 million.

Characteristics

| | |
|----------------------------------|--|
| Affiliated Hospital (since 2013) | |
| For Profit Organization | |
| Founded in | 1996 |
| Built up area | 10,000 m ² |
| Clinical staff organization | mixed |
| Hospital accreditation | National Accreditation Organization (ONA II) |

Main Indicators (2012)

| | |
|---|----------------|
| Total number of available beds | 117 |
| Number of beds in ICUs | 31 |
| Number of registered doctors | 528 |
| Number of actives employees | 557 |
| Number of emergency | 134,611 |
| Number of emergency visits | 104,045 |
| Number of outpatients visits | 7,752 |
| Number of surgeries per year (except deliveries) | 9,701 |
| Number of deliveries per year | 458 |
| Number of tests performed at the Diagnostics and Therapy Unit | not applicable |
| Gross Revenues (in million R\$): | 62.8 |



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HOSPITAL SANTA IZABEL

Brief History of the Organization

Santa Casa de Misericórdia da Bahia, a 462-year-old organization, has built its history by taking care of the health of people in Bahia and investing in culture, education and, above all, supporting the needy people. Origin of medicine in Bahia, scenery for the first medical school in Brazil, Santa Casa is proud of having affected so decisively the training of many medical professionals in Bahia.

Member of Santa Casa de Misericórdia da Bahia and heir of this legacy of commitment with healthcare, Hospital Santa Izabel (HSI) continuously reinvents itself. A reference in many medical specialties and one of the most respected hospitals in the country, HSI has its history linked with the forefront medicine practiced in the country.

Highlights 2012

HSI is an important center for performance of heart surgeries, interventional cardiology, high complexity procedures, specifically in orthopedics and oncology surgeries.

It has been certified by Ministry of Education and Health as a Teaching and Research Hospital. In such condition, it is the main healthcare training center in Bahia. There are 105 annual seats for medical residence, 270 seats for internship and 100 for medical fellowship, in addition to partnership with seven higher education organizations. The hospital also works as a member of Rede Cegonha to support admissions and high complexity surgeries in neonates with congenital cardiopathy. Within the commitment to meet the main demands and needs of the healthcare area, HSI has expanded its investments in 2012 to adjust and expand its facilities, qualify processes and professional teams, acquire new and modern technological equipment, make early and more detailed diagnoses and less invasive surgeries. All interventions are executed in accordance with the strategic planning, hospital vocation and changes in epidemiological pattern of the population.

All in all, there were almost thirty investment projects that comprised new services and improvement in the structure, including the Service of Radiotherapy, new clinical neurology, cardiology and pediatric ICU beds – expected to double the number of pediatric cardiologic surgical procedures, PET-CT imaging center, gamma chamber, 128-channel CT scan, and installation of three cath lab devices, among others.

Other highlights were the renovation in the rooms, interventions in the outpatient areas and in other support areas, such as: Admission, pre-admission, new cafeteria, and complete renovation of the Nutrition Area (production and distribution).

The year 2012 has also witnessed the significant progress of the works of Instituto Baiano de Cancer (IBC), which will be centralized in 4,000 m² a well-structured area dedicated to oncology patients, with more offices, new linear accelerator, and duplication of outpatient oncology center (chemotherapy).

As to Teaching and Research, there is now a modern Integrated Teaching and Research Center, expanding the partnerships with national and international organizations, which will enable exchange opportunities for professionals.

Characteristics

| | |
|----------------------------------|-----------------------|
| Affiliated Hospital (since 2013) | |
| Non Profit Organization | |
| Founded in | 1549 |
| Built up area | 49,063 m ² |
| Clinical staff organization | opened |
| Hospital accreditation | in progress |

Main Indicators (2012)

| | |
|---|-------------|
| Total number of available beds | 525 |
| Number of beds in ICUs | 83 |
| Number of registered doctors | 1,586 |
| Number of active employees | 3,461 |
| Number of emergency | 126,680 |
| Number of emergency visits | 423,496 |
| Number of outpatient visits | 17,307 |
| Number of surgeries per year (except deliveries) | 13,635 |
| Number of deliveries per year | undisclosed |
| Number of tests performed at the Diagnostics and Therapy Unit | 1,285,699 |
| Gross Revenues (in million R\$): | 314.0 |



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Diamond



Gold



Silver





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