Exhibit 372

JIMMY LARAMORE V. UNITED STATES OF AMERICA
CAMP LEJEUNE WATER LITIGATION

EXPERT REPORT OF DR. HENRY MILLER

APRIL 8, 2025

Contents

1. INTRODUCTION

My name is Henry Miller, Ph.D. I am a Managing Director in the Health Analytics practice of Berkeley Research Group, LLC. I have been working on health care cost and health insurance issues for more than fifty years. I have conducted studies on these issues for the federal Medicare program, several state Medicaid programs and more than forty health insurers. I have testified on these issues in the U.S. Congress, several State legislatures and in federal, state and local courts and in arbitrations. My curriculum vita is attached to this report as Appendix A. My firm is compensated at $825 per hour for my time on this matter and payments are not contingent upon the outcome of the matter.

2. BACKGROUND OF THE CASE

This case relates to the injury of Jimmy Carroll Laramore ("Plaintiff"). Plaintiff suffers from Bladder Cancer and related medical conditions allegedly due to water contamination at the Marine Corps Base Camp Lejeune.[1] Plaintiff currently resides in Edinburg, Texas.[2] A Life Care Plan has been prepared for Plaintiff by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP, QRP that describes the services that Fryar believes will be needed for the Plaintiff throughout his life expectancy. A Life Care Plan was also prepared by Deborah Navarro, MA, CRC, CLCP, CVE that includes modifications to Fryar's Life Care Plan and services that Navarro believes will be needed for the Plaintiff throughout his life expectancy.

3. SCOPE OF REPORT

I was asked by the Department of Justice to apply my expertise in health care costs to the matter of Jimmy Laramore v. United States of America, which is part of the Camp Lejeune Water Litigation in the United States District Court for the Eastern District of North Carolina. I was specifically asked to address the following issues related to Plaintiff:

- Analyze the projected health care costs identified by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP, QRP,[3] (Fryar's Life Care Plan) and identify the amount that would be paid by TriWest under the VA Community Care Network for Plaintiff and
- Analyze the projected health care costs identified by Deborah Navarro, MA, CRC, CLCP, CVE,[4] (Navarro's Life Care Plan) and identify the amount that would be paid by TriWest for Plaintiff.

[1] Cost Analysis for Mr. Jimmy Laramore, prepared by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP QRP, dated February 6th, 2025.
[2] Cost Analysis for Mr. Jimmy Laramore, prepared by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP QRP, dated February 6th, 2025.
[3] Cost Analysis for Mr. Jimmy Laramore, prepared by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP QRP, dated February 6th, 2025.
[4] Life Care Plan for Jimmy Carroll Laramore, prepared by Deborah Navarro, MA, CRC, CLCP CVE, dated April 8th, 2025.

4. TRIWEST COVERAGE

TriWest manages care for military veterans and some members of the National Guard and Reserves. TriWest is a Third Party Administrator ("TPA") for regions 4 and 5[5] of the Veterans Health Administration Community Care Network ("CCN"). CCN is the provider network used to deliver services to veterans.

5. METHODOLOGY FOR CALCULATION OF COSTS

To determine the rate paid by TriWest, I first identified if each service/supply, included in the life care plans submitted by the plaintiff and the defense, were covered under the benefits offered by TriWest. I found that each of the services/supplies were covered by TriWest. Next, I identified the rate that would be paid by TriWest for a service/supply. As a contractor for the U.S. Department of Veterans Affairs, TriWest follows the VHA rate methodologies, which first look to the Medicare rate for a service/supply as the VHA pays providers at a rate equal to the Medicare rate should a Medicare rate exist. For those services without a Medicare rate, I followed the methodologies outlined on the VHA's website to identify the rate paid. I also incorporated any exceptions to Medicare methodology that the VHA uses such as reimbursement for anesthesia. Sources for both the Medicare rates and the VHA rates are listed in Appendix B of this report.

6. SUMMARY OF COSTS BASED ON TRIWEST COVERAGE FOR FRYAR'S LIFE CARE PLAN

Plaintiff's future service unit costs based on VHA coverage for Fryar's Life Care Plan are summarized in Table 1 below. VHA rates reflect standardized rates for what the VHA would pay for a service, removing patient responsibility amounts such as copayments. According to Plaintiff's Veteran Benefits Administration (VBA) documentation, Plaintiff has a service-connected disability rating of over 70%, meaning that copayments do not apply for many services, such as outpatient care, medications, and nursing homes.[6]

Fryar identifies testimony from Dr. Sfakianos who advises that the plaintiff's life expectancy is dependent upon the stage of cancer if it reoccurs, noting that the 5-year survival rate for bladder cancer patients is dependent on this. Thus, Fryar defers to medical professionals to determine an individualized life expectancy for the Plaintiff.[7]

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[5] Region 4 is comprised of American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, New Mexico, Nevada, Northern Mariana, Islands, Oregon, Texas, Utah, Washington, Wyoming. Region 5 is Alaska. https://www.va.gov/COMMUNITYCARE/providers/Community-Care-Network.asp.

[6] Current VHA health care copay rates for 2025, available at: https://www.va.gov/health-care/copay-rates/#:~:text=in%20a%20hospital)-,If%20you%20have%20a%20service-connected%20disability%20rating%20of%2010,a%20copay%20for%20inpatient%20care.

[7] Cost Analysis for Mr. Jimmy Laramore, prepared by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP QRP, dated February 6th, 2025.

Table 1

TriWest Coverage and Costs for Fryar's Life Care Plan

Description*	Frequency as Described in LCP	Unit Defined	VHA Rate
PROCEDURES:			
Option 1:			
Bladder Removal (With Neo-Bladder Establishment) Surgeon Fees	1 time occurrence	Per visit	$2,227.16
Bladder Removal (With Neo-Bladder Establishment) Anesthesia Fees	1 time occurrence	Per visit	$939.68
Bladder Removal (With Neo-Bladder Establishment) Facility Fees - 5 day LOS	1 time occurrence	Per visit	$10,830.54
Option 2:			
Bladder Removal (Without Neo-Bladder Establishment) Surgeon Fees	1 time occurrence	Per visit	$2,062.24
Bladder Removal (Without Neo-Bladder Establishment) Anesthesia Fees	1 time occurrence	Per visit	$767.25
Bladder Removal (Without Neo-Bladder Establishment) Facility Fees - 5 day LOS	1 time occurrence	Per visit	$10,830.54

*Based on Fryar's Life Care Plan.[8]

[8] Cost Analysis for Mr. Jimmy Laramore, prepared by Michael A. Fryar, M.S., RN, CRC, CCM, CLCP QRP, dated February 6th, 2025.

7. SUMMARY OF COSTS BASED ON TRIWEST COVERAGE FOR NAVARRO'S LIFE CARE PLAN

Plaintiff's future service unit costs based on VHA coverage for Navarro's Life Care Plan are summarized in Table 2 below. VHA rates reflect standardized rates for what the VHA would pay for a service, removing patient responsibility amounts such as copayments. According to Plaintiff's Veteran Benefits Administration (VBA) documentation, Plaintiff has a service-connected disability rating of over 70%, meaning that copayments do not apply for many services, such as outpatient care, medications, and nursing homes.[9]

Navarro does not explicitly include a life expectancy in her report. Therefore, the life expectancy was based on the recommended frequencies and durations of medical treatments provided in Navarro's Life Care Plan.[10]

[9] Current VHA health care copay rates for 2025, available at: https://www.va.gov/health-care/copay-rates/#:~:text=in%20a%20hospital)-,If%20you%20have%20a%20service-connected%20disability%20rating%20of%2010,a%20copay%20for%20inpatient%20care.

[10] Life Care Plan for Jimmy Carroll Laramore, prepared by Deborah Navarro, MA, CRC, CLCP CVE, dated April 8th, 2025.

Table 2

TriWest Coverage and Costs for Navarro's Life Care Plan

Description*	Frequency as Described in LCP	Unit Defined	VHA Rate
DIAGNOSTIC TESTS			
Cystoscopy	Every 3 months Every 6 months 1 time per year	Per visit	$204.10
CT Urogram	1 time per year Every 2 years	Per visit	$173.93
Option 1:			
Bladder Removal (Without Neo-Bladder Establishment)	To Be Determined	Per visit	$13,660.02
Surgeon Fees	To Be Determined	Per visit	$2,062.24
Facility Fees (5-day LOS)	To Be Determined	Per visit	$10,830.54
Anesthesia Fees	To Be Determined	Per visit	$767.25
Option 2:			
Bladder Removal (With Neo-Bladder Establishment)	To Be Determined	Per visit	$13,997.37
Surgeon Fees	To Be Determined	Per visit	$2,227.16
Facility Fees (5-day LOS)	To Be Determined	Per visit	$10,830.54
Anesthesia Fees	To Be Determined	Per visit	$939.68

*Based on Navarro's Life Care Plan.[11]

[11] Life Care Plan for Jimmy Carroll Laramore, prepared by Deborah Navarro, MA, CRC, CLCP CVE, dated April 8th, 2025.

8. SUMMARY OF OPINIONS

This report is based on information known to me as of this date. I have analyzed the information provided to me for the Plaintiff and assessed publicly available data to arrive at my opinion as to the rates for care covered by the Plaintiff's insurer. If additional information is made available, I may modify my report. I may also be asked to present opinions on additional issues in this case.

Henry Miller, Ph.D.
April 8, 2025

APPENDIX A
DR. HENRY MILLER
CURRICULUM VITAE

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SUMMARY

Henry Miller is Managing Director, Health Analytics in the Phoenix, AZ office of the Berkeley Research Group. He has more than 50 years of experience as a healthcare consultant and researcher specializing in health care finance, public policy, regulatory analysis, and strategic planning. In addition, he has provided expert testimony to the U.S. Congress, several state legislatures, in Federal, State, and local courts and in arbitration proceedings.

Dr. Miller has worked with more than 50 health plans, including some of the largest plans in the U.S., Blue Cross and Blue Shield plans and regional health plans on varied aspects of their operations, including evaluation of premium rate setting strategies, medical loss ratios, administrative issues, organizational structure, community relations, network management, provider payment systems, operating systems, and strategic planning.

Dr. Miller has worked on provider payment systems and network management issues for more than forty years. He was a member of the Medicare oversight committee for the effort to develop the practice expense component of the RBRVS physician fee schedule. He assisted CMS on several projects related to the development of the Medicare Hospital Outpatient Prospective Payment System and directed a project to assess opportunities to improve the Medicare Inpatient Prospective Payment System (IPPS) based on DRGs. Dr. Miller also directed the Medicare program's evaluation of the appropriateness of paying a facility fee to ambulatory surgery centers and has prepared reports on reimbursement issues for the Medicare program that were responses to Congressional requests.

He has designed hospital, physician, and pharmaceutical payment systems for seven Medicaid programs and more than thirty Blue Cross and Blue Shield plans and other health plans. This work has included both in network and out of network payment. In several instances, Dr. Miller negotiated provider contracts on behalf of health plans.

Dr. Miller has worked with various entities on developing competitive bidding programs, including design of Requests for Proposals, and bid evaluation formats. This work focuses on bids for health coverage submitted to employers by health insurers. He has also assisted health insurers who submitted bids for health coverage to private sector and government entities.

Dr. Miller has provided expert testimony on the reasonable costs of medical care, medical payments and network management issues in worker's compensation and personal injury cases. This testimony was

based on the methods to measure reasonable value of medical care that Dr. Miller developed. Methods have been accepted in state and Federal courts.

Dr. Miller's work for health plans includes several assignments relating to the operation of Medicare Advantage plans, including issues relating to data submission to the Medicare program, provider contracting, and the development of provider payment approaches and rates. He has also worked for the Medicare program on these issues, especially as related to the quality and availability of data that is submitted by MA plans to the Federal government.

Dr. Miller has directed several public policy and regulatory analysis projects. He has directed evaluations of several programs for the Department of Health and Human Services, including programs managed by the Office of Women's Health, the Health Resources and Services Administration (HRSA), the National Center for Health Statistics, the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health. Much of this work focused on delivery and financing alternatives for improving care to vulnerable populations. He directed a project that investigated innovative approaches to care management initiated by Federally Qualified Health Centers. This project examined programs in nine U.S. communities. He directed studies of research on access to care for disadvantaged, minority, and disabled populations for AHRQ. In other work, he developed a strategic plan for a managed care plan for the uninsured and low-income populations in Hillsborough County, Florida and designed an innovative delivery system for low-income populations in Rochester, New York. His work for HRSA includes evaluations of health care for the homeless programs as well as several federally funded women's and maternal and child health programs. He has conducted similar projects for New York State. Dr. Miller directed an evaluation of the Medicare clinical laboratory payment system for the National Academy of Medicine. He conducted an evaluation of the impact of Medicare regulations on clinical laboratories for the American Clinical Laboratory Association as well as national laboratory chains and hospital-based laboratories.

Dr. Miller directed key elements of the work conducted by the Governor's Commission for Rationalizing Healthcare in New Jersey. He was the lead consultant to the Commission on analyzing the financial status of the State's hospitals as well as measuring the impact of potential hospital closings. He also served as the economic advisor to the Alaska Department of Insurance in its review of the application by Premera Blue Cross to convert to for-profit status. He assisted several Primary Care Trusts and Strategic Health Authorities in the U.K. as they addressed changes in National Health Service requirements.

Dr. Miller has directed several technology related projects, including work in which he presented new technologies to the Centers for Medicare and Medicaid Services (CMS) to obtain their approval and payment. This work included analysis of a radiotherapy for non-Hodgkins lymphoma, a new device for the treatment of posterior uveitis and a cryogenic stent. In addition, he prepared the strategic plan for a Regional Health Information Organization (RHIO) for the Maryland and Virginia area. This work included an assessment of the feasibility of linking electronic medical records across hospitals and physicians' offices.

Dr. Miller developed resource costing, a tool for the measurement of costs in healthcare settings in a series of projects completed for the Office of the Assistant Secretary for planning and Evaluation of the Department of Health and Human Services. He applied resource costing to a project for the Medicare Payment Advisory Commission (MedPAC) in which he used the approach to assess the accuracy of Medicare Cost Reports as a research and policy analysis tool and to another project to measure the

costs of more than 300 hospital outpatient procedures to support efforts by the Centers for Medicare and Medicaid Services (CMS) to develop the Medicare Hospital Outpatient Prospective Payment System (HOPPS) based on APCs.

PROFESSIONAL EXPERIENCE

Provider Payment System Design and Evaluation

Dr. Miller played a key role in the development of the Medicare Hospital Outpatient Prospective Payment System (HOPPS). In this work for CMS, he conducted a major pricing study, analyzed the impact of key aspects of the APC approach and assisted in drafting regulations. Subsequently, he conducted a study of the impact of the HOPPS on the quality of care provided to Medicare beneficiaries for MedPAC. Dr. Miller also designed hospital outpatient payment systems for Medicaid programs in New York, New Jersey, North Dakota, and the District of Columbia. He has developed hospital outpatient payment approaches for Blue Cross and Blue Shield plans in New York, New Jersey, Virginia, Georgia, Arkansas, Minnesota, and California.

Dr. Miller also directed an assessment of opportunities to improve the Medicare Inpatient Prospective Payment System (IPPS), based on DRGs. He has designed or evaluated hospital inpatient payment systems for Medicaid programs in Virginia, Pennsylvania, Iowa, New York, and West Virginia. His inpatient payment system design work for health plans includes projects conducted for Blue Cross and Blue Shield plans in Virginia, Pennsylvania, Florida, Texas, North Dakota, Illinois, Colorado, Kansas City and Tennessee. Dr. Miller also evaluated the method used by the Federal government to pay children's hospitals for their investment in medical education.

Dr. Miller completed a study to update the payment system used by the Medicare program to pay Federally Qualified Health Centers (FQHCs). This work was undertaken to address payment issues that arose because payment levels had not been adjusted other than for inflation for more than fifteen years. Recommendations were made to the Health Resources and Services Administration and the Centers for Medicare and Medicaid Services.

Dr. Miller has worked with several State Medicaid programs on home health agency payment systems. He reviewed licensing criteria for home health agencies and other providers in Vermont and New York. He led the design of nursing home reimbursement systems for the Medicaid programs in Virginia, Pennsylvania, Vermont, and Iowa. He directed a study of the Medicare laboratory fee schedule for the National Institute of Medicine. His reimbursement system design work for health plans includes design of systems to pay hospitals, ambulatory surgery centers, physicians, nursing homes, home healthcare agencies, dialysis centers and other providers. He has also developed fee schedules used for out of network payment for several large health plans. He has worked with more than two-thirds of the nation's Blue Cross and Blue Shield plans as well as national health plans on reimbursement issues.

In other work, Dr. Miller evaluated and made recommendations to improve the payment methods used by worker's compensation programs in Ohio and California. He completed a study of access to healthcare for injured workers in California. Dr. Miller has also worked with personal injury insurers on methods used to pay medical claims.

Public Policy and Regulatory Analysis

Dr. Miller has directed several major studies of key public policy issues for the Federal government as well as for states and private sector clients. Examples of this work include:

- Economic advisor to the Alaska Insurance Department on the application by Premera Blue Cross to convert to for-profit status,
- Financial advisor to the Governor's Commission for the Rationalization of Healthcare in New Jersey,
- Consultant to several U.K agencies on development of responses to changes in the National Health Service, including Yorkshire and the Humber Strategic Health Authority, North Lincolnshire Primary Care Trust, Calderdale Primary Care Trust, and the Swansea Primary Care Trust,
- Analysis of the Highmark Blue Cross and Blue Shield and Independence Blue Cross proposal to merge,
- Validation of the diagnostic information used in the CMS-RCC risk adjustment formula used by the Medicare program to develop payment rates for Medicare Advantage plans,
- Analysis and recommendation of innovative approaches to improve access to primary care services for low-income populations for the Greater Rochester Health Foundation,
- Evaluation of the Rural and Frontier Coordinating Center program of the Federal Office of Women's Health,
- Evaluation of the costs and use of case management in a home health care program funded by the Federal government,
- Evaluation of the impact of the New York State All-Payer Case-Based Prospective Hospital Reimbursement System (NYPHRM) for the Council on Health Care Financing and the New York State legislature,
- Evaluation of several Federal and New York State programs to provide services to people with HIV/AIDS,
- Development and evaluation of community-based healthcare data systems, including a data system to collect and manage data that describe health care markets for the Agency for Healthcare Research and Quality, the Maryland Medical Care Database for the Maryland Health Care Commission and the database used to support hospital quality initiatives by the American Data Network,
- Evaluation of the Healthcare Community Access Program (HCAP), a national effort to reduce uncompensated care in over 150 communities for the Health Resources and Services Administration,
- Evaluation of the Federal Government's Black Lung Clinics program, and
- Completion of several projects for the National Center for Health Statistics including an assessment of the impact of using ICD-10 for diagnosis coding, an evaluation of the uses of provider surveys including the National Hospital Discharge Survey and the National Ambulatory Medical Care Survey and the design of a national survey of ambulatory surgery.

Strategic planning

Dr. Miller's strategic planning work includes assignments completed for hospitals, managed care companies, major employers, and government agencies. These projects include:

- Support on strategic issues for several hospital systems, including Johns Hopkins Medicine, University of Rochester Health System, University of Maryland Medical System, The Christ Hospital, Sutter Health System, and Memorial Hermann Health System.
- Evaluation of health benefits options for major employers including AT&T and Verizon,
- Preparation of a strategic and operational plan for an innovative managed care plan for the uninsured in Hillsborough County, Florida,
- Support for the preparation of the initial Vermont Health Resources Allocation plan for the Vermont Bureau of Insurance, Securities and Health Care Administration,
- Support to the State of New York for the development of a Global Budgeting program, and
- Several studies of the comparative value of health care benefit programs provided by health plans in efforts to identify optimal arrays of benefits.

Expert Testimony

Dr. Miller has served as an expert witness in several health care cases in recent years and has testified in federal and state courts, in arbitrations and in administrative hearings. His testimony addressed:

- Hospital/health plan contract disputes,
- Role of the Affordable Care Act in measuring medical costs in personal injury cases,
- Reasonable costs of medical care in personal injury cases,
- Class action certification,
- Out of network provider payment,
- Rates paid to health care providers by worker's compensation insurers and personal injury insurers,
- Medicare and Medicaid managed care contracts,
- Health plan operations and health plan/provider relationships,
- Health care competition issues,
- Applications by non-profit health insurers seeking to convert to for-profit status, and
- Efforts to obtain certificates of need for health care services.

EDUCATION

Ph.D., (Accounting and Economics), University of Illinois
M.B.A., City College of New York
B.B.A., City College of New York

PRESENT POSITION

Berkeley Research Group, Managing Director, Health Analytics, 2010 to present

FULL-TIME TEACHING EXPERIENCE

University of Baltimore, Associate Professor
State University of New York at Binghamton, Assistant Professor
University of Illinois, Instructor

OTHER POSITIONS HELD

LECG, LLC, Managing Director, 2008-2010
Navigant Consulting, Inc., Managing Director, 2002-2008
Center for Health Policy Studies, President, 1979-2002

Miller & Byrne, Inc., President, 1975-1979

SELECTED COMMUNITY ACTIVITIES

United Cerebral Palsy of Central Maryland, Chairman, Board of Directors, 2007 to 2011
Heifetz International Music Institute, Treasurer, Board of Directors, 2010 to 2013
Glenelg Country School, Treasurer, Board of Trustees, 1991-2000
Howard County General Hospital, Chairman, Board of Trustees, 1987-1989

SELECTED PUBLICATIONS

1. C. Turck, W. Marsh, J. Stevenson, J. York, H. Miller and S. Patel, "Pharmacoeconomics of Surgical Interventions vs. Cyclooxygenase Inhibitors for the Treatment of Patent Ductus Arteriosus," The Journal of Pediatric Pharmacology and Therapeutics, Vol. 12, No. 3, July-September 2007
2. H. Miller, "Outpatient Payment in the Private Sector," in N. Goldfield and W. Kelly, Outpatient Prospective Payment, (Gaithersburg, MD, Aspen Publishing, 1999)
3. H. Miller, B. Cassidy, and D. Karr, "Resource Costing for Healthcare Services," in N. Goldfield and W. Kelly, Outpatient Prospective Payment, (Gaithersburg, MD, Aspen Publishing, 1999)
4. D. Karr, H. Miller, and S. McCue, "the Effect of Instrument Type on the Cost of Laparoscopic Surgery," Surgical Endoscopy, 1996
5. H. Miller and W. Kelly, "Prospective Per Case Payment in New York State: An Analysis," in N. Goldfield and P. Boland, Physician Profiling and Risk Adjustment, (Gaithersburg, MD Aspen Publishing, 1996)
6. B. Balicki, H. Miller, W. Kelly, "Benchmarks and Tools for Evaluating Ambulatory Surgery: A Model for Examining Cost Competitiveness," Healthcare Financial Management, Spring, 1995
7. W. Kelly, H. Miller, T. Parciak, "The Need for Alternatives to Capitation Under Managed Care," Managed Care Quarterly, Summer, 1994
8. H. Miller, "Outpatient Prospective Payment Approaches for Use by Insurers," Journal of Ambulatory Care Management, Spring, 1993
9. B. Balicki, H. Miller, W. Kelly, T. Yates, "Guidelines for Managing Ambulatory Surgery Programs in the 1990's, Journal of Ambulatory Care Management, Winter, 1991
10. H. Miller, et.al., "Costs of Ambulatory Care: Implications for Outpatient Prospective Payment Systems," Journal of Ambulatory Care Management, Winter, 1991
11. W. Kelly, P. Tenan, H. Fillmore, H. Miller, "Products of Ambulatory Care Patient Classification System," Journal of Ambulatory Care Management, Winter, 1990

TESTIMONY (2016 – Present)

2025

- *Demia Thomas and George Lowery v. Medstar Washington Hospital Center Corporation,* Superior Court for the District of Columbia, Case No. 2022-CAB-005443, (Deposition).

2024

- *Cipla, USA, Inc. v. Ipsen Biopharmaceuticals, Inc.,* United States District Court for the District of Delaware, Case No. 22-cv-00552 GBW, *(Deposition).*
- *Scripps Health v. Blue Shield of California,* American Arbitration Association, Case No. 01-23-0000-9314, *(Deposition).*

- *Leslie J. Gelber v. Caithness Services, LLC,* American Arbitration Association, Case 01-23-0002-7637, *(Deposition).*
- *Jonathan Mendoza and Maria Mendoza, on behalf of their minor son, Jazziel Mendoza Oliveros v. Hospital Development of West Phoenix, Inc. d/b/a/ Abrazo West Campus,* Superior Court of the State of Arizona, County of Maricopa, Case No. CV2021-094672, *(Deposition).*
- *Anjil Jeter v. Comanche Construction of Georgia, LLC.,* State Court of DeKalb County, State of Georgia, Civil Action 21A03631, *(Deposition).*
- *Farid Almasri v. Target Corporation,* Superior Court of the State of California, County of Los Angeles, Case No.: 22STCV08524, *(Deposition).*

2023

- *Fitzgerald, Kloess & Pope Advisors, LLC v. Premier Parking of Tennessee, LLC, Premier Parking Management Company, LLC*, Chancery Court for Davidson County, Tennessee, Case No. 21-1299-BC, *(Deposition).*
- *Dr. Timothy Munderloh, et al. v. Biegler GMBH, Solace Advancement, LLC, et al.*, United States District Court, District of Arizona, Case No. 3:21–CV-08004-GMS, *(Deposition).*
- *Anthony Azzinaro and Kathryn Lindsay v. The Shyft Group, Inc. and the Shyft Group, USA, Inc.,* U.S District Court, District of Arizona, Case No. 2:21-CV-01990-JJT, *(Deposition).*

2022

- *Alpha Omega Lanier Edwards II v. Fast Lane Transportation, Inc.,* Superior Court of the State of California, County of Los Angeles, Case No. 21STCV09757, *(Deposition).*
- *David Wayne Edwards, Jr.; Lyinda Gillman v. Queen of the Valley Medical Center; Shea Pribyl, D.O.,* Superior Court of the State of California, County of Sacramento, Case No. 34-2019-00248337, *(Deposition)*.
- *Jafar Roubakhshyengejeh v. Beatrice Montanez*, Superior Court of the State of California, County of Los Angeles. Case No. 19STCV30292, *(Deposition).*
- Gloria Banda v. Food 4 Less of California, Inc., Superior Court of the State of California, County of Los Angeles, Case No. BC663290, *(Deposition).*
- *Beau Towne v. Multicare Health System d/b/a Mary Bridge Children's Hospital,* Superior Court of the State of Washington for Pierce County, Case No. 20-2-04518-2, *(Testimony).*
- *Medical Society of the State of New York v. United Health Group*, United States District Court, Southern District of New York, Civil Action No. 16-CV-5265 (JPO), (*Testimony*).
- *Lori Bush v. Dignity Health,* Superior Court of the State of California for the County of San Bernadino, Case No. CIVDS-1613161, *(Deposition and Testimony).*

2021

- *Adventist Health System/Sunbelt, Inc. v. Humana Medical Plan, Inc.* (Arbitration – American Arbitration Association Case No. 01-19-0002-6864) *(Deposition).*
- *Christopher Bentley v. Scott Gragson,* District Court, Clark County, Nevada, Case No. A-19-796424-C, *(Deposition).*
- *Kaweah Delta Medical Center v. Kaiser Foundation Hospitals*, Superior Court of the State of California for Tulare County, Case No. AH015680 *(Deposition and Trial Testimony)*
- *Medical Mutual of Ohio v. FrontPath Health Coalition*, Court of Common Pleas, Lucas County, Ohio, Case No. CI201703154 *(Deposition)*

- *Kaiser Foundation Hospitals v. Palomar Health F/K/A Palomar Pomerado Health,* Arbitration, JAMS Reference Number 1220063770, *(Deposition).*
- *Perry David Maxwell v. The Boeing Company and Paris Edward Cooper,* United States District Court, Central District of California, Case No. 2:19-cv-05204-DSF-KS *(Deposition).*
- *Baptist Memorial Health Care Corp. v. CIGNA Health Care of Tennessee,* Arbitration, *Deposition and Testimony).*

APPENDIX B
MATERIALS RELIED UPON

Materials Relied Upon
2024 ASA Survey.pdf
Anesthesia CY 2025 locality adjusted CF_floor extension 23DEC24 Procedures.xlsx
CMS-1807-F_Work_Time_16OCT24 Procedures.xlsx
CY_2022_Anesthesia_Base_Units_110921 Procedures.xlsx
MPFS Procedures_2025.csv
Search the Physician Fee Schedule _ CMS.pdf
DHR Health (450869) IPPS Web Pricer Procedures.pdf
Mission Regional Medical Center (450176) IPPS Web Pricer Procedures.pdf
Rio Grande Regional Hospital (450711) IPPS Web Pricer Procedures.pdf
2025 Wage Index.xlsx
Locality Code 2024.xlsx
Bladder Cancer Plaintiff Jimmy Laramore - Expert Report of Michael Fryar - Materials Considered
Bladder Cancer - Jimmy Laramore - LCP - Expert Report of Michael Fryar - 2-6-2025
2025.04.04 Laramore Final LCP
Keller-Laramore Supplement to Declaration 4.2.25-kc
OIG Report For Keller and Laramore
WPS_Laramore
DOJ Camp Lejeune List - Updated 040125 2025-04-01 14.45.03
DOJ Data Memorandum
Exhibit 1 - Final Copy of 25 plaintiffs and service members with PII Total Costs
VHA CLJA Narrative Summary_Final_3-18-25
VBA Disability Ratings, Conditions, and Amounts (03.13.2025)
VA SC Conditions 2025
(Incomplete) VBA Disability Raitings, Conditions, and Amounts (2025)