Agenda
Mangum City Hospital Authority
January 23, 2024 at 5:00 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on January 23, 2024, at 5:00 PM, in the City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

ROLL CALL AND DECLARATION OF A QUORUM

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

1. Approve November 28, 2023regular meeting minutes as presented.
2. Approve November 2023 Quality meeting minutes as presented.
3. Approve November 2023 Medical Staff meeting minutes as presented.
4. Approve November 2023 Quality Report.
5. Approve November 2023 Clinic Report.
6. Approve November 2023 CCO Report.
7. Approve November 2023 CEO Report.
8. Approve December 28th, 2023, Emergency Meeting Minutes as presented.
9. Approve December 2023 Quality meeting minutes as presented.
10. Approve December 2023 Medical Staff meeting minutes as presented.
11. Approve December 2023 Quality Report.
12. Approve December 2023 Clinic Report.
13. Approve December 2023 CCO Report.
14. Approve December 2023 CEO Report.
15. Discussion and possible action to approve the following forms, policies, appointments, and procedures previously approved through Corporate Management, on 12/14/23 Quality Committee and on 12/14/23 Medical Staff.

16. Discussion and possible action to approve the Policy & Procedure: Quality Policy Manuel.

17. Discussion and possible action to approve the Policy & Procedure: Drug Room Policy Manuel.

18. Discussion and possible action to approve the Policy & Procedure: Radiology Policy Manuel.

19. Discussion and possible action to approve the Policy & Procedure: Emergency Department Policy Manuel.

20. Discussion and possible action to approve the Policy & Procedure: IT Department Manuel.

21. Discussion and possible action to approve the Policy & Procedure: Hospital Policy/Form/Order Set/Protocols and other Document Review Process.

22. Discussion and possible action to approve the Policy & Procedure: Policy, Protocols, Forms, or other Document Development, Review, and Implementation Process.

FURTHER DISCUSSION
Consideration of any items removed from the consent agenda.

REMARKS
Remarks or inquiries by the audience not pertaining to any item on the agenda. (Two-minute limit)

REPORTS

23. November and December Financial Reports 2023.

24. Mangum FY2024 Budget Assumptions.

25. Mangum FY2024 Budget (Cash basis).

26. Presentation on the Mangum Regional Medical Center audit from CLA, LLP, for the period ending December 31, 2021.

OTHER ITEMS

27. Discussion and possible action to approve the Pharmacy Consultants-Consulting Agreement.

28. Discussion and possible action to approve the Memorandum of Understanding Between Mangum Regional Medical Center and The Oklahoma Department of Mental Health and Substance Abuse Services.

29. Discussion and possible action to approve the Hospital Administrator to sign the agreement for MRMC-Master Service Agreement with CliftonLarsonAllen LLP.

30. Discussion and possible action to approve the Hospital Administrator to sign the agreement for MRMC-Statement of Work- Agreed Upon Procedures with CliftonLarsonAllen LLP.

31. Discussion and possible action to approve the Hospital Administrator to sign the agreement for MRMC-LifeShare for organ and tissue procurement.

32. Discussion and possible action to approve the MRMC- Aetna Better Health Hospital Agreement.

33. Discussion and possible action to approve the MRMC-Aetna Better Health Provider Agreement.

34. Discussion and possible action to approve the MRMC- Aetna Better Health RHC Agreement Mangum Family Clinic

35. Discussion and possible action to approve the MRMC-Evident Subscription Services Agreement Service Addendum Adding Communication Center.

36. Discussion and possible action to approve the FY2024 Budget (Accrual Basis).

37. Discussion and possible action to approve calendar year 2024 meeting dates.

38. Discussion and possible action to accept the FY2021 Audit completed by CLA, LLP, for the period ending December 31, 2021, and submitting the audit in accordance with applicable state statutes.

EXECUTIVE SESSION

39. Discuss and make a decision to enter into executive session for the review and approval of **medical staff privileges/credentials/contracts** for the following providers pursuant to 25 O.S. § 307(B)(1):

- **Credentialing- DIA Associates**
  - Jeremiah Daniel, DO – Courtesy
  - Nancy Emelife, MD- Courtesy
  - Nehyar-Hefazi Torghabeh, MD– Courtesy
  - Austin Marsh, MD- Courtesy
  - Jessica Millslap, MD- Courtesy
  - Aubrey Jade Slaughter, MD- Courtesy
- **Contract-** Dr. Fei Ling Yeh D.O.

OPEN SESSION

40. Discussion and possible action in regard to executive session, if needed.

EXECUTIVE SESSION

41. Discussion and possible action with regard to approving the settlement agreement between the Mangum City Hospital Authority and Surgery Center of Altus, LLC; Alliance Health Southwest Oklahoma, LLC d/b/a Affinity Health Partners; Medsurg Consulting LLC, Alliance Management Group, LCC; Quartz Mountain Investments, LLC; Praxeo Health LLC d/b/a Praxeo Health Services, LLC; Darrell Parke; Frank Avignone IV; Greenfield Resources Ltd. Co.; The Rybar Group; Affinity Health Partners, LLC; Chimeric Consulting LLC; Chicane Group LLC; and any other third-party defendants or litigants involved in the litigation consolidated under case number CJ-2019-04 (Greer County, Oklahoma) where, with advice of counsel, public disclosure will seriously impair the public body's ability to process the claim, litigation, or proceeding in the public interest, with possible executive session in accordance with 25 O.S. 307(B)(4).

OPEN SESSION

42. Discussion and possible action in regard to executive session, if needed.

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, City Manager, City Attorney or City Employees

NEW BUSINESS
Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

ADJOURN
Motion to Adjourn

Duly filed and posted at **4:00 p.m. on the 19th day of January 2024**, by the Secretary of the Mangum City Hospital Authority.

_____
Ally Kendall Secretary

Minutes
Mangum City Hospital AuthoritySession
November 28, 2023 at 5:00 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on November 28, 2023, at 5:00 PM, in the City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

Chairman Vanzant called the meeting to order at 5:00pm.

ROLL CALL AND DECLARATION OF A QUORUM

Present:

Trustee Cheryl Lively
Trustee Michelle Ford
Chairman Carson Vanzant
Trustee Lisa Hopper
Trustee Ronnie Webb

Also present: Interim City Manager Erma Mora

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

1. Approve October 24, 2023regular meeting minutes as presented.
2. Approve November 13, 2023 Special Meeting Minutes as presented.
3. Approve October 2023 Quality meeting minutes as presented.
4. Approve October 2023 Medical Staff meeting minutes as presented.
5. Approve October 2023 Claims
6. Approve November 2023 Estimated Claims.
7. Approve October 2023 Quality Report.
8. Approve October 2023 Clinic Report.
9. Approve October 2023 CCO Report.

10. Approve October 2023 CEO Report.

11. Approve the following forms, policies, appointments, and procedures previously approved by Corporate Management, on 11/16/23 Quality Committee and on 11/21/23 Medical Staff.

12. Discussion and possible action with regard to accept the Policy & Procedure: 340B Drug Discount Purchasing Program

13. Discussion and possible action with regard to accept the Policy & Procedure: OnCall and Call Back Responsibilities for Radiology

14. Discussion and possible action with regard to accept the Policy & Procedure: Nursing Education Personal Belonging and Valuables

15. Discussion and possible action with regard to accept the Policy & Procedure: Drug Diversion

16. Discussion and possible action with regard to accept the Policy & Procedure: Temporary Absence Release for Patients

17. Discussion and possible action with regard to accept the Policy & Procedure: Temporary Absence Release Form

18. Discussion and possible action with regard to accept the Policy & Procedure: Patient Belongings and Valuables

19. Discussion and possible action with regard to accept the Policy & Procedure: Corporate Patient Belongings List

20. Discussion and possible action with regard to accept the Policy & Procedure: Patient Valuables Record

21. Discussion and possible action with regard to accept the Policy & Procedure: Lost and Found Property Report

22. Discussion and possible action with regard to accept the Policy & Procedure: Lost and Found Log

23. Discussion and possible action with regard to accept the Policy & Procedure: Behavioral Observation Checklist

24. Discussion and possible action with regard to accept the Policy & Procedure: Medication Error and Near Miss Report

25. Discussion and possible action with regard to accept the Policy & Procedure: Intravenous (IV) Extravasation Management and Treatment

26. Discussion and possible action with regard to accept the Policy & Procedure: Appendix A Extravasation Management Strategies

Trustee Lively curious on patient quality reports. Reports on nurses being rude, is it the same nurse or multiple and has that been addressed. Cohesive states it is not the same person and believes it has been corrected. Chairman Vanzant expresses concern with what could be considered rude and is

Cohesive taking appropriate measures on filtering those complaints. Cohesive confirms how they filter claims by meeting with the patients to verify patients' perception of care.

Motion to approve Consent Agenda made by Trustee Webb. Second by Chairman Vanzant.
Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

FURTHER DISCUSSION

None.

REMARKS
Remarks or inquiries by the audience not pertaining to any item on the agenda.

None.

REPORTS

27. October Financial Reports

    Adrian Brown reports on October Financials.

    Trustee Lively asks, "How much does the hospital have in reserve exactly?" Dennis responds stating it's over $800K in account plus the $712K in a covid account totaling $1.5M.

OTHER ITEMS

28. Discussion and Possible Action to Approve the Siemens Healthineers Agreement with Mangum Regional Medical Center

    Kelly reports a $8 increase for services over a 2 year period.

    Motion made by Trustee Ford, Seconded by Trustee Webb.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

29. Discussion and Possible Action to Approve the Mangum-BCBSOK Professional Group Agreement/Addendums for Hospital Based Providers

    Kelly reports no significant changes.

    Motion made by Chairman Vanzant, Seconded by Trustee Lively.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

30. Discussion and Possible Action to Approve the Equipment Maintenance Agreement between DP Medical Services

    Motion made by Trustee Ford, Seconded by Trustee Lively.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee

Webb

31. Discussion and Possible Action to Terminate the agreement with Commercial Medical Electronics Maintenance Agreement and Mangum Regional Medical Center

    Motion made by Chairman Vanzant, Seconded by Trustee Webb.

    Voting Yea: Trustee Lively, Trustee FORD, Chairman Vanzant, Trustee Hopper, Trustee Webb

32. Discussion and Possible Action to Approve the agreement Fiberoptic Endoscopic Evaluation of Swallowing services between Freeborn Dysphagia Associates LLC and Mangum Regional Medical Center

    Kelly states currently if a speech therapist recommends a swallow study Mangum Regional is having to send or transport patients to Elk City or Jackson County because they have to have a radiologist on site to read it. This agreement does away with transport making it easier for the patient as well as it is more cost effective for the hospital as this service is bedside available. It is not a cost unless used and something we can offer our patients.

    Motion made by Trustee Webb, Seconded by Trustee Hopper.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

33. Discussion and Possible Action to Approve the addendum to Service Agreement for RevOPS AVID

    AVID services allow the Hospital to check if patients are covered under any insurance. This service is at no cost to the Hospital.

    Motion made by Trustee Hopper, Seconded by Chairman Vanzant.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

34. Discussion and possible action to approve the MRMC- HIPAA Security Officer Appointment- Tim Hopen

    Motion made by Chairman Vanzant, Seconded by Trustee Hopper.
    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

35. Discussion and possible action regarding the review and approval of RHC patient balances.

    Kelly asks the Board how they would like the Hospital to handle patient debt, options being after a year write them off or send a final letter as an attempt to collect. Kelly explains typically the procedure is to mail the patient a bill for three consecutive months and if no response the Hospital is to write them off. This procedure hasn't been done. Cohesive has started using a collection agency for the clinic but asking for those that have passed the one year mark.

Motion made by Trustee Webb on sending one more final bill. Second by Trustee Hopper.
Voting Yea: Trustee Lively, Trustee Ford, Trustee Hopper, Trustee Webb
Voting Abstaining: Chairman Vanzant

36. Discussion and possible to Approve moving forward with a Debit Card linked to the Hospital account instead of a Credit Card

Cohesive has requested a credit card for emergency purchases only however after several attempts many agencies require a guarantor. Cohesive is suggesting to go through their local bank to get a card that is directly linked to the bank account with a limit of $5K in a Trustees name of their choosing with strict instruction of approval prior to making purchases.

Motion made to approve credit card for Cohesive by Trustee Webb, Seconded by Trustee Hopper.
Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

37. Discussion and action to establish a contract for the professional services of a Certified Public Accountant (the “auditor”) for financial and compliance audits for fiscal years 2018, 2019, 2020, 2021, and 2022 for Mangum Regional Hospital and Mangum Regional Medical Center managed by, Cohesive Healthcare Management & Consulting LLC. The last update the board received was November 2022 wherein, the board was advised the audit would soon be done. These audits are to be performed in accordance with generally accepted auditing standards as set forth by the American Institute of Certified Public Accountants, the standards for financial audits set forth in Government Auditing Standards issued by the comptroller General of the United States, and the audit requirements of Title 2 US Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance), including any future changes or replacement of these requirements applicable to the audit period in question. The completion/status is required for the City of Mangum's annual audit to be complete.

Cohesive states a proposal has been given to the City Attorney for review, they received it too late to attached in the agenda. This proposal is believed to meet the requirements requested by the City and waiting on the City Attorney to be sure it meets the state requirements as well.

Interim City Manager Erma Mora states our audit is coming up in December and we need to present something to our auditor/consultant. City Attorney has not notified anyone about a proposal so this is the first we’ve heard. Godwin emailed the proposal to Corry late but stated it meets the requirements requested by the State Statutes. Erma says we will need to have an emergency meeting regarding an audit if necessary and possibly find the hospital one if this proposal doesn’t meet our auditors’ standards but we cannot afford to get dinged every year for this. Cohesive presented a copy of the proposal to Erma and the board to review.

Motion to approve tentatively, pending the proposal meets the appropriate guidelines with the City and the State.

Motion made by Chairman Vanzant, Seconded by Trustee Webb.
Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee

Webb

EXECUTIVE SESSION

38. Discussion and possible action to enter into executive session to discuss the approval of medical staff privileges/credentials/contracts for the following providers pursuant to 25 O.S. § 307(B)(1):

    Motion to amend Dr. Barry Davenport agreement made by Trustee Ford, Seconded by Chairman Vanzant.

    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

    Motion to accept Dr. Gregory Morgan's Resignation effective January 31st, 2024 made by Chairman Vanzant, Seconded by Trustee Hopper

    Voting Yea: Trustee Lively, Trustee Ford, Chairman Vanzant, Trustee Hopper, Trustee Webb

OPEN SESSION

39. Discuss and make a decision to come out of executive session

    No executive session required.

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, Hospital CEO, City Attorney or Hospital Employees

NEW BUSINESS
Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

Appoint someone for mediation. Board votes Chairman Vanzant.

Motion made by Trustee Hopper, Seconded by Trustee Webb.
Voting Yea: Trustee Lively, Trustee Ford, Trustee Hopper, Trustee Webb
Voting Nay: Chairman Vanzant

ADJOURN
Motion to Adjourn

Motion to Adjourn at 6:12pm

Carson Vanzant, Chairman

Ally Kendall, City Clerk

Mangum Regional Medical Center
Quality Assurance & Performance Improvement Committee Meeting

Meeting Minutes						
CONFIDENTIALITY STATEMENT: These minutes contain privileged and confidential information. Distribution, reproduction, or any other use of this information by any party other than the intended recipient is strictly prohibited.						
Date:	**11/16/2023**	**13:02**	**Recorder: D. Jackson**		**Reporting Period: Oct. 2023**	

Members Present					
Chairperson: Dr. C		CEO: Kelly Martinez		dical Representative: Dr C	
Name	**Title**	**Name**	**Title**	**Name**	**Title**
Nick Walker	CNO	Danielle Cooper	Bus Office	Tonya Bowen	Lab
Bethany Moore	HR	Kaye via Teams	Credentialing		IT
Jennifer Dryer	HIM	Mark Chapman	Maintenace/EOC	Marla Abernathy	Dietary
Chrissy Smith Chelsea Church/Lynda James	PT Pharmacy	Melissa Tunstall Chasity Howell	Radiology Case Management	Meghan Smith	IP

TOPIC	FINDINGS – CONCLUSIONS	ACTIONS – RECOMMENDATIONS	FOLLOW-UP
I. CALL TO ORDER			
Call to Order	The hospital will develop, implement, and maintain a performance improvement program that reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.	This meeting was called to order on 11/16/2023 by 1st Kelley/ 2nd Nick	
II. REVIEW OF MINUTES			
A. Quality Council Committee	10/12/2023	Committee reviewed listed minutes A-F. Motion to approve minutes as distributed made by Kelley / 2nd by Dr C. Minutes A-F approved. Present a copy of the MeetingMinutes at the next Medical Executive Committee and Governing Board meeting.	
B. EOC/ Patient Safety Committee	10/10/2023		
C. Infection Control Committee	10/05/2023		
D. Pharmacy & Therapeutics Committee	09/21/2023		
E. HIM/Credentialing Committee	10/05/2023		
F. Utilization Review Committee	10/05/2023		

III. REVIEW OF COMMITTEE MEETINGS			
A. EOC/Patient Safety	11/14/2023		
B. Infection Control	11/07/2023		
C. Pharmacy & Therapeutics	09/21/2023 [Next meeting 12/2023]		
D. HIM-Credentials	11/07/2023		
E. Utilization Review	11/08/2023		
F. Compliance	10/18/2023 - Next meeting 01/2024		
IV. OLD BUSINESS			
A. Old Business	Staff Influenza Vaccine Program Seasonal Influenza Form		
V. NEW BUSINESS			
A. New Business	Approval of policies/procedures - see below		
VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT			
A. Volume & Utilization			
1. Hospital Activity	Total ER – 138 Total OBS pt - 3 Total Acute pt - 11 Total SWB - 11 Total Hospital Admits (Acute/SWB) - 22 Total Hospital DC (Acute/SWB) - 21 Total pt days - 263 Average Daily Census - 9		
2. Blood Utilization	total units administered 6 for the reporting period with no adverse reactions		
B. Care Management			
1. CAH Readmissions	4 for the reporting period - 1) Pt admitted with primary dx ; Readmitted with secondary dx 2) Pt admitted with primary dx, readmitted with primary dx 3) Pt admitted with primary dx, readmitted with primary dx 4) Pt admitted with primary dx ; Readmitted with secondary dx		
2. IDT Meeting Documentation	9/9 (100%) completed within 24 hours of IDT		
3. Insurance Denials	2 insurance denials for the reporting period – insurance denied In-pt status, pt switched to OBS		

4. IMM Notice	13/13 (100%) notices signed within 2 days prior to discharge		
C. Risk Management			
1. Incidents	3 ER AMA; 1.) 1 pt to the ER requesting meds for c/o anxiety/depression sx, pt reports that med for c/o previously prescribed are not being taken with no follow up in regards to c/o. Provider spoke with pt about importance of compliance with previously prescribed meds/treatment, pt not receptive to education and left ER. Pt left ER w/o signing AMA. 2.) Pt to the ER for N/V, agreeable to all testing and treatments, Provider wanted to admit pt to in-pt for further treatment, pt declined and wanted to go home. Risks/benefits explained, pt signed AMA. 3.) Pt to the ER for c/o esophagus pain. Pt allowed testing/treatment, after provider discussed findings with pt, pt left the ER before final nurse assessment/discharge. Left before signing AMA.	AMAs - We will continue to default to provider recommendations for treatment/care of patients and provide education as needed to patients/families 2-4) MRMC will continue to provide care to the patients based on needs, however patients have the right to refuse care at anytime, education will be provided as needed to patient/families	
2. Reported Complaints	None for reporting period		
3. Reported Grievances	None for reporting period		
4. Patient Falls without Injury	None for reporting period		
5. Patient Falls with Minor Injury	None for reporting period		
6. Patient Falls with Major Injury	None for reporting period		
7. Fall Risk Assessment	None for reporting period		
8. Mortality Rate	2 - (1 ER/ 1 inpt) - 1 pt to the ER with CPR in		

	progress, attempts unsuccessful and pt expired in the ER. 1 SWB pt admitted to in-pt and transitioned to SWB, over the course of hospital stay patient declined and acquired pneumonia, pt continued to decline and family agreed on comfort measures due to patient's overall decline, pt expired while in SWB status		
9. Deaths Within 24 Hours of Admission	None for the reporting period		
10. Organ Procurement Organization Notification	2 reported deaths with 2 declines for reporting period – 1 reported greater than 60 min d/t delay in provider bedside response time.	Education to nurse about contacting LS with RN TOD	
D. Nursing			
1. Critical Tests/Labs	82 for the reporting period		
2. Restraint Use	None for the reporting period		
3. Code Blue	1 - Pt arrived to the ER with CPR in progress, attempts unsuccessful and pt expired in the ER.		
4. Acute Transfers	2 for the reporting period		
5. Inpatient Transfer Forms	2 completed for reporting period		
E. Emergency Department			
1. ED Nursing DC/ Transfer Assessment	20/20 (100%)		
2. ED Readmissions	5 for the reporting period - 1) Pt was seen for primary c/o and dx with secondary. During visit pt refused imaging services and advised to f/u with specialist on outpatient basis. Pt returned to ED for secondary complications r/t secondary dx at last er visit 2) Pt was seen for primary c/o, treated and released. returned to er for primary complaint. 3) Pt was initially seen for primary c/o, treated and released, returned with continued c/o and found secondary dx at this visit. Pt was	1) Pt did not follow up with specialist as primarily advised, continued to advise and stress the need for the outpatient specialist 2) Treatment again administered and the patient was again educated on treatment plan. 3) Pt was advised on the need for specialty services on outpatient basis 4) Upon return pt was admitted for further treatment 5) No further treatment deemed necessary, educated on treatment plan and f/u as needed	

	treated and released with instructions to f/u with specialist on out-pt basis. 4) Pt initially seen and diagnosed with kidney stone. The pt later returned c/o increased pain and was admitted for pain control. 5) Pt seen for primary c/o, treated and released, returned with same c/o		
3. ER Log & Visits	138 (100%)		
4. MSE	Quarterly		
5. EMTALA Transfer Form	10/10 (100%)		
6. Triage	20/20 (100%)		
7. ESI Triage Accuracy	20/20 (100%)		
8. ED Transfers	10 for the reporting period - Patients transferred to Higher Level of Care for: 1.) Renal Failure – ICU 2.) V-Tach – Cardiology 3.) SI/SH – InPt Psych 4.) GI Bleed – ICU 5.) SI/SH – InPt Psych 6.) Pneumonia/ICU 7.) Metabolic Acidosis – ICU 8.) Gastric Ulcer – ICU/Surgical Services 9.) NSTEMI – Cardiology 10.) Appendicitis – Gen Surgery	All ER transfers for the reporting period appropriate for higher level of care	
9. Stroke Management	None for reporting period		
10. Brain CT Scan – Stroke (OP-23)	None for reporting period		
11. Suicide Management	2 for the reporting period		

12. STEMI Care	No STEMIs for reporting period 1 NSTEMI for the reporting period; pt did not present or c/o any cardiac s/sx, complete work up and treatment based on s/sx at presentation, NSTEMI noted with EKG and troponin. Total ER time 4 hrs 19 min, extended ER time due to work up needed for initial complaints and treatments for stabilization prior to transfer	Will continue to defer to providers recommendations for needed treatment prior to transfers as needed for patient stabilization	
13. Chest Pain	4/6 EKG (67%) 1 delay in EKG time due to spacelabs not functioning, required rest for proper function. 1 ekg completed in 10 min, RT reports responding to bedside for ekg as soon as called	Spacelabs has been functioning without issue, RT response as soon as called. RT will monitor these issues for any further trends noted	
14. ED Departure - (OP-18)	Quarterly		
F. Pharmacy & Medication Safety			
1. After Hours Access	81 for the reporting period		
2. Adverse Drug Reactions	None for reporting period		
3. Medication Errors	1 for the reporting period: 1) A bag of Clinimax was not properly activated/mixed. The provider was notified, a new bag was obtained, mixed properly and hung. This did not result in harm to the patient.	1) Procedures in regards to properly activating/mixing Clinimix was discussed with staff. Advised that we need to take our time and ensure it is completely mixed, especially since this is a two person sign off medication.	
4. Medication Overrides	51 for the reporting period		
5. Controlled Drug Discrepancies	8 for the reporting period - All discrepancies were from nurses miscounting medications at shift change.		
G. Respiratory Care Services			
1. Ventilator Days	0 for the reporting period		

2. Ventilator Wean	0 for the reporting period		
3. Unplanned Trach Decannulations	None for the reporting period		
H. Wound Care Services			
1. Development of Pressure Ulcer	None for the reporting period		
2. Wound Healing Improvement	None for the reporting period		
3. Wound Care Documentation	100% for initial assessment and discharge assessment documentation completed on time		
I. Radiology			
1. Radiology Films	3 films repeated due to technical error – 118 total for the reporting period; 1-3 artifact on film		
2. Imaging	12 for the reporting period; with 12 consents for CT obtained		
3. Radiation Dosimeter Report	Quarterly		
J. Laboratory			
1. Lab Reports	0 repeated /2078 total for the reporting period		
2. Blood Culture Contaminations	None for the reporting period		
K. Infection Control and Employee Health			
1. Line Events	1 for the reporting period – surgically inserted device incidentally removed, sent for replacement		
2. CAUTI's	0 for the reporting period		
3. CLABSI's	0 for the reporting period		
4. Hospital Acquired MDRO's	0 for the reporting period		

5. Hospital Acquired C-diff	0 for the reporting period		
6. HAI by Source	3 for the reporting period – 1) pt reported weakness, dx with uti. Treated per recommendations on C&S. 2) Pt with significant respiratory hx, developed productive cough while in-pt. Dx with pneumonia. Treated per recommendations on C&S 3) Pt with drainage post surgical procedure, site cultured, pt treated per C&S recommendations	All nursing protocols and procedures were followed. No IC recommendations at this time	
7. Hand Hygiene/ PPE & Isolation Surveillance	86 % HH / 90 % PPE	1.) Education provided about importance of hand hygiene and PPE. Will have further education at skills fair. 2.) Planning with maintenance to place more hand sanitizer stations outside of patient rooms.	
8. Patient Vaccinations	0 received influenza vaccine / 0 received pneumococcal vaccine		
9. VAE	None for the reporting period		
10. Employee Health Summary	0 employee event/injury, 73 employee health encounters (vaccines/testing) 8 reports of employee illness/injury		
L. Health Information Management (HIM)			
1. History and Physicals Completion	20/20 (100%) completed within 24 hrs of admit		
2. Discharge Summary Completion	20/20 (100%) completed within 72 hrs of discharge		
3. Progress Notes (Swing bed & Acute)	Weekly SWB notes – 20/20 (100%) Daily Acute notes – 20 /20 (100%)		

4. Swing Bed Indicators	11/11 (100%) SWB social HX completed within 24 hrs/first business day after admit		
5. E-prescribing System	20/20 (100%) of medications were electronically sent this reporting period		
6. Legibility of Records	20/20 (100%)		
7. Transition of Care	Obs to acute – none for the reporting period, Acute to SWB – 6/6 (100%) of appropriate orders for admit from Acute to SWB status		
8. Discharge Instructions	16/20 (80%) - There were 4 er's missing the d/c instructions. D/c instructions were created but a signed copy did not make it to HIM. Noted all the same ER nurse, spoke with nurse who reports using e-signature	Met with CEO/CNO/QA/Nurse, spoke with IT to verify that there is not a malfunction with CPSI capturing the signature	
9. Transfer Forms	12/12 (100%) for ER and in-pt transfers to higher level of care for the reporting period		
M. Dietary			
1. Weekly Cleaning Schedules	64/64 (100%)		
2. Daily Cleaning Schedules	403/403 (100%)		
3. Wash Temperature	75/75 (100%)		
4. Rinse Temperature	75/75 (100%)		
N. Therapy			
1. Discharge Documentation	9/9 (100%) completed within 72 hours of discharge		
2. Equipment Needs	9/9 (100%)		

3. Therapy Visits	PT 137– OT 124 - ST 2		
4. Supervisory Log	2 PTA supervisory logs completed for reporting period		
5. Functional Improvement Outcomes	PT 9/9 (100%) – OT 9/9 (100%) – ST 0/0 (100%) - pts discharged during the reporting period with improvement outcomes		
O. Human Resources			
1. Compliance	100%		
2. Staffing	Hired – 1, Termed - 1		
P. Registration Services			
1. Compliance	100%		
Q. Environmental Services			
1. Terminal Room Cleans	8/8 (100%)		
R. Materials Management			
1. Materials Management Indicators	6 – Back orders, 1 – Late orders, 1 – Recalls, 1064 items checked out properly		
S. Life Safety			
1. Fire Safety Management	0 fire drills for the reporting period – 24 fire extinguishers checked		
2. Range Hood	100%		
3. Biomedical Equipment	100%		
T. Emergency Preparedness			
1. Orientation to EP Plan	1/1 (100%)		
U. Information Technology			
A. IT Incidents	20		
V. Outpatient			

1. Therapy Visits	66/75 (88%) 5 no show/no call missed visits, 4 visits which patients called and rescheduled.		
2. Discharge Documentation	4/4 (100%) discharge notes completed within 72 hrs of discharge		
3. Functional Improvement Outcomes	3/4 (100%) 1 non-visit discharge (unable to obtain standard testing with non-visits)		
4. Outpatient Wound Services	(100%)		
W. Strong Mind Services			
1. Record Compliance	N/A	N/A	N/A
2. Client Satisfaction Survey	N/A	N/A	N/A
3. Master Treatment Plan	N/A	N/A	N/A
4. Suicidal Ideation	N/A	N/A	N/A
5. Scheduled Appointments	N/A	N/A	N/A
VII. POLICY AND PROCEDURE REVIEW			
1. Review and Retire	None for this reporting period		
2. Review and Approve	1) HIPPA Officer Appointment – Tim Hopen 2) 340B Drug Policy – Revision 3) On-Call and Call Back Responsibilities Policy for Radiology 4) Nursing Education for Patient Belongings and Valuables 5) Drug Diversion Policy 6) Temporary Absence Release for Patients Policy 7) Patient Belongings and Valuables Policy 8) Temporary Absence Release Form	1.) Approved - Kelley/Melissa 2 - 16) Approved – Kelley / Dr C 17- 21) Tabled – Nick / Kelley	

	9) Patient Belongings List 10) Patient Valuables Record Form 11) Lost and Found Property Report 12) Lost and Found Log 13) Behavioral Observation Checklist 14) Medication Error and Near Miss Report 15) Extravasation Management Strategies – Appendix 16) Intravenous (IV) Extravasation Management and Treatment Policy 17) Radiology Policy Manuel (See TOC attached) 18) Emergency Department Policy Manuel (See TOC attached) 19) Quality Policy Manuel 20) Risk Policy Manuel 21) Drug Room Policy Manuel (See TOC attached)		
VIII. CONTRACT EVALUATIONS			
1. Contract Services			
IX. REGULATORY AND COMPLIANCE			
A. OSDH & CMS Updates	None for this reporting period		
B. Surveys	None for this reporting period		
C. Product Recalls	Med Line trach care kit		
D. Failure Mode Effect Analysis (FMEA)	Water Line Break – Final at Corporate for approval		
E. Root Cause Analysis (RCA)	None for this reporting period		
X. PERFORMANCE IMPROVEMENT PROJECTS			
A. PIP	Proposed – STROKE; The Emergency Department will decrease the door to		

	transfer time to < 60 minutes for all stroke patients who present to the Emergency Department at least 65% of the time or greater by December 2023. Proposed –STEMI/CP; The Emergency Department will decrease the door to transfer time to < 60 minutes for all STEMI patients who present to the Emergency Department at least 80% of the time or greater by December 2023.		
XI. CREDENTIALING/NEW APPOINTMENT UPDATES			
A. Credentialing/New Appointment Updates	Credentialing/Re-credentialing at Med Staff		
XII. EDUCATION/TRAINING			
A. Education/ Training	Lunch and Learn: with Dr Rumsey HH/PPE Education – All Staff		
XIII. ADMINISTRATOR REPORT			
A. Administrator Report			
XIV. CCO REPORT			
A. CCO Report			
XV. STANDING AGENDA			
A. Annual Approval of Strategic Quality Plan	Approved 04/2023	Approved 04/2023	
B. Annual Appointment of Infection Preventionist	Approved 02/2023	Approved 02/2023	
C. Annual Appointment of Risk Manager	Approved 02/2023	Approved 02/2023	
D. Annual Appointment of Security Officer	On 11/16/2023 appointed - Tim Hopen	First - Kelley / Second - Melissa	
E. Annual Appointment of Compliance Officer	Approved 02/2023	Approved 02/2023	

F. Annual Review of Infection Control Risk Assessment (ICRA)	Approved 02/2023	Approved 02/2023	
G. Annual Review of Hazard Vulnerability Analysis (HVA)	Approved 10/2023		
Department Reports			
A. Department reports			
Other			
A. Other	None		
Adjournment			
A. Adjournment	There being no further business, meeting adjourned by Chasity seconded by Josey at 13:46	The next QAPI meeting will be – tentatively scheduled for 12/14/2023	

Mangum Regional Medical Center
Medical Staff Meeting
Thursday
November 21, 2023

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Greg Morgan, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

David Arles, APRN-CNP
Mary Barnes, APRN-CNP

NON-MEMBERS PRESENT:

Kelley Martinez, RN, CEO
Chelsea Church, PharmD
Nick Walker, RN, CCO
Chasity Howell, RN, Utilization Review Director
Megan Smith, RN, Infection Control
Lynda James, LPN, Pharmacy Tech
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 11:30 am by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the October 19, 2023, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. We are looking to get our Strong Mind Program up and running. There is where we will provide mental health for those in need.
    b. We have been having a monthly potluck for the staff and to observe birthdays.

- Operations Overview
  - We have completed the cafeteria floor and new equipment is in place.
  - We are continuing to work with EMS to enhance patient care.
  - We continue to have some coding issues, but we are catching those before claims go to insurance companies to ensure we are timely filling and that we have clean claims.
  - We continue to look for a Dr. and a Nurse Practitioner for the clinic with Amy Sims turning in her resignation.
  - We are also looking at a Part-Time Practitioner for the clinic so we do not have any drop in service after Amy departs us.
  - We are starting to do a thorough look at all our contracts to ensure we utilize them.
  - As of January 1, 2024, our cafeteria will no longer be serving lunch to the staff for free. There will be a price list coming soon.

Written report remains in the minutes.

5. Committee / Departmental Reports
   a. Medical Records
      i. Written report remains in the minutes.

   b. Nursing

Patient Care

- MRMC Education included:
  1. Flu vaccines administered through the month.
  2. Education regarding EMTALA requirements/documentation.
  3. Hand hygiene education and monitoring by Infection Control..
- MRMC Emergency Department reports no patient Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set(s).
- MRMC Infection Prevention reports 0 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Total Patient Days increased with 263 patient days in October as compared to 256 patient days in September. This represents an average daily census of 9. In addition, MRMC Emergency Department provided care to 138 patients in October.
- MRMC Case Management reports 22 Total Admissions for the month of October 2023.

- October 2023 COVID-19 Stats at MRMC: Swabs (6 PCR & 58 Antigen) with 9 Positive.

Preserve Rural Jobs

- MRMC placed one part time CNA to full-time and have placed a need for a part-time CNA.
- All allowable/available positions regarding nursing staff filled at this time!

Written report remains in minutes.

c. Infection Control

- Old Business
  a Employee Influenza Vaccine Program
  MRMC Starts flu shot vaccinations
- New Business:
  a. N/A
- Data:
  a, N/A
- Policy & Procedures Review:
  a. Pending Corporate Review of Manual.
- Education/In Services
  a. Monthly EPIC meeting for IP education
  b. Weekly Call with Corp. IP
  c. Weekly Lunch and Learn
  d. Staff education on influenza vaccines and hand hygiene
- Updates: No updates at this time.
- Annual Items:
  a. Completed March 2023

Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Continuing to work on the building. Flooring in Nurses break area and Med Prep room needing replaced – Tile is on site.
b. 15 AMP Receptacles – all 15 AMP Receptacles will be replaced with 20 AMP Receptacles throughout Hospital – replacement has started. Complete in needed areas 9-22-2023.
c. Replace all receptacles on generator circuit at Clinic with red receptacles. Complete 9-29-2023.
d. ER Provider office flooring needing replaced. Tile is onsite.
e. Damaged ceiling tile in patient area due to electrical upgrade-will need more tile to complete.

f. Replace ceiling tile that do not fit properly – will need more tile to complete.
g. North wall in Nurses breakroom in need of repair.
h. Chrome pipe needs cleaned and escutcheons replaced on hopper in ER - - Could not replace escutcheons due to corroded pipping in wall. Capped off leaking pipe under the floor to stop leaking. Will remove or cover hopper.
i. Ceramic tile around toilet paper dispenser is missing in restroom in Room 17.
j. ISO Caddys installed in patient rooms – ISO Caddys on site. All Caddys installed except rooms 16 and 28. Those rooms were occupied.
k. Sanitizer brackets – Brackets onsite – Need installed in rooms 17 and 31
l. EOC, EM and Life Safety Plans will be evaluated and approved in the November EOC meeting.

i.i.i. New Business
a. Approve Annual HVA Assessment – 1st Kelley Martines and 2nd – Josey Kenmore

Written report remains in minutes.

e. Laboratory
i. Tissue Report – None - October, 2023
i.i. Transfusion Report – Approved – October, 2023

f. Radiology
i. There was a total of – 178 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates:
- The PM was completed on the CT and the Xray Room.

Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacy Tech.
i.i. COVID-19 Medications-Have 1 dose of Bebtelovimab, 30 doses of Remdesivir and 18 Paxlovid doses in-house.
i.i.i. P & T Committee Meeting – Will be held on December 14, 2023
iv. Solu-Medrol has been added to the shortage list. We have plenty in house at this time.

Written report remains in the minutes.

h. Physical Therapy
i. No report.

i. Emergency Department
i. No report

j. Quality Assessment Performance Improvement
Risk

- Risk Management
  - Grievance – 0
  - 1 - Fall with no injury
  - 0 - Fall with minor injury
  - 0 – Fall with major injury
  - Death – 2
  - AMA/LWBS – 6/0
- Quality
  - Quality Minutes from previous month included as attachment.

- HIM – H&P – Completion 20/20 = 100% - Discharge Summary 20/20 = 100%
- Med event – 3
- Afterhours access was – 97
- Compliance
  Written report remains in minutes.

k. Utilization Review
i. Total Patient days for October: 263
i.i. Total Medicare days for October: 222
i.i.i. Total Medicaid days for October: 1
iv. Total Swing Bed days for October: 225
v. Total Medicare SB days for October: 202
Written report remains in the minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for October, 2023.

6. New Business
   a. Review & Consideration of Approval of HIPAA Officer Appointment: MRMC – HIPAA Officer Appointment – Tim Hopen
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve HIPAA Officer Appointment – Time Hopen.
   b.Review & Consideration of Approval of Policy & Procedure: MRMC – 340B Drug Policy - Revision
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – 340B Drug Policy – Revision
   c.Review & Discussion of Approval of Policy & Procedure: MRMC – On-Call and Call Back Responsibilities Policy for Radiology
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – On Call and Call Back Responsibilities Policy for Radiology.
   d.Review & Discussion of Approval of Policy & Procedure: MRMC – Nursing Education for Patient Belongings and Valuables.
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure:

MRMC – Nursing Education for Patient Belongings and Valuables.

e.Review & Consideration of Approval of Policy & Procedure: MRMC – Drug Diversion Policy

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Drug Diversion Policy.

f.Review & Consideration of Approval of Policy & Procedure: MRMC – Temporary Absence Release for Patients Policy

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Temporary Absence Release for Patients Policy.

g. Review & Consideration of Approval of Policy & Procedure: MRMC – Patient Belongings and Valuables Policy

i.Motion: made by John Chiaffitelli,, DO, Medical Director, to approve Policy & Procedure: MRMC – Patient Belongings and Valuables Policy.

h. Review & Consideration of Approval of Policy & Procedure: MRMC – Temporary Absence Release Form

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Temporary Absence Release Form.

i.Review & Consideration of Approval of Policy & Procedure: MRMC – Patient Belongings List

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Patient Belongings List.

j. Review & Consideration of Approval of Policy & Procedure: MRMC – Patient Valuables Record Form

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Patient Valuables Record Form.

k. Review & Consideration of Approval of Policy & Procedure: MRMC – Lost and Found Property Report

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Lost and Found Property Report.

l.Review & Consideration of Approval of Policy & Procedure: MRMC – Lost and Found Log

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Lost and Found Log

m.Review & Consideration of Approval of Policy & Procedure: MRMC – Behavioral Observation Checklist

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Behavioral Observation Checklist.

n.Review & Consideration of Approval of Policy & Procedure: MRMC – Medication Error and Near Miss Report

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Medication Error and Near Miss Report.

o. Review & Consideration of Approval of Policy & Procedure: MRMC – Extravasation Management Strategies – Appendix

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Extravasation Management Strategies – Appendix.

p. Review & Consideration of Approval of Policy & Procedure: MRMC – Intravenous (IV) Extravasation Management Treatment Policy

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy &

Procedure: MRMC – Intravenous (IV) Extravasation Management and Treatment Policy.

7. Adjourn
    a. Dr Chiaffitelli made a motion to adjourn the meeting at 11:50 am.

_____ _____

Medical Director/Chief of Staff Date

QUALITY MANAGEMENT REPORT

SUMMARY

Current Year 2023
Month : 11

ID	Group	METRICS	Unit	Monthly				Cumulative			
				Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change	Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change
		VOLUME & UTILIZATION									
00101	Volume & Utilization	Total ER visits	#	203.00		145.00	-58.00	1852.00		1611.00	-241.00
00102	Volume & Utilization	Total # of Observation Patients admitted	#			1.00	1.00	6.00		19.00	13.00
00103	Volume & Utilization	Total # of Acute Patients admitted	#	12.00		22.00	10.00	169.00		164.00	-5.00
00104	Volume & Utilization	Total # of Swing Bed Patients admitted	#	8.00		8.00		111.00		119.00	8.00
00105	Volume & Utilization	Total Hospital Admissions (Acute & Swing bed)	#	20.00		30.00	10.00	280.00		283.00	3.00
00106	Volume & Utilization	Total Discharges (Acute & Swing bed)	#	19.00		26.00	7.00	263.00		278.00	15.00
00107	Volume & Utilization	Total Patient Days (Acute & Swing bed)	#	259.00		243.00	-16.00	3612.00		3875.00	263.00
00108	Volume & Utilization	Average Daily Census (Acute & Swing bed)	#	9.00		8.10	-0.90	10.00		127.30	117.30
00109	Volume & Utilization	Left Against Medical Advice (AMA)	#	2.00	2.00	5.00	3.00	38.00	2.00	49.00	11.00
		CARE MANAGEMENT									
00201	Care Management	CAH 30 Day Readmission Rate per 100 patient discharges	%	2.00	0.05	0.12	94%	0.07	0.05	0.07	7%
		RISK MANAGEMENT									
00301	Risk Management	Total Number of Events	#	5.00		3.00	40%	79.00		2.67	97%
00302	Risk Management	Total number of complaints	#							0.27	
00304	Risk Management	Total number of complaints from ED	#							0.09	
00306	Risk Management	Total number of grievances	#					1.00		0.09	91%
00308	Risk Management	Total number of grievances from ED	#							0.09	
00310	Risk Management	Inpatient falls without injury	#	2.00		2.00	0%	22.00		1.18	95%
00312	Risk Management	ED patient falls without injury	#					3.00			100%
00314	Risk Management	Patient falls with minor injury	#					5.00		0.45	91%
00316	Risk Management	ED patient falls with minor injury	#								
00318	Risk Management	Total number of patient falls with major injury	#					1.00			100%
00320	Risk Management	Total number of ED patient falls with major injury	#								
00323	Risk Management	Inpatient Mortality Rate	%		0.10	0.00		15.00	0.10	0.00	100%
00325	Risk Management	ED Mortality Rate	%		0.10			9.00	0.10	0.00	100%
00327	Risk Management	OPO Notification Compliance	%	100.00	1.00	1.00	99%	95.00	1.00	0.94	99%
		NURSING									
00408	Nursing	Total Number of Code Blues during reporting period	#	1.00			100%	12.00			100%
00409	Nursing	Total number of CAH patients transferred to tertiary facility	#	2.00			100%	14.00		1.09	92%
		EMERGENCY DEPARTMENT									
00508	Emergency Department	ED Left Without Being Seen Rate	#					100.00		1.00	99%
00509	Emergency Department	Total number of ED patients transferred to a tertiary facility	#	10.00		4.00	60%	118.00		4.00	97%

Clinic Operations Report

Mangum Family Clinic

November 2023

Monthly Stats	November 22	November 23
Total Visits	221	212
Provider Prod	120	140
RHC Visits	198	186
Nurse Visits	13	9
Televisit	0	0
Swingbed	10	17

Provider Numbers	RHC	TH	SB
Barnes	8		7
Chiaffitelli			8
Sims	178		
other			2

Payor Mix	
Medicare	52
Medicaid	71
Self	7
Private	82

Visits per Geography	
Mangum	180
Granite	12
Willow	9
Blair	3

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Visits	167	123	164	166	164	127	148	198	192	206	212		

Clinic Operations:

- Amy Sims, worked 18 days in November for an avg of 10 pts per day.
- 56 revenue generating referrals to the hospital ancillary depts.
- Working diligently to replace Amy Sims for both interim coverage and long term.

Quality Report:

Improvement Measure	Actual	Goal	Comments
Reg Deficiencies	0	0	10 audited
Patient Satisfaction	4	5	All 4 noted "excellent"
New Patients	33	10	Extremely impressive given the circumstances
No Show	6.6%	<12%	17
Expired Medications	0	0	None noted.

Outreach:

- Nothing specific to report. Clinic continues to support the community by providing quality compassionate care.

Summary :

Very solid month considering holiday hours and provider departure. The Clinic continues to stand firm and committed to the community. Administration is working diligently to find a permanent replacement who will commit for the long run and totally "buy in" to the community. More to come.

"You love, you serve, and you show people you care. It's the simplest, most powerful, greatest, success model of all time." Joe Gordon.

Mangum Regional Medical Center

Chief Clinical Officer Report
November 2023

Patient Care

- MRMC Education included:

  1. Updated sepsis documentation

  2. Education regarding consents in ER and upon admission

  3. Preparation for Nursing Skills Fair December 5-7

- MRMC Emergency Department reports no patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set(s).
- MRMC Infection Prevention reports 1 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Total Patient Days decreased with 243 patient days in November as compared to 263 patient days in October. This represents an average daily census of 8. In addition, MRMC Emergency Department provided care to 145 patients in November.
- MRMC Case Management reports 30 Total Admissions for the month of November 2023.
- November 2023 COVID-19 Stats at MRMC: Swabs (0 PCR & 67 Antigen) with 6 Positive.

Mangum Regional Medical Center												
31 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec 22
Inpatient	13	17	19	11	16	19	22	33	21	22	30	22
Swing Bed	14	14	15	5	12	12	10	15	8	11	8	6
Observation	1	1	1	1	1	1	2	6	0	3	1	0
Emergency Room	159	119	168	138	148	130	152	154	160	138	145	210
Lab Completed	2542	2159	2804	1897	2191	1802	1987	2409	2156	2078	2063	2337
Rad Completed	211	185	244	204	192	196	160	184	123	130	158	214
Ventilator Days	0	0	31	30	7	0	0	0	0	0	0	0

Preserve Rural Jobs

- MRMC hired two new monitor technician/unit secretary
- All other allowable/available positions regarding nursing staff filled at this time!

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
November 2023

Operations Overview

- We are working with an Architect to ensure our spaces are up to code for moving Physical Therapy from its current location to a large room so we can place the Strong Minds Program in their current area.
- We have completed the remodel of the nurses break room and medication prep area.
- We are continuing to work with EMS to enhance patient care. We are going to start doing joint classes with them and exercises.
- We continue to have some coding issues, but we are catching those before claims go to insurance companies to ensure we are timely filling and that we have clean claims.
- We are currently in deep conversations and negotiations with a Nurse Practitioner to fill Amy Sims position in the clinic.
- We are also in final discussions with a Part-Time Practitioner for the clinic.
- We are starting to do a thorough look at all our contracts to ensure we utilize them and that they are providing the service they say they are.
- We continue to look for new opportunities for the facility and the community.
- I also continue to do rounds on patients to ensure we are fulfilling their needs.
- The nursing home and I are also in contact with one another to ensure that both of the organizations are working well with one another.

Minutes
Mangum City Hospital Authority- Emergency Meeting
December 28, 2023 at 5:00 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in an Emergency session on December 28, 2023, at 5:00 PM, in the City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

Chairman Vanzant called the meeting to order at 5:05pm

ROLL CALL AND DECLARATION OF A QUORUM

PRESENT:
Trustee Michelle Ford
Chairman Vanzant
Trustee Lisa Hopper

ABSENT:
Trustee Cheryl Lively
Trustee Ronnie Webb

EXECUTIVE SESSION

1. Discussion and possible action to review and approve medical staff privileges/credentials/contracts for the following providers with possible executive session in accordance with 25 O.S. 307(B)(1). Failure to convene in emergency session will result the Emergency Room at the Mangum Regional Medical Center closing which will cause immediate financial loss and injury to persons and the time requirements for public notice of a special meeting is impractical and increase the likelihood of injury or financial loss:

    - **Re-Credentialing-** Barry Davenport, MD-Courtesy
    - **Re-Credentialing-** Trent Elliot, DO – Courtesy

    Chairman Vanzant made a motion to enter into executive session at 5:05pm

OPEN SESSION

2. Action taken as a result of executive session, if any.

    Chairman Vanzant declares out of executive session at 5:06pm.

    Motion to accept Re-credentialing of both Mr. Barry Davenport, MD and Mr. Trent Elliot, DO effective December 28th, 2023.

Motion made by Chairman Vanzant, Seconded by Trustee Hopper.
Voting Yea: Trustee Ford, Chairman Vanzant, Trustee Hopper.

ADJOURN

Motion to adjourn at 5:06pm
Motion made by Chairman Vanzant, Seconded by Trustee Hopper
Voting Yea: Trustee Ford, Chairman Vanzant, Trustee Hopper.

Carson Vanzant, Chairman

Ally Kendall, Interim City Clerk

Mangum Regional Medical Center
Quality Assurance & Performance Improvement Committee Meeting

Meeting Minutes

CONFIDENTIALITY STATEMENT: These minutes contain privileged and confidential information. Distribution, reproduction, or any other use of this information by any party other than the intended recipient is strictly prohibited.

Date:	**12/14/2023**	**Time:**	**13:09**	**Recorder: D. Jackson**		**Reporting Period: Nov. 2023**	

Members Present

Chairperson: Dr. C | CEO: Kelly Martinez | dical Representative: Dr C

Name	Title	Name	Title	Name	Title
Nick Walker	CNO	Danielle Cooper	Bus Office	Tonya Bowen	Lab
Bethany Moore	HR	Kaye via Teams	Credentialing		IT
Jennifer Dryer	HIM	Mark Chapman	Maintenace/EOC	Marla Abernathy	Dietary
Chrissy Smith Chelsea Church/Lynda James	PT Pharmacy	Melissa Tunstall Chasity Howell	Radiology Case Management	Meghan Smith	IP

TOPIC	FINDINGS – CONCLUSIONS	ACTIONS – RECOMMENDATIONS	FOLLOW-UP
I. CALL TO ORDER			
Call to Order	The hospital will develop, implement, and maintain a performance improvement program that reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.	This meeting was called to order on 12/14/2023 by 1st Kelley/ 2nd Meghan	
II. REVIEW OF MINUTES			
A. Quality Council Committee	11/16/2023	Committee reviewed listed minutes A-F. Motion to approve minutes as distributed made by Kelley / 2nd by Pam Minutes A-F approved. Present a copy of the Meeting Minutes at the next Medical Executive Committee and Governing Board meeting.	
B. EOC/ Patient Safety Committee	11/14/2023		
C. Infection Control Committee	11/07/2023		
D. Pharmacy & Therapeutics Committee	09/21/2023		
E. HIM/Credentialing Committee	11/07/2023		
F. Utilization Review Committee	11/08/2023		
III. REVIEW OF COMMITTEE MEETINGS			

A. EOC/Patient Safety	12/12/2023		
B. Infection Control	12/07/2023		
C. Pharmacy & Therapeutics	09/21/2023 [Next meeting 12/14/2023]		
D. HIM-Credentials	12/07/2023		
E. Utilization Review	12/08/2023		
F. Compliance	10/18/2023 - Next meeting 01/2024		
IV. OLD BUSINESS			
A. Old Business	1) HIPPA Officer Appointment – Tim Hopen 2) 340B Drug Policy – Revision 3) On-Call and Call Back Responsibilities Policy for Radiology 4) Nursing Education for Patient Belongings and Valuables 5) Drug Diversion Policy 6) Temporary Absence Release for Patients Policy 7) Patient Belongings and Valuables Policy 8) Temporary Absence Release Form 9) Patient Belongings List 10) Patient Valuables Record Form 11) Lost and Found Property Report 12) Lost and Found Log 13) Behavioral Observation Checklist 14) Medication Error and Near Miss Report 15) Extravasation Management Strategies – Appendix 16) Intravenous (IV) Extravasation Management and Treatment Policy	Approved 11/16/2023	
V. NEW BUSINESS			
A. New Business	Approval of policies/procedures - see below		
VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT			
A. Volume & Utilization			
1. Hospital Activity	Total ER – 145 Total OBS pt - 1		

	Total Acute pt - 22 Total SWB - 8 Total Hospital Admits (Acute/SWB) - 30 Total Hospital DC (Acute/SWB) - 26 Total pt days - 243 Average Daily Census - 8		
2. Blood Utilization	None for the reporting period		
B. Care Management			
1. CAH Readmissions	3 for the reporting period - 1) Pt admitted with primary dx; Readmitted with secondary dx, released then readmitted for the third time with different dx. 2) Pt admitted with primary dx, readmitted with different dx 3) Pt admitted with primary dx, readmitted with primary dx		
2. IDT Meeting Documentation	5/5 (100%) completed within 24 hours of IDT		
3. Insurance Denials	None for the reporting period		
4. IMM Notice	12/12 (100%) notices signed within 2 days prior to discharge		
C. Risk Management			

1. Incidents	4 ER/1 in-pt; ER1.) Pt to the ER for testing post accident, pt attempted to give false sample for testing, this was noted and reported to nursing staff. Pt became upset and left without completing testing. Did not sign AMA form. 2.) Pt in for complaint of dizziness, when discussed specimens needed for testing, pt declined testing and left the er, provider attempted to speak with pt but they would not respond to provider. Pt left without signing AMA. 3.) Pt in for c/o shob, testing/treatment in ED, provider recommended admit, pt declined admit and signed out ama. 4.) Pt to ER for c/o allergic reaction, testing/treatment provided in the ER, when discussing test results pt wanted to leave, pt would not wait for provider to give discharge orders, signed out ama. 1 in-pt AMA - pt admitted for wc and IV ABT, pt became anxious and wanted to leave, provider in to discuss the patient's current dx needs, pt continued to be adamant that they wanted to leave. pt signed out ama.	AMAs 1-5; MRMC will continue to provide care to the patients based on needs, however patient's have the right to refuse care at anytime, education will be provided as needed to patient/families	
2. Reported Complaints	None for reporting period		
3. Reported Grievances	None for reporting period		
4. Patient Falls without Injury	2 for the reporting period - 1.) pt became weak during assisted transfer, CNA lowered pt to the floor, no injuries noted 2.) Pt called out for assistance mid-self-transfer d/t dizziness. Nurse to pt side and assisted pt to floor as they were not able to complete transfer. Pt noted to have low b/p, provider notified, and medication adjusted, no injuries noted		
5. Patient Falls with Minor Injury	None for reporting period		

6. Patient Falls with Major Injury	None for reporting period		
7. Fall Risk Assessment	2 assessments completed post 2 in-pt fall for the reporting period		
8. Mortality Rate	1 - (1 inpt) - 1 SWB, admitted with complications and decline multiple time since initial stroke in Sept 2023, during this hospital stay pt continued with significant decline, pt was dnr and expired while in patient		
9. Deaths Within 24 Hours of Admission	None for the reporting period		
10. Organ Procurement Organization Notification	1 reported death with 1 decline for reporting period		
D. Nursing			
1. Critical Tests/Labs	69 for the reporting period - 2 not entered into pt chart/15 not documented in the critical lab book.	CNO is auditing book weekly and reminding staff that critical labs must be documented in both the book and pt chart	
2. Restraint Use	None for the reporting period		
3. Code Blue	None for the reporting period		
4. Acute Transfers	None for the reporting period		
5. Inpatient Transfer Forms	None completed for reporting period		
E. Emergency Department			
1. ED Nursing DC/ Transfer Assessment	20/20 (100%)		
2. ED Readmissions	2 for the reporting period - 1) Pt was seen for primary c/o. Treated and released. Pt returned to ED for continued c/o. 2) Pt was seen for primary c/o, treated and released. returned to er for primary complaint. Treated for dx found during exam, with improvement and discharged	1) Pt did not follow d/c instructions as previously directed, admitted for further care. 2) Treatment administered and the patient was educated on treatment plan and need for specialist outpatient follow up.	

3. ER Log & Visits	145 (100%)		
4. MSE	Quarterly		
5. EMTALA Transfer Form	4/4 (100%)		
6. Triage	20/20 (100%)		
7. ESI Triage Accuracy	20/20 (100%)		
8. ED Transfers	4 for the reporting period - Patients transferred to Higher Level of Care for: 1.) Back pain – testing not available at MRMC/Neuro 2.) NSTEMI – Cards 3.) NSTEMI – Cards 4.) SI/SH – In-pt psych	All ER transfers for the reporting period appropriate for higher level of care	
9. Stroke Management	None for reporting period		
10. Brain CT Scan – Stroke (OP-23)	None for reporting period		
11. Suicide Management	2 for the reporting period - 1 sent home with safety plan per LMHP recommendations		
12. STEMI Care	No STEMIs for reporting period 2- NSTEMIs 1.) pt did not present or c/o any cardiac s/sx, complete work up and treatment based on s/sx at presentation, NSTEMI noted with EKG and troponin. Total ER time 2 hrs 48 min, extended ER time due to pt initial decline for transfer, after family discussion pt agreeable to transfer. 2.) pt did not present or c/o any cardiac s/sx, complete work up and treatment based on s/sx at presentation, NSTEMI found at work up, Total ER	Pt will continue to be worked up based on c/o and immediate needs as deemed necessary by provider, staff will continue to attempt transfer options as available however weather and staff conditions will determine their capabilities	

	time; 19 hrs 29 min, delay in transportation due to monitoring of labs before determining need for higher level of care, difficulty with ground and air transport (ground – no availability/air - weather conditions)		
13. Chest Pain	4/5 EKG (80%) 1 ekg is documented in pt chart as being completed at bedside upon arrival, RT was not able to get printer to work until later time (greater than 5 min post arrival) ekg scanned in patient chart reflects later than 5 min	Will continue to trouble shoot space lab issues as needed, only issue noted with chest pain patients. RT director continues to monitor for any trends with operational issues	
14. ED Departure - (OP-18)	Quarterly		
F. Pharmacy & Medication Safety			
1. After Hours Access	48 for the reporting period		
2. Adverse Drug Reactions	None for reporting period		
3. Medication Errors	None for the reporting period		
4. Medication Overrides	40 for the reporting period		
5. Controlled Drug Discrepancies	2 for the reporting period - All discrepancies were from nurses miscounting medications at shift change.		
G. Respiratory Care Services			
1. Ventilator Days	0 for the reporting period		
2. Ventilator Wean	0 for the reporting period		
3. Unplanned Trach Decannulations	None for the reporting period		
H. Wound Care Services			
1. Development of Pressure Ulcer	None for the reporting period		

2. Wound Healing Improvement	None for the reporting period		
3. Wound Care Documentation	100% for initial assessment and discharge assessment documentation completed on time		
I. Radiology			
1. Radiology Films	4 films repeated due to technical error – 144 total for the reporting period; 1-3 anatomy clipped, 4 films with artifacts on film		
2. Imaging	14 for the reporting period; with 14 consents for CT obtained		
3. Radiation Dosimeter Report	Quarterly		
J. Laboratory			
1. Lab Reports	1 repeated /2063 total for the reporting period – 1 incorrect specimen sent for specific test ordered	Redraw preformed, tech educated on correct specimen requirements	
2. Blood Culture Contaminations	None for the reporting period		
K. Infection Control and Employee Health			
1. Line Events	1 for the reporting period – inserted device incidentally removed; device denied by patient, provider was notified of event		
2. CAUTI's	1 for the reporting period - uti dx while in-pt, pt treated per results	Staff educated on CAUTI prevention	
3. CLABSI's	0 for the reporting period		
4. Hospital Acquired MDRO's	0 for the reporting period		
5. Hospital Acquired C-diff	0 for the reporting period		
6. HAI by Source	3 for the reporting period – 1) uti dx while in-pts due to febrile state. Treated per recommendations on C&S. 2) Pt with lethargy. Dx with uti. Treated per recommendations on C&S	Staff educated on UTI prevention, new foley procedures	

7. Hand Hygiene/ PPE & Isolation Surveillance	100 % HH / 100 % PPE		
8. Patient Vaccinations	0 received influenza vaccine / 0 received pneumococcal vaccine		
9. VAE	None for the reporting period		
10. Employee Health Summary	0 employee event/injury, 9 employee health encounters (vaccines/testing) 10 reports of employee illness/injury		
L. Health Information Management (HIM)			
1. History and Physicals Completion	20/20 (100%) completed within 24 hrs of admit		
2. Discharge Summary Completion	20/20 (100%) completed within 72 hrs of discharge		
3. Progress Notes (Swing bed & Acute)	Weekly SWB notes – 20/20 (100%) Daily Acute notes – 20 /20 (100%)		
4. Swing Bed Indicators	8/8 (100%) SWB social HX completed within 24 hrs/first business day after admit		
5. E-prescribing System	20/20 (100%) of medications were electronically sent this reporting period		
6. Legibility of Records	20/20 (100%)		
7. Transition of Care	Obs to acute – none for the reporting period, Acute to SWB – 6/6 (100%) of appropriate orders for admit from Acute to SWB status		
8. Discharge Instructions	9/20 (45%) - There were 10 er's/1 swb missing the d/c instructions. D/c instructions were created but	HIM sent out an email to the CEO, CCO and Quality. CCO let the nurses know to start	

	a signed copy did not make it to HIM.	printing the d/c instructions, getting signature and then scanning back in.	
9. Transfer Forms	4/4 (100%) for ER and in-pt transfers to higher level of care for the reporting period		
M. Dietary			
1. Weekly Cleaning Schedules	49/62 (79%) a whole week of QAPI data is missing (cleaning sheet)	make sure the sheets are put in the right place, Director has designated area for sheets	
2. Daily Cleaning Schedules	390/390 (100%)		
3. Wash Temperature	45/45 (100%) - dishwasher was out of service for the first two weeks of November. temps monitored for working weeks	Maintenace/dishwasher company notified of issue/visit made/parts ordered for fix	
4. Rinse Temperature	45/45 (100%) - dishwasher was out of service for the first two weeks of November. temps monitored for working weeks	Maintenace/dishwasher company notified of issue/visit made/parts ordered for fix	
N. Therapy			
1. Discharge Documentation	14/14 (100%) completed within 72 hours of discharge		
2. Equipment Needs	13/13 (100%)		
3. Therapy Visits	PT 107– OT 90 - ST 5		
4. Supervisory Log	0 PTA supervisory logs completed for reporting period		
5. Functional Improvement Outcomes	PT 4/6 (67%) – OT 6/6 (100%) – ST 1/1 (100%) - pts discharged during the reporting period with improvement outcomes PT - 2 PT patients discharged with no change in standardized assessment scores on admission vs discharge. Limited motivation to further functional abilities demonstrated by both patients/both patients did discharge at prior level of function.		

O. Human Resources			
1. Compliance	100%		
2. Staffing	Hired – 2, Termed - 2		
P. Registration Services			
1. Compliance	100%		
Q. Environmental Services			
1. Terminal Room Cleans	10/10 (100%)		
R. Materials Management			
1. Materials Management Indicators	10 – Back orders, 0 – Late orders, – Recalls, 1023/1035 items checked out properly		
S. Life Safety			
1. Fire Safety Management	0 fire drills for the reporting period – 24 fire extinguishers checked		
2. Range Hood	Quarterly		
3. Biomedical Equipment	Quarterly		
T. Emergency Preparedness			
1. Orientation to EP Plan	2/2 (100%)		
U. Information Technology			
A. IT Incidents	10		
V. Outpatient			
1. Therapy Visits	49/65 (75%) 5 no show/no call missed visits, 11 visits which patients called and rescheduled. 1 non-visit discharge		
2. Discharge Documentation	3/3 (100%) discharge notes completed within 72 hrs of discharge		

3. Functional Improvement Outcomes	2/3 (67%) 1 non-visit discharge (unable to obtain standard testing with non-visits)		
4. Outpatient Wound Services	(100%)		
W. Strong Mind Services			
1. Record Compliance	N/A	N/A	N/A
2. Client Satisfaction Survey	N/A	N/A	N/A
3. Master Treatment Plan	N/A	N/A	N/A
4. Suicidal Ideation	N/A	N/A	N/A
5. Scheduled Appointments	N/A	N/A	N/A
VII. POLICY AND PROCEDURE REVIEW			
1. Review and Retire	None for this reporting period		
2. Review and Approve	1) Radiology Policy Manuel (See TOC attached) 2) Emergency Department Policy Manuel (See TOC attached) 3) Quality Policy Manuel (See TOC attached) 4) IT Policy Manuel (See TOC attached) 5) Drug Room Policy Manuel (See TOC attached) 6) Hospital Policy/Form/Order Set/Protocol and other Document Review Process Policy 7) Policy, Protocols, Forms, or other Document Development, Review, and Implementation Process Policy	1-5 – Approved by Kelley/Dr C 6-7 – Approved by Kelley/Dr C	
VIII. CONTRACT EVALUATIONS			

1. Contract Services			
IX. REGULATORY AND COMPLIANCE			
A. OSDH & CMS Updates	None for this reporting period		
B. Surveys	Life Safety complaint survey 11		
C. Product Recalls	None for this reporting period		
D. Failure Mode Effect Analysis (FMEA)	Water Line Break – Final at Corporate for approval		
E. Root Cause Analysis (RCA)	None for this reporting period		
X. PERFORMANCE IMPROVEMENT PROJECTS			
A. PIP	Proposed – STROKE; The Emergency Department will decrease the door to transfer time to < 60 minutes for all stroke patients who present to the Emergency Department at least 65% of the time or greater by December 2023. Proposed –STEMI/CP; The Emergency Department will decrease the door to transfer time to < 60 minutes for all STEMI patients who present to the Emergency Department at least 80% of the time or greater by December 2023.		
XI. CREDENTIALING/NEW APPOINTMENT UPDATES			
A. Credentialing/New Appointment Updates	Credentialing/Re-credentialing at Med Staff		
XII. EDUCATION/TRAINING			

A. Education/ Training			
XIII. ADMINISTRATOR REPORT			
A. Administrator Report			
XIV. CCO REPORT			
A. CCO Report			
XV. STANDING AGENDA			
A. Annual Approval of Strategic Quality Plan	Approved 04/2023	Approved 04/2023	
B. Annual Appointment of Infection Preventionist	Approved 02/2023	Approved 02/2023	
C. Annual Appointment of Risk Manager	Approved 02/2023	Approved 02/2023	
D. Annual Appointment of Security Officer	Approved 11/2023	Approved 11/2023	
E. Annual Appointment of Compliance Officer	Approved 02/2023	Approved 02/2023	
F. Annual Review of Infection Control Risk Assessment (ICRA)	Approved 02/2023	Approved 02/2023	
G. Annual Review of Hazard Vulnerability Analysis (HVA)	Approved 10/2023	Approved 10/2023	
Department Reports			
A. Department reports			
Other			
A. Other	None		
Adjournment			
A. Adjournment	There being no further business, meeting adjourned by Chasity seconded by Pam at 13:29	The next QAPI meeting will be – tentatively scheduled for 01/11/2024	

Mangum Regional Medical Center
Medical Staff Meeting
Thursday
December 14, 2023

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Greg Morgan, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

David Arles, APRN-CNP
Mary Barnes, APRN-CNP

NON-MEMBERS PRESENT:

Kelley Martinez, RN, CEO
Chelsea Church, PharmD
Nick Walker, RN, CCO
Chasity Howell, RN, Utilization Review Director
Megan Smith, RN, Infection Control
Lynda James, LPN, Pharmacy Tech

1. Call to order
    a. The meeting was called to order at 13:30 by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the November 21, 2023, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. We are working with an Architect to ensure our spaces are up to code for moving Physical Therapy from its current location to a large room se we can place the Strong Minds Program in their current area.

- Operations Overview
  - We have completed the remodel of the nurse's break room and medication prep area.
  - We are continuing to work with EMS to enhance patient care. We are going to start doing joint classes with them and exercises.
  - We continue to have some coding issues, but we are catching those before claims go to insurance companies to ensure we are timely filling and that we have clean claims.
  - We are currently in deep conversations with and negotiations with a Nurse Practitioner to fill Amy Sims position in the clinic.
  - We are also in final discussions with a Part-Time Practitioner for the clinic.
  - We are starting to do a thorough look at all our contracts to ensure we utilize them and that they are providing the service they say they are.
  - We continue to look for new opportunities for the facility and the community.
  - I also continue to do rounds on patients to ensure we are fulfilling their needs.
  - The nursing home and myself are also in contact with one another to ensure that both of the organizations are working well with one another.

    Written report remains in the minutes.

5. Committee / Departmental Reports
   a. Medical Records
      1. Discussed missing signatures on discharge instructions. CNO provided education to the nurses.
      2. There isn't any credentialing/re-credentialing for the month of December, 2023.
         i. Written report remains in the minutes.

   b. Nursing

      Patient Care

      - MRMC Education included:
        1. Updated sepsis documentation.
        2. Education regarding consents in ER and upon admission.
        3. Preparation for Nursing Skills Fair December 5-7

- MRMC Emergency Department reports no patient Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set(s).
- MRMC Infection Prevention reports 1 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Total Patient Days increased with 243 patient days in November as compared to 263 patient days in October. This represents an average daily census of 8. In addition, MRMC Emergency Department provided care to 145 patients in November. 2023.
- MRMC Case Management reports 30 Total Admissions for the month of November 2023.
- November 2023 COVID-19 Stats at MRMC: Swabs (0 PCR & 67 Antigen) with 6 Positive.

Preserve Rural Jobs

- MRMC hired two new monitor technician/unit secretary
- All allowable/available positions regarding nursing staff filled at this time!

Written report remains in minutes.

c. Infection Control

- Old Business
  a Employee Influenza Vaccine Program
  MRMC Started flu shot vaccinations for employees on Oct 1st, 2023.
- New Business:
  a. New Sepsis Screen in CPSI
  b. 1.) Intervention is live. Provide further education at skills fair.
- Data:
  a, N/A
- Policy & Procedures Review:
  a. Corporate Policy Review Committee is currently looking at all Policies associated with Influenza Vaccines.
- Education/In Services
  a. Monthly EPIC meeting for IP education
  b. Weekly Call with Corp. IP
  c. Weekly Lunch and Learn
  d. Staff education on influenza vaccines and hand hygiene
  e. Skills fair scheduled for 12/05/2023 through 12/07/2023.
- Updates: No updates at this time.
- Annual Items:
  a. Completed March 2023

Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Continuing to work on the building. Flooring in Nurses break area and Med Prep room needing replaced – Tile is on site-Remodel started 11-13-2023.
b. ER Provider office flooring needing replaced. Tile is onsite.
c. Damaged ceiling tile in patient area due to electrical upgrade-will need more tile to complete.
d. Replace ceiling tile that do not fit properly – will need more tile to complete.
e. North wall in Nurses breakroom in need of repair-remodel started 11/13/2023.
f. Chrome pipe needs cleaned and escutcheons replaced on hopper in ER - - Could not replace escutcheons due to corroded pipping in wall. Capped off leaking pipe under the floor to stop leaking. Will remove or cover hopper-hopper will be covered.
g. Ceramic tile around toilet paper dispenser is missing in restroom in Room 17.
h. ISO Caddys installed in patient rooms – ISO Caddys on site. All Caddys installed except room 16. This room was occupied.
i. Sanitizer brackets – Brackets onsite – Need installed in rooms 17 and 31-Complete 10/19/2023.
j. EOC, EM and Life Safety Plans will be evaluated and approved in the December EOC meeting.
k. Approve annual HVA assessment – Approved 10/10/2023 1st Kelley Martinez and 2nd – Josey Kenmore.

i.i.i. New Business

a. Add additional sanitizer dispensers in patient wing – will need more dispensers.

Written report remains in minutes.

e. Laboratory

i. Tissue Report – None - November, 2023
i.i. Transfusion Report – None – November, 2023

f. Radiology

i. There was a total of – 224 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates:
- No updates.

Written report remains in minutes.

g. Pharmacy

i. Verbal Report by Pharmacy Tech.

i.i. COVID-19 Medications-Have 1 dose of Bebtelovimab, 30 doses of Remdesivir and 18 Paxlovid doses in-house.
i.i.i. P & T Committee Meeting – P&T Meeting held on Dec 14, 2023
iv. Solu-Medrol has been added to the shortage list. We have plenty in house at this time.
Written report remains in the minutes.

h. Physical Therapy
i. No report.

i. Emergency Department
i. No report

j. Quality Assessment Performance Improvement
Risk

- Risk Management
  - Grievance – 0
  - 0 - Fall with no injury
  - 0 - Fall with minor injury
  - 0 – Fall with major injury
  - Death – 2
  - AMA/LWBS – 3/0
- Quality
  - Quality Minutes from previous month included as attachment.

- HIM – H&P – Completion 20/20 = 100% - Discharge Summary 20/20 = 100%
- Med event – 1
- Afterhours access was – 81
- Compliance

Written report remains in minutes.

k. Utilization Review
i. Total Patient days for November: 243
i.i. Total Medicare days for November: 197
i.i.i. Total Medicaid days for November: 12
iv. Total Swing Bed days for November: 178
v. Total Medicare SB days for November: 165
Written report remains in the minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for November, 2023.

6. New Business
   a. Review & Consideration of Approval of Policy & Procedure: MRMC – Quality Policy Manual – Table of Contents Attached

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve MRMC – Quality Policy Manual – Table of Contents attached.

b.Review & Consideration of Approval of Policy & Procedure: MRMC – IT – Policy Manual – Table of Contents attached

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve MRMC -IT Policy Manual – Table of Contents attached.

c.Review & Discussion of Approval of Policy & Procedure: MRMC – Radiology Policy Manual - Table of Contents attached

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Radiology Policy Manual – Table of Contents attached.

d.Review & Discussion of Approval of Policy & Procedure: MRMC – ED Policy Manual – Table of Contents attached

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – ED Policy Manual – Table of Contents attached.

e.Review & Consideration of Approval of Policy & Procedure: MRMC – Drug Room Policy Manual - Table of Contents attached

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Drug Room Policy Manual – Table of Contents attached

f.Review & Consideration of Approval of Policy & Procedure: MRMC – Hospital Policy/Form/ Order Set/Protocol and Other Document Review Process

i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC – Hospital Policy/Form/Order Set/Protocol and Other Document Review Process.

g. Review & Consideration of Approval of Policy & Procedure: MRMC – Policy, Protocols, Forms or other Document Development, Review and Implementation Process

i.Motion: made by John Chiaffitelli,, DO, Medical Director, to approve Policy, Protocols, Forms or other Document Development, Review, and Implementation Process.

7. Adjourn

a. Dr Chiaffitelli made a motion to adjourn the meeting at 13:46.

_____ _____

Medical Director/Chief of Staff Date

QUALITY MANAGEMENT REPORT

SUMMARY

Current Year 2023
Month : 12

ID	Group	METRICS	Unit	Monthly				Cumulative			
				Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change	Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change
		VOLUME & UTILIZATION									
00101	Volume & Utilization	Total ER visits	#	209.00		147.00	-62.00	1852.00		1758.00	-94.00
00102	Volume & Utilization	Total # of Observation Patients admitted	#			3.00	3.00	6.00		22.00	16.00
00103	Volume & Utilization	Total # of Acute Patients admitted	#	16.00		19.00	3.00	169.00		183.00	14.00
00104	Volume & Utilization	Total # of Swing Bed Patients admitted	#	6.00		12.00	6.00	111.00		131.00	20.00
00105	Volume & Utilization	Total Hospital Admissions (Acute & Swing bed)	#	22.00		31.00	9.00	280.00		314.00	34.00
00106	Volume & Utilization	Total Discharges (Acute & Swing bed)	#	17.00		34.00	17.00	263.00		312.00	49.00
00107	Volume & Utilization	Total Patient Days (Acute & Swing bed)	#	281.00		254.00	-27.00	3612.00		4129.00	517.00
00108	Volume & Utilization	Average Daily Census (Acute & Swing bed)	#	9.10		8.20	-0.90	10.00		135.50	125.50
00109	Volume & Utilization	Left Against Medical Advice (AMA)	#	4.00	2.00	3.00	-1.00	38.00	2.00	52.00	14.00
		CARE MANAGEMENT									
00201	Care Management	CAH 30 Day Readmission Rate per 100 patient discharges	%	4.00	0.05		100%	0.07	0.05	0.06	15%
		RISK MANAGEMENT									
00301	Risk Management	Total Number of Events	#	6.00		1.00	83%	79.00		2.50	97%
00302	Risk Management	Total number of complaints	#			1.00				0.33	
00304	Risk Management	Total number of complaints from ED	#							0.08	
00306	Risk Management	Total number of grievances	#					1.00		0.08	92%
00308	Risk Management	Total number of grievances from ED	#							0.08	
00310	Risk Management	Inpatient falls without injury	#					22.00		1.08	95%
00312	Risk Management	ED patient falls without injury	#	2.00			100%	3.00			100%
00314	Risk Management	Patient falls with minor injury	#			1.00		5.00		0.50	90%
00316	Risk Management	ED patient falls with minor injury	#								
00318	Risk Management	Total number of patient falls with major injury	#					1.00			100%
00320	Risk Management	Total number of ED patient falls with major injury	#								
00323	Risk Management	Inpatient Mortality Rate	%		0.10			15.00	0.10	0.00	100%
00325	Risk Management	ED Mortality Rate	%		0.10			9.00	0.10	0.00	100%
00327	Risk Management	OPO Notification Compliance	%	100.00	1.00			95.00	1.00	0.94	99%
		NURSING									
00408	Nursing	Total Number of Code Blues during reporting period	#	1.00			100%	12.00			100%
00409	Nursing	Total number of CAH patients transferred to tertiary facility	#	2.00		1.00	50%	14.00		1.08	92%
		EMERGENCY DEPARTMENT									
00508	Emergency Department	ED Left Without Being Seen Rate	#					100.00		1.00	99%
00509	Emergency Department	Total number of ED patients transferred to a tertiary facility	#	17.00		9.00	47%	118.00		9.00	92%

Clinic Operations Report

Mangum Family Clinic

December 2023

Monthly Stats	December 22	December 23
Total Visits	188	177
Provider Prod	148	134
RHC Visits	188	151
Nurse Visits	9	1
Televisit	0	0
Swingbed	0	25

Provider Numbers	RHC	TH	SB
Barnes			15
Chiaffitelli			3
Sims	151		
other			

Payor Mix	
Medicare	59
Medicaid	48
Self	5
Private	63

Visits per Geography	
Mangum	125
Granite	9
Altus	6
Duke	4

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Visits	167	123	164	166	164	127	148	198	192	206	212	177	2044

Clinic Operations:

- Amy Sims completed her contractual obligations as of 12/29/23. She left having fulfilled all requirements and with no outstanding charts.
- 69 revenue generating referrals to the hospital ancillary depts. Up from last month.
- Kristi Fry, C-NP has signed a contract to be the Mangum Clinic provider.
- Still negotiating start date but expect somewhere in the line of 4/1/2024.
- Clinic will operate on a fairly consistent basis with providers filling in until the expected start of 4/1. Please be aware that there are some uncovered days noted. Walkins will be deferred to hospital ER on those days.

Quality Report:

Improvement Measure	Actual	Goal	Comments
Reg Deficiencies	0	0	10 audited
Patient Satisfaction	45	5	All 45 noted "excellent"
New Patients	22	10	Extremely impressive given the circumstances
No Show	10.2%	<12%	24 no shows for the month
Expired Medications	0	0	None noted.

Outreach:

- Nothing specific to report. Clinic continues to support the community by providing quality compassionate care.

Summary :

2023 ended on a strong note. 22 "new patients" indicates the growth and reliability of the Mangum Family Clinic. There have been several major changes throughout the year but the one thing that remains constant is the dedication and commitment that the Mangum Family Clinic staff has to the community. MFC looks forward to the new year and looks forward to assessing and implementing service lines to accommodate our patient's healthcare needs. We are excited for the new provider that is schedule to start. MFC will initiate a media advertisement campaign once the start date is established. High expectations for the 2024 year!!!

"You love, you serve, and you show people you care. It's the simplest, most powerful, greatest, success model of all time." Joe Gordon.

Mangum Regional Medical Center

Chief Clinical Officer Report
December 2023

Patient Care

- MRMC Education included:

  1. Continued sepsis documentation changes/education with nursing and providers.

  2. Education on blood administration with nursing staff.

  3. Completed nursing skills fair.

- MRMC Emergency Department reports no patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set(s).
- MRMC Infection Prevention reports 0 CAUTI.
- MRMC Infection Prevention report 0 CLABSI.
- MRMC Infection Prevention reports 0 HAI, or MDRO for the month of December.

Client Service

- Total Patient Days increased with 254 patient days in December as compared to 243 patient days in November. This represents an average daily census of 8. In addition, MRMC Emergency Department provided care to 147 patients in December.
- MRMC Case Management reports 31 Total Admissions for the month of December 2023.
- December 2023 COVID-19 Stats at MRMC: Swabs (1 PCR & 93 Antigen) with 8 Positive.

Mangum Regional Medical Center												
Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient	13	17	19	11	16	19	22	33	21	22	30	31
Swing Bed	14	14	15	5	12	12	10	15	8	11	8	12
Observation	1	1	1	1	1	1	2	6	0	3	1	3
Emergency Room	159	119	168	138	148	130	152	154	160	138	145	147
Lab Completed	2542	2159	2804	1897	2191	1802	1987	2409	2156	2078	2063	2167
Rad Completed	211	185	244	204	192	196	160	184	123	130	158	149
Ventilator Days	0	0	31	30	7	0	0	0	0	0	0	0

Preserve Rural Jobs

- MRMC filled a fulltime CAN position.
- MRMC has one, full-time RN position open currently.

Mangum Regional Medical Center

Chief Clinical Officer Report
December 2023

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
December 2023

Operations Overview

- We are still looking for a clinic provider to replace Amy Sims.
- We are continuing to work with EMS to enhance patient care. We continue to work with them on bringing Mangum residents to our facility.
- We continue to look for new opportunities for the facility and the community. Currently we are working on getting the Strong Mind program up and running. We are still needing to find a van for this program, a tech to transport patients and assist with patient care. We are talking with a licensed counselor to assist with this program and see patients in the clinic.
- We are also talking with a Dr. for possible clinic and hospital coverage. This provider will admit to the hospital from the clinic. He only wants to cover 10 days per month.
- I also continue to do rounds on patients to ensure we are fulfilling their needs.
- We continue to work with the local long term care facility to ensure seamless patient care.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
Mangum Regional Medical Center

HOSPITAL POLICY/FORM/ORDER SET/PROTOCOL AND OTHER DOCUMENT REVIEW PROCESS

The Corporate Policy Committee shall be responsible for reviewing and approving all new and significant revisions for policies and procedures, protocols, standing order sets, forms, and other documents for implementation at the hospital based on one (1) of the processes below.

The Committee shall ensure policies and procedures, protocols, standing orders and forms are properly developed, approved, and implemented according to Federal and State Regulations, standards of practice, guidelines, and other recommendations specific to the document or form being presented.

The Committee meets on the third (3rd) Friday of each month unless otherwise indicated by committee needs.

General Procedure for All Submissions:

A. **Identify Need for or Revision to Document:**
   1. Hospital discusses need/request or revision for a policy, form, order set, protocol, or other document with the Hospital Administrator, Chief Clinical Officer (CCO), Quality Manager (QM) and all pertinent Department Managers.
      OR
   2. Cohesive Department Director (CDD) identifies a need/request or revision for a policy, form, order set, protocol, or other document (hereafter referred to as "document") to be created or revised.

B. Requests for all new or revised documents shall be submitted to the Chair of the Corporate Policy Committee (CPC) (Angela Williams [Director of Quality Management]) by the identified time frame based on the type of submission.
   1. A secondary contact for submission shall be Ivy Bowden, Director of Infection Control (CPC committee member).
   2. All requests and submissions of documents to the CPC shall be submitted utilizing the Draft Policy/Documents Submission & Communication Tracking Form (FMAD-010).

C. The Chair of the CPC (Angela Williams [Director of Quality Management]) shall discuss the request with the CPC members and obtain an Approval or Denial within the identified time frame based on the type of submission.

D. If approved the document shall be reviewed by the CPC and approved based on the type of submission identified below.

E. Once the document(s) have been approved, finalized and signed off by the CPC and the Hospital document owner and/or the CDD the CPC Chair or designated CPC member shall send the approved document(s) via email to the Hospital Quality Manager to add to the Hospital's next Quality Committee agenda and begin the Hospital approval process.

F, A designated CPC member shall be responsible for maintaining a CPC policy/document tracking log for the purposes of tracking a document through the CPC until it is sent to the Hospital Quality Manager.

NON-URGENT SUBMISSION PROCESS

A. All requests for non-urgent new or revised documents shall be submitted to the CPC Chair **21 business days prior** to the CPC meeting.

B. The CPC Chair shall review all requests with the CPC members and communicate an Approval or Denial back to the Hospital or CDD via email **within five (5) business days**.
   1. If the request is Denied the CPC Chair shall notify the Hospital Quality Manager and/or the CDD.

C. Approval Procedure:
   1. If not submitted with request the document draft shall be submitted **no later than 14 business days prior** to the CPC meeting.
   2. Document draft shall be sent to all applicable Hospitals for 14 business day review.
      a. All Hospital revisions, recommendations and questions/comments shall be documented on the Hospital Review and Feedback Form (FMAD-014).
      b. Hospitals shall have reviews returned to CPC Chair (Angela Williams [Director of Quality Management]) via email **no later than the 14 business days or the day of the CPC meeting**.
         i. Extension may be extended depending on the volume of documents to be reviewed.
   3. All submitted documents shall be reviewed by the CPC at the next CPC meeting after the documents are submitted and Approved by the committee (exception shall be in those circumstances where large volumes of documents have been submitted).
      a. The Hospital document owner or CDD shall be present either in person or via virtual meeting at the CPC meeting otherwise the document(s) shall be tabled until the next meeting when they can be available for review.

4. The Hospital document owner or CDD shall have **30 business days** to complete all revisions identified by the CPC.
    a. Extension may be extended depending on the volume of documents to be reviewed.
5. The Hospital document owner or CDD shall return the final draft of the document(s) to the CPC Chair for review, finalization, and final approval.
    a. If there is a need for additional revisions the Hospital document owner or CDD shall have an additional **14 business days** to complete those revisions and return the final draft to the CPC Chair.
6. Upon finalization of the document(s) the CPC Chair or designated CPC member shall send the document(s) to the Hospital Quality Manager.

URGENT SUBMISSION PROCESS

A. All requests for urgent review of new or revised document(s) shall be submitted to the CPC Chair via email using the Draft Policy/Documents Submission & Communication Tracking Form (FMAD-010).
    1. Identify on the form the need for urgent review.
    2. Identify the reason for urgent review.
        a. Urgent reviews should be reserved for the following but not limited to the following circumstances:
            i. Patient safety issues,
            ii. Root cause analysis findings,
            iii. Survey findings, and
            iv. Risks to staff and visitors.

B. The CPC Chair shall review the urgent request with the CPC members and communicate an Approval or Denial within **two (2) business days or sooner** via email to the Hospital document owner or CDD.
    1. If the request is Denied the CPC Chair shall notify the Hospital Quality Manager and/or the CDD.

C. Approval Process:
    1. If not submitted with request the document(s) draft shall be submitted within **two (2) business days** or sooner to the CPC Chair for the CPC members to review via an ad hoc CPC meeting.
    2. Upon receipt of the document(s) the CPC Chair shall send notification to the CPC members of the document(s) availability for review in the Policy Committee folder.
        a. The CPC shall have **two (2) business days** to review the document(s) and return any revisions to the Hospital document owner or CDD.

b. The CPC Chair shall send the document(s) to the applicable Hospitals for a **two (2) business day** review.
    i. All Hospital revisions, recommendations and questions/comments shall be documented on the Hospital Review and Feedback Form (FMAD-014)

3. The Hospital document owner or CDD shall have **two (2) business days** to complete revisions and return the documents to the CPC Chair for final approval.
4. After the CPC has received the final draft of the document(s) the CPC will complete the final review, finalization, and approval **within two (2) business days**.
    a. If there is a need for additional revisions the Hospital document owner or CDD shall have an additional **two (2) business days** to complete those revisions and return the final draft to the CPC Chair.
5. Upon finalization of the document(s) the CPC Chair or designated CPC member shall send the document(s) to the Hospital Quality Manager.

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

Policy, Protocols, Forms, or other Document Development, Review, and Implementation Process

A. **Determine need for policy, forms, or other documents:**
   1. Facilitate adherence with professional practices and evidence-based practice.
   2. Promote compliance with regulations, laws:
      a. Conditions of participation (COP's),
      b. Health Insurance Portability and Accountability Act (HIPAA),
      c. Emergency Medical Treatment and Labor Act (EMTALA), etc.
   3. Reduce practice variation.
   4. Resource for staff.
   5. Reduce reliance on memory for staff.

B. **Utilize references in writing policies, forms, or other documents:**
   1. Professional Associations, for example:
      a. American Hospital Association (AHA),
      b. American Society of Anesthesiologists (ASA), and
      c. Association for Professionals in Infection Control and Epidemiology (APIC).
   2. Professional Journals, for example:
      a. Journal of the American Medical Association (JAMA),
      b. American Journal of Infection Control (AJIC), and
      c. Critical Care Nurse (CCN).
   3. Accrediting Agencies, for example:
      a. Joint Commission (JC), and
      b. Center for Improvement in Healthcare Quality (CIHQ).
   4. Governmental Agencies, for example:
      a. Centers for Disease Control and Prevention (CDC),
      b. Centers for Medicare and Medicaid Services (CMS),
      c. Department of Health and Human Services (DHHS),
      d. Office of Inspector General (OIG),
      e. Office of Civil Rights (OCR), and
      f. Federal Register.
   5. Evidence-based practices and standards of care.

C. **Components and Design of Policy or other documents**:
   1. **Scope of the policy:**
      a. The scope statement is a description of the affected staff, departments, and functions.
      b. This statement is used to guide the development of the policy and provide a summary of the proposed policy and ensure that those who might be affected by the policy are identified, considered, and consulted.

2. **Purpose of Policy:**
   a. A concise statement of the rationale for the policy/plan.
3. **Definitions:** (If needed)
   a. Uncommon words or words with meanings unique to higher education shall be defined and listed in alphabetical order.
   b. Only utilized when applicable.
   c. Consider the following when writing definitions:
      i. Is the word a new, uncommon, and/or specialized term?
      ii. Does the term have a different meaning in different contexts?
      iii. Are the definitions in alphabetical order?
4. **Policy:**
   a. Describes and clarifies the actual guiding principles by which the Hospital administers the policy and defines what is to be done.
   b. Policy statements serve to protect the Hospital from misunderstandings that might lead to unauthorized behavior or other adverse outcomes.
   c. The policy statement shall contain the following:
      i. Align with the purpose statement,
      ii. Clearly articulate what the policy is and what it is to accomplish,
      iii. No procedural related content, and
      iv. Consistent with all laws, regulations, and standards of practice.
5. **Procedure:**
   a. The procedure is a description of the principal steps or tasks to be taken to complete the performance of an operation.
      i. This is generally provided in a step-by-step format.
   b. Consider the following when developing and writing the procedure section:
      i. Do the procedural steps align with the policy statement?
      ii. Are there specific steps or actions identified clearly to comply with the policy?
      iii. Ensure the procedural steps are reasonable for the Hospital staff involved.
      iv. Are the procedural steps consistent with all laws, regulations, and standards of practice?
6. **References:**
   a. A list of all supporting or source material or documentation used to validate the policy and procedure. (i.e., scientific journals, websites, regulations, standards, etc.).
   b. Information or material that is utilized in the policy to guide the activities, practices, and operations of the Hospital.
7. **Attachments:**
   a. Additional documents that are associated with the policy and are utilized in the activities, practices, and/or operations of the Hospital.
      i. Documents shall be given a form number that shall be associated with the appropriate departmental manual.
         1. All forms shall start with FM and the second two (2) letters shall be associated with the appropriate departmental manual.

2. The number given to the form shall be dependent upon where the policy is within the manual and where the form is located within the policy.
3. For example, if the policy is an Emergency Department policy the form would be FMED-0xx.

D. **Writing Style for Policy/Plan Documents:**

1. Concise, clear, minimum verbiage.
2. Factual-double check accuracy.
3. Do not include information that may be quickly outdated (e.g., names, product names, etc.).
4. If an acronym is used for the first time, spell out the acronym (e.g., Registered Nurse [RN]).
5. Not too technical-simple enough to be understood by a new employee.
6. Use Times New Roman and Size 12 for font.
7. Use the Hospital approved policy protocol or standing order template for the applicable documents (See Hospital Policy Template FMAD-012 for further details).

E. **Table of Contents (TOC):**

1. Each department policy manual must have a Table of Contents.
2. Update TOC as needed (policies additions, deletions, revisions).

F. **Policy Form, Protocol, or Other Document Review:**

1. Review document for content relevance, grammatical and spelling errors.
2. All policies, plans, forms, and other documents should be submitted to the Quality Manager or the Department's Corporate Partner per the Hospital Policy/Form/Order Set/Protocol Review Process (FMAD-009) for review.
3. A Draft Policy/Documents Submission & Communication Tracking Form (FMAD-010) should be submitted per the review process either prior to submission of the policy/document or with the policy/document.

G. **Policy, Form or Other Document Approval:**

1. Policies must be submitted to and approved by the Corporate Policy Review Committee prior to submission to Quality, Medical Staff, and Governing Board Committees per the Hospital Policy/Form/Order Set/Protocol Review Process for review (FMAD-009).
2. Policies must be submitted to the Quality Committee (QC), Medical Staff Committee (MSC), Governing Board (GB) for final approval prior to implementation.
3. Once approved retain policy/plan in electronic and/or paper form.
4. Provide policy, form or other document education to the appropriate Hospital staff including contract agency staff as required or indicated and provide verification of education to the Quality Manager (QM).

H. **Biennial (Every two [2] year) Review:**

1. All policies, forms, protocols or other documents must be reviewed by the responsible party on a biennial (every two [2] year) basis, unless otherwise mandated by regulatory requirements.
    a. The review shall be completed per the Hospital Policy/Protocol and Other Document Development and Review policy (AMD-009).
2. Prior to submission to Hospital committees all new policies, forms, or other documents and those with significant revisions must be submitted to the Corporate Policy Committee for review and approval.
    a. A significant revision shall be considered to include but are not limited to the following:
        i. Changes or additions to procedures or processes,
            1. This would not include minor changes including grammatical revisions.
        ii. Removal of portions of a policy or other document.
3. The policy, form or other document(s) shall be submitted to the Corporate Policy Committee using the Draft Policy/Documents Submission & Communication Tracking Form.
4. Once the policy, form or other document(s) have been reviewed and approved by the Corporate Policy Committee they shall be submitted to the Quality Committee (QC), Medical Staff Committee (MSC), Governing Board (GB) for final approval.
5. A signed policy cover sheet shall be maintained for each policy manual with the biennial review and approval process.

I. **Policy, Form, Protocol or Other Document Tracking:**
1. The QM or designee shall maintain a list of all policy manuals, forms, protocols or other documents and TOC.
2. The QM shall maintain the Hospital Policy/Form/Document/Appointments & Other Reviews Log to include the following:
    a. the biennial review for all policies, forms, protocols, standing orders and other documents.
    b. the annual review of appointments and risk assessments.

Mangum Board Meeting Financial Reports
November 30, 2023

	REPORT TITLE
1	Financial Summary (Overview)
2	Cash Receipts - Cash Disbursements - NET
3	Financial Update (page 1)
4	Financial Update (page 2)
5	Stats
6	Balance Sheet Trend
7	Cash Collections Trend
8	Medicare Payables (Receivables)
9	Current Month Income Statement
10	Income Statement Trend
11	RHC YTD Income Statement
12	AP Aging Summary

Mangum Regional Medical Center
Financial Summary
November 30, 2023

	Prior Month	Current Month	**Nov-23** Year-to-Date	**Mthly Avg** Year-to-Date
ADC (Average Daily Census)	**8.48**	**8.07**	**11.61**	**11.61**
Payer Mix % (Acute):				
MCR	52.63%	50.00%	56.61%	
MCR Mgd Care	44.74%	25.00%	20.99%	
All Others	2.63%	25.00%	22.40%	
Total	100.00%	100.00%	100.00%	
Payer Mix % (SWB):				
MCR	89.78%	92.70%	90.97%	
MCR Mgd Care	10.22%	7.30%	9.03%	
All Others	0.00%	0.00%	0.00%	
Total	100.00%	100.00%	100.00%	
Operating margin	(173,615)	(143,439)	(1,810,257)	*(164,569)*
Operating Margin (Current Month vs Mthly Avg)	*(9,046)*	*21,130*		
NPR (Net Patient Revenue)	1,193,166	1,230,041	14,755,540	*1,341,413*
NPR (Current Month vs Mthly Avg)	*(148,246)*	*(111,372)*		
Operating Expenses	1,379,782	1,392,672	16,742,017	*1,522,002*
Oper Exp (CM vs Mthly Avg)	*(142,219)*	*(129,329)*		
NPR % of Oper Exp	**86.5%**	**88.3%**	**88.1%**	
Patient Days	263	242	3,877	*352*
Oper Exp / PPD	$ 5,246	$ 5,755	$ 4,318	
# of Months	**1**	**1**	**11**	
Cash Receipts (rnd)	**1,211,980**	**985,475**	**16,360,935**	*1,487,358*
Cash Receipts (CM vs Mthly Avg)	*(275,378)*	*(501,883)*		
Cash as a % of NPR (s/b 100% min)	**101.6%**	**80.1%**	**110.9%**	
Calendar Days	31	30	334	
Operating Exp / Day	$ 44,509	$ 46,422	$ 50,126	
Cash - (unrestricted)	712,301	335,731	335,731	
Days Cash-On-Hand	**16.0**	**7.2**	**6.7**	
Cash - (including restricted)	1,524,490	1,147,920	1,147,920	
Days Cash-On-Hand	**34.3**	**24.7**	**22.9**	
MCR Rec (Pay) - "as stated - but to be adjusted"	(2,680,074)	(2,349,751)		
AP & Accrued Liab	13,467,838	13,537,006		
Accounts Receivable (at net)	1,318,350	1,314,243		
Per AP aging schedule (incl. accruals)	**Oct-23**	**Nov-23**	Net Change	
Account Payable - Cohesive	10,287,358	10,894,650	607,292	
Account Payable - Other	2,287,756	1,749,632	(538,124)	
Total	12,575,114	12,644,282	69,168	
Cohesive Loan	5,334,882	5,303,866	(31,017)	

Mangum Regional Medical Center
Cash Receipts - Cash Disbursements Summary
November 2023

	Current Month	COVID	Total Less COVID	Year-To-Date	COVID	Year-To-Date Less COVID
Cash Receipts	$ 985,475	$ -	$ 985,475	$ 16,360,935	$ -	$ 16,360,935
Cash Disbursements	$ (1,355,224)	$ -	$ (1,355,224)	$ (16,551,789)	$ 139,447	$ (16,412,342)
NET	$ (369,749)	$ -	$ (369,749)	$ (190,854)	$ 139,447	$ (51,407)

December 26, 2023

Board of Directors
Mangum Regional Medical Center

November 2023 Financial Statement Overview

- Statistics
  - The average daily census (ADC) for November 2023 was **8.07** – (Year-To-Date **11.61** vs PY fiscal year end of **9.86**).
  - Year-To-Date Acute payer mix was approximately **77%** MCR/MCR Managed Care combined & consistent with the prior fiscal year end.
  - Year-To-Date Swing Bed payer mix was **91%** MCR & **9%** MCR Managed Care. For the prior year end those percentages were **93% & 7%,** respectively.

- Balance Sheet Highlights
  - The cash balance as of November 30, 2023, inclusive of both operating & reserves, was **$1.14M**. This decrease of **$377K** from October 31, 2023, balance was primarily due to a decrease in patient cash receipts which decreased by **$227K** from the prior month.
  - Days cash on hand, inclusive of reserves, was **24.7** based on November YTD expenses.
  - Net AR decreased by **$4K** from October.
  - Payments of approximately **$1.36M** were made on AP (prior 3-month avg was **$1.33M**).
  - Cash receipts were **$227K** less than in the previous month **($985K vs $1.2M).**
  - The Medicare principal balance decreased by **$333K.** The ERS loans were approved, and the CY2023 liability was approximately **$182K** less than previously projected, net of a **$69K** downpayment. In addition, a principal payment of **$82K** was applied against the FY17 ERS loan. The FY17 loan should be paid-in-full in March 2024.

- Income Statement Highlights

    - Net patient revenue for November was **$1.23M**, which is approximately a decrease of **$122K** over the prior month year-to-date average due to the decrease in ADC.
    - Operating expenses, exclusive of interest & depreciation, were $1.34M and decreased from the prior month year-to-date average **of $1.47M by $137K (contract labor).**
    - 340B revenues were **$17K** for November & YTD**, $143K**. Net profit from this service line YTD is **$49K**.

- Clinic (RHC) Income Statement Highlights as incurred & projected.
    - Year-To-Date average visits per day = 07.23; Nov 2023 = 08.89.
    - Projected operating revenues (YTD) = $394K
    - Projected operating expenses (YTD) = $892K
    - Projected operating loss (YTD) = -($497K)

MANGUM REGIONAL MEDICAL CENTER
Admissions, Discharges & Days of Care
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	12/31/2023 YTD	12/31/2022 PY Comparison
Admissions													
Inpatient	13	16	19	11	16	12	13	19	13	11	16	159	138
Swingbed	14	14	15	5	12	7	10	15	8	17	8	125	95
Observation	0	1	1	1	2	1	2	6	0	3	1	18	6
	27	31	35	17	30	20	25	40	21	31	25	302	239
Discharges													
Inpatient	15	16	20	10	16	12	10	18	16	11	14	158	136
Swingbed	10	11	14	11	6	12	12	14	9	12	7	118	98
Observation	0	1	1	1	2	1	2	6		3	1	18	6
	25	28	35	22	24	25	24	38	25	26	22	294	240
Days of Care													
Inpatient-Medicare	23	31	43	22	35	27	25	39	24	20	32	321	274
Inpatient-Other	33	29	32	13	19	11	8	21	30	18	32	246	183
Swingbed-Medicare	371	356	386	289	328	240	222	281	171	202	165	3,011	2,414
Swingbed-Other	0	2	42	51	30	39	40	28	31	23	13	299	204
Observation	0	1	1	1	2	1	2	6	0	3	1	18	6
	427	419	504	376	414	318	297	375	256	266	243	3,895	3,081
Calendar days	31	28	31	30	31	30	31	31	30	31	30	334	304
ADC - (incl OBS)	13.77	14.96	16.26	12.53	13.35	10.60	9.58	12.10	8.53	8.58	8.10	11.66	10.13
ADC	13.77	14.93	16.23	12.50	13.29	10.57	9.52	11.90	8.53	8.48	8.07	11.61	10.12
ER	158	119	169	136	148	132	152	154	162	160	87	1,577	1,446
Outpatient	176	132	182	141	177	152	171	190	158	165	96	1,740	2,426
RHC	170	123	167	162	164	125	142	196	159	196	199	1,803	1,723

MANGUM REGIONAL MEDICAL CENTER
Comparative Balance Sheet - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	Prior Month Variance
Cash And Cash Equivalents	980,584	677,752	684,122	724,967	556,140	627,470	566,073	654,397	850,824	712,301	335,731	**(376,570)**
Reserved Funds	-	-	800,000	1,400,000	768,400	968,400	662,189	812,189	812,189	812,189	812,189	-
Patient Accounts Receivable, Net	1,696,258	1,823,404	2,265,664	2,231,841	2,003,361	1,480,786	1,551,449	1,915,345	1,399,933	1,318,350	1,314,243	**(4,106)**
Due From Medicare	74,934	74,956	-	-	-	-	-	-	-	-	-	-
Inventory	243,297	235,738	244,725	260,940	270,700	234,397	228,685	239,652	246,453	247,888	246,327	**(1,560)**
Prepaids And Other Assets	1,990,291	1,968,284	1,941,610	1,993,890	1,977,854	1,958,215	1,941,193	1,550,814	1,891,626	1,899,170	1,885,591	**(13,579)**
Capital Assets, Net	2,325,712	2,274,924	2,224,332	2,174,390	2,126,662	2,104,656	2,056,492	2,008,327	2,004,456	1,936,608	1,889,335	**(47,273)**
Total Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,725	7,205,480	6,926,505	6,483,416	(443,089)
Accounts Payable	16,893,910	16,526,357	11,418,965	11,562,124	11,770,040	11,703,708	12,099,854	12,315,821	12,559,363	12,575,114	12,644,282	**69,168**
AHSO Related AP	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	-
Due To Medicare	2,586,010	2,840,280	3,653,730	4,246,353	3,336,103	3,256,838	2,720,743	2,880,235	2,761,845	2,680,074	2,349,751	**(330,322)**
Covid Grant Funds	-	-	-	-	-	-	-	-	-	-	-	-
Due To Cohesive - PPP Loans	-	-	-	-	-	-	-	-	-	-	-	-
Notes Payable - Cohesive	-	-	5,552,000	5,520,983	5,489,966	5,458,950	5,427,933	5,396,916	5,365,899	5,334,882	5,303,866	**(31,017)**
Notes Payable - Other	23,565	23,565	23,565	95,369	88,382	81,409	74,366	67,281	60,197	52,990	45,362	**(7,629)**
Alliantz Line Of Credit	-	-	-	-	-	-	-	-	-	-	-	-
Leases Payable	273,074	269,075	265,054	261,011	256,946	280,019	276,961	276,057	275,582	274,465	274,615	**150**
Total Liabilities	20,669,282	20,552,001	21,806,037	22,578,564	21,834,161	21,673,647	21,492,580	21,829,034	21,915,610	21,810,250	21,510,600	(299,649)
Net Assets	(13,358,207)	(13,496,944)	(13,645,584)	(13,792,536)	(14,131,044)	(14,299,723)	(14,486,500)	(14,648,309)	(14,710,130)	(14,883,745)	(15,027,184)	**(143,439)**
Total Liablities and Net Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,725	7,205,480	6,926,505	6,483,416	(443,089)

Mangum Regional Medical Center
Cash Receipts & Disbursements by Month

2021				2022				2023		
Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Disbursements
Jan-21	830,598		695,473	Jan-22	2,163,583		1,435,699	Jan-23	1,290,109	1,664,281
Feb-21	609,151		1,472,312	Feb-22	1,344,463	254,626	1,285,377	Feb-23	1,506,708	1,809,690
Mar-21	910,623	49,461	866,387	Mar-22	789,800		1,756,782	Mar-23	1,915,435	1,109,683
Apr-21	742,500		999,127	Apr-22	1,042,122		1,244,741	Apr-23	2,005,665	1,365,533
May-21	816,551		1,528,534	May-22	898,311		1,448,564	May-23	1,436,542	2,237,818
Jun-21	936,092		1,455,892	Jun-22	1,147,564		1,225,070	Jun-23	1,777,525	1,506,459
Jul-21	1,009,037		1,774,932	Jul-22	892,142		979,914	Jul-23	1,140,141	1,508,702
Aug-21	1,292,886	100,000	2,156,724	Aug-22	890,601		1,035,539	Aug-23	1,600,786	1,352,905
Sep-21	278,972		753,559	Sep-22	2,225,347		1,335,451	Sep-23	1,490,569	1,295,680
Oct-21	1,954,204		1,343,425	Oct-22	1,153,073		1,233,904	Oct-23	1,211,980	1,345,813
Nov-21	1,113,344	316,618	1,800,166	Nov-22	935,865		1,476,384	Nov-23	985,475	1,355,224
Dec-21	1,794,349	305,543	1,325,063	Dec-22	1,746,862		1,073,632	Dec-23		
	12,288,308	771,623	16,171,592		15,229,733	254,626	15,531,057		16,360,935	16,551,789
Subtotal FY 2021	13,059,930			Subtotal FY 2022	15,484,359			Subtotal FY 2023	16,360,935	

Mangum Regional Medical Center
Medicare Payables by Year

	Original Balance	Balance as of 11/30/2023	Total Interest Paid as of 11/30/2023
2016 C/R Settlement	1,397,906.00	-	205,415.96
2017 Interim Rate Review - 1st	723,483.00	-	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	-	20,332.88
2017 6/30/17-C/R Settlement	1,614,760.00	-	7,053.79
2017 12/31/17-C/R Settlement	(535,974.00)	336,128.00	262,600.59
2017 C/R Settlement Overpayment	3,539,982.21	-	-
2018 C/R Settlement	1,870,870.00	-	241,040.31
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	-	277,488.75
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement	(3,145,438.00)	-	-
FY21 MCR pay (rec) estimate	(1,631,036.00)	-	-
FY22 MCR pay (rec) estimate	(318,445.36)	-	-
2016 C/R Audit - Bad Debt Adj	348,895.00	-	16,927.31
2018 MCR pay (rec) Audit est.	(34,322.00)	-	-
2019 MCR pay (rec) Audit est.	(40,612.00)	-	-
2020 MCR pay (rec) Audit	(74,956.00)	-	-
FY23 (8-month IRR) L4315598	95,225.46	95,225.46	-
FY23 (8-month IRR) L4315599	1,918,398.00	1,918,398.00	-
FY23 MCR pay (rec) remaining estimate	-	-	-
FY24 MCR pay (rec) estimate	-	-	
Total	**7,009,696.31**	**2,349,751.46**	**1,185,922.21**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended November 30, 2023
Unaudited

MTD					YTD			
Actual	Budget	Variance	% Change		Actual	Budget	Variance	% Change
412,239	186,753	225,486	121%	Inpatient revenue	3,063,443	2,061,609	1,001,834	49%
869,292	652,392	216,900	33%	Swing Bed revenue	12,920,446	7,274,516	5,645,930	78%
585,065	582,428	2,637	0%	Outpatient revenue	6,544,623	6,481,372	63,251	1%
162,673	157,682	4,991	3%	Professional revenue	1,826,530	1,754,901	71,629	4%
2,029,270	1,579,256	450,015	29%	Total patient revenue	24,355,042	17,572,398	6,782,644	39%
624,573	206,655	417,917	202%	Contractual adjustments	5,932,867	2,317,331	3,615,536	156%
-	-	-	#DIV/0!	Contractual adjustments: MCR Settlement	2,680,967		2,680,967	#DIV/0!
174,657	106,442	68,215	64%	Bad debts	985,668	1,184,380	(198,712)	-17%
799,230	313,097	486,133	155%	Total deductions from revenue	9,599,502	3,501,711	6,097,791	174%
1,230,041	1,266,159	(36,118)	-3%	Net patient revenue	14,755,540	14,070,687	684,853	5%
2,119	3,616	(1,497)	-41%	Other operating revenue	33,078	39,787	(6,710)	-17%
17,073	54,703	(37,631)	-69%	340B REVENUES	143,142	608,716	(465,574)	-76%
1,249,233	1,324,479	(75,246)	-6%	Total operating revenue	14,931,759	14,719,191	212,569	1%
				Expenses				
396,357	356,119	40,238	11%	Salaries and benefits	4,464,126	3,958,084	506,042	13%
128,259	139,529	(11,270)	-8%	Professional Fees	1,585,774	1,544,486	41,288	3%
287,889	419,251	(131,361)	-31%	Contract labor	3,972,803	4,667,674	(694,871)	-15%
109,083	106,809	2,274	2%	Purchased/Contract services	1,445,822	1,187,887	257,935	22%
225,000	225,000	-	0%	Management expense	2,475,000	2,475,000	-	0%
86,906	85,976	930	1%	Supplies expense	1,044,197	956,210	87,988	9%
24,466	29,567	(5,100)	-17%	Rental expense	325,413	326,670	(1,257)	0%
12,869	16,788	(3,919)	-23%	Utilities	196,448	184,673	11,775	6%
652	1,201	(549)	-46%	Travel & Meals	11,504	13,282	(1,778)	-13%
12,767	12,070	697	6%	Repairs and Maintnenance	130,357	133,005	(2,648)	-2%
10,556	12,596	(2,040)	-16%	Insurance expense	124,704	138,551	(13,847)	-10%
34,146	21,818	12,327	57%	Other Expense	251,328	240,046	11,282	5%
11,961	32,586	(20,625)	-63%	340B EXPENSES	93,999	362,787	(268,787)	-74%
1,340,912	1,459,310	(118,398)	-8%	Total expense	16,121,476	16,188,355	(66,879)	0%
(91,679)	(134,831)	43,152	-32%	EBIDA	(1,189,717)	(1,469,164)	279,447	-19%
-7.3%	-10.2%	2.84%		EBIDA as percent of net revenue	-8.0%	-10.0%	2.01%	
3,596	3,638	(41)	-1%	Interest	75,397	76,559	(1,162)	-2%
48,164	48,039	125	0%	Depreciation	545,144	525,788	19,356	4%
(143,439)	(186,508)	43,068	-23%	Operating margin	(1,810,257)	(2,071,511)	261,253	-13%
-	-	-		Other	-	-	-	
-	-	-		Total other nonoperating income	-	-	-	
(143,439)	(186,508)	43,068	-23%	Excess (Deficiency) of Revenue Over Expenses	(1,810,257)	(2,071,511)	261,253	-13%
-11.48%	-14.08%	2.60%		Operating Margin %	-12.12%	-14.07%	1.95%	

MANGUM REGIONAL MEDICAL CENTER
Statement of Revenue and Expense Trend - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	YTD
Inpatient revenue	**248,170**	**273,130**	**272,704**	**168,264**	**292,654**	**256,424**	**217,685**	**346,918**	**329,664**	**245,590**	**412,239**	3,063,443
Swing Bed revenue	**857,835**	**848,580**	**1,159,897**	**1,415,031**	**1,815,525**	**1,219,155**	**1,228,096**	**1,406,639**	**971,812**	**1,128,584**	**869,292**	12,920,446
Outpatient revenue	**569,774**	**479,203**	**655,242**	**450,232**	**596,547**	**566,829**	**643,187**	**672,465**	**707,757**	**618,323**	**585,065**	6,544,623
Professional revenue	**165,566**	**172,559**	**183,040**	**122,822**	**164,587**	**152,378**	**159,248**	**182,030**	**183,508**	**178,118**	**162,673**	1,826,530
Total patient revenue	1,841,345	1,773,472	2,270,883	2,156,349	2,869,312	2,194,786	2,248,217	2,608,052	2,192,741	2,170,615	2,029,270	24,355,042
Contractual adjustments	**(121,100)**	**19,061**	**(134,294)**	**(23,053)**	**1,539,024**	**831,011**	**916,605**	**836,330**	**624,540**	**820,169**	**624,573**	5,932,867
Contractual adjustments: MCR Settlement	**533,168**	**285,044**	**920,000**	**702,755**	**-**	**-**	**-**	**240,000**	**-**	**-**	**-**	2,680,967
Bad debts	**25,723**	**134,415**	**12,093**	**118,358**	**49,948**	**41,945**	**53,383**	**99,904**	**117,963**	**157,280**	**174,657**	985,668
Total deductions from revenue	437,792	438,520	797,799	798,060	1,588,972	872,957	969,988	1,176,234	742,503	977,449	799,230	9,599,502
Net patient revenue	1,403,553	1,334,952	1,473,084	1,358,289	1,280,341	1,321,829	1,278,229	1,431,818	1,450,237	1,193,166	1,230,041	14,755,540
Other operating revenue	**643**	**481**	**1,746**	**782**	**4,037**	**14,751**	**920**	**1,035**	**2,826**	**3,737**	**2,119**	33,078
340B REVENUES	**17,199**	**11,534**	**9,264**	**6,654**	**7,518**	**25,149**	**6,901**	**12,515**	**20,071**	**9,265**	**17,073**	143,142
Total operating revenue	1,421,395	1,346,967	1,484,094	1,365,725	1,291,895	1,361,730	1,286,050	1,445,369	1,473,134	1,206,168	1,249,233	14,931,759
	89.8%	89.9%	90.2%	89.8%	78.5%	86.4%	86.8%	89.1%	94.5%	86.5%	88.3%	88.1%
Expenses												
Salaries and benefits	**361,005**	**411,948**	**411,789**	**381,508**	**403,854**	**366,863**	**401,488**	**441,681**	**457,827**	**429,806**	**396,357**	4,464,126
Professional Fees	**149,199**	**131,495**	**159,564**	**139,183**	**153,226**	**141,955**	**140,784**	**141,126**	**143,727**	**157,258**	**128,259**	1,585,774
Contract labor	**467,147**	**361,407**	**425,232**	**351,293**	**409,120**	**355,927**	**361,836**	**396,420**	**308,448**	**248,085**	**287,889**	3,972,803
Purchased/Contract services	**107,498**	**115,260**	**160,858**	**144,976**	**166,564**	**132,525**	**102,698**	**144,927**	**143,947**	**117,485**	**109,083**	1,445,822
Management expense	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	2,475,000
Supplies expense	**85,209**	**77,055**	**109,037**	**83,909**	**96,572**	**145,554**	**92,679**	**108,407**	**95,857**	**63,012**	**86,906**	1,044,197
Rental expense	**25,693**	**25,335**	**22,200**	**40,587**	**37,323**	**28,670**	**21,353**	**36,558**	**34,038**	**29,191**	**24,466**	325,413
Utilities	**19,305**	**20,759**	**20,147**	**17,598**	**17,253**	**19,058**	**18,169**	**15,749**	**18,780**	**16,761**	**12,869**	196,448
Travel & Meals	**721**	**1,537**	**2,377**	**1,470**	**2,279**	**1,610**	**101**	**170**	**535**	**52**	**652**	11,504
Repairs and Maintnenance	**14,713**	**10,390**	**11,618**	**10,943**	**11,837**	**10,109**	**12,289**	**10,891**	**14,871**	**9,927**	**12,767**	130,357
Insurance expense	**13,940**	**13,997**	**5,518**	**6,394**	**12,379**	**12,386**	**12,384**	**12,384**	**12,384**	**12,384**	**10,556**	124,704
Other	**14,963**	**25,844**	**14,797**	**47,046**	**32,512**	**22,132**	**23,495**	**8,940**	**15,970**	**11,484**	**34,146**	251,328
340B EXPENSES	**9,702**	**6,242**	**5,693**	**5,170**	**7,268**	**13,332**	**5,975**	**10,877**	**10,871**	**6,909**	**11,961**	93,999
Total expense	1,494,096	1,426,270	1,573,830	1,455,077	1,575,186	1,475,120	1,418,248	1,553,130	1,482,254	1,327,353	1,340,912	16,121,476
EBIDA	$ (72,701)	$ (79,303)	$ (89,736)	$ (89,352)	$ (283,290)	$ (113,390)	$ (132,198)	$ (107,762)	$ (9,120)	$ (121,185)	$ (91,679)	$ (1,189,717)
EBIDA as percent of net revenue	-5.1%	-5.9%	-6.0%	-6.5%	-21.9%	-8.3%	-10.3%	-7.5%	-0.6%	-10.0%	-7.3%	-8.0%
Interest	**10,509**	**9,096**	**8,824**	**7,659**	**7,489**	**7,125**	**6,414**	**5,883**	**4,536**	**4,265**	**3,596**	75,397
Depreciation	**58,070**	**50,338**	**50,080**	**49,942**	**47,728**	**48,164**	**48,164**	**48,164**	**48,164**	**48,164**	**48,164**	545,144
Operating margin	$ (141,280)	$ (138,737)	$ (148,640)	$ (146,952)	$ (338,508)	$ (168,680)	$ (186,776)	$ (161,810)	$ (61,821)	$ (173,615)	$ (143,439)	$ (1,810,257)
Other	-	-	-	-	-	-	-	-	-	-	-	-
Total other nonoperating income	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess (Deficiency) of Revenue Over Expenses	(141,280)	(138,737)	(148,640)	(146,952)	(338,508)	(168,680)	(186,776)	(161,810)	(61,821)	(173,615)	(143,439)	(1,[illegible]
Operating Margin % (excluding other misc. reve	-9.94%	-10.30%	-10.02%	-10.76%	-26.20%	-12.39%	-14.52%	-11.20%	-4.20%	-14.39%	-11.48%	[illegible]

	11/30/2023		"Annualized"
On-Site Visits -->	1,700	**On-Site Visits -->**	1,855
On-Site Visit / Bus Day -->	7.23	**On-Site Visit / Bus Day -->**	7.16

Mangum Family Clinic

Eleven Months Ended 11/30/2023

Description	YTD FS Per General Ledger	Eliminate Rev Deduct & Other Inc	Adj Rev Deduct to RHC Calc	Cost Report Allocations	11 RHC Financial Statements	FY 2023 "Annualized" RHC Financial Statements
Gross Patient Revenue	214839.77	-	-	-	214,840	234,371
Less: Revenue deductions	229291.11	(229,291)	147,186	-	147,186	160,567
Net Patient Revenue	444130.88	(229,291)	147,186	-	362,026	394,938
Other Income (if any)	2765.18	(2,765)	-	-	-	-
Operating revenue	446896.06	(232,056)	147,186	-	362,026	394,938
Operating Expenses:						
Salaries	126356.63	-	-	-	126,357	137,844
Benefits	0.00	-	-	-	-	-
Prof Fees	161980.49	-	-	38,062	200,042	218,228
Contract Labor	41166.58	-	-	-	41,167	44,909
Purch Serv	67107.77	-	-	-	67,108	73,208
Supplies	5797.38	-	-	-	5,797	6,324
Rent	25711.38	-	-	-	25,711	28,049
Utilities	9616.84	-	-	-	9,617	10,491
Repairs	1425.40	-	-	-	1,425	1,555
Other	4242.25	-	-	-	4,242	4,628
Insurance	2372.37	-	-	-	2,372	2,588
Travels & Meals	4585.51	-	-	-	4,586	5,002
Management Fee Direct Exp	0.00	-	-	126,943	126,943	138,483
Critical Access Hospital Overhead Allocation (a)	0.00	-	-	202,525	202,525	220,936
Total Operating Expenses	450362.60	-	-	367,530	817,893	892,245
Net Income (loss)	**(3,467)**	**(232,056)**	**147,186**	**(367,530)**	**(455,867)**	**(497,307)**

MGMT Fee Allocation est. 2023	1 months	11,540	
IP Rounding allocation based on 8/31/22 IRR estimate	8 months	27,681	212.96
CAH Overhead Allocation - from Chris based on last filed cost report -------->	12 months	220,936	481.11
Total allocation ------->		260,157	
			(268.16)

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	11/30/2023	10/31/2023	9/30/2023	8/31/2023
ALCO SALES & SERVICE CO	Patient Supplies	-	-	-	-	-	299.80	-	-
AMERICAN HEART ASSOCIATION INC	Supplies	-	-	-	-	-	-	242.22	-
AMERICAN PROFICIENCY INSTITUTE	Lab Supplies	-	-	-	-	-	-	50.00	-
ANESTHESIA SERVICE INC	Patient Supplies	1,050.00	-	-	-	1,050.00	-	914.14	2,510.17
APEX MEDICAL GAS SYSTEMS, INC	Supplies	-	-	-	-	-	-	-	-
ARAMARK	Linen Services	12,051.80	6,025.90	-	-	18,077.70	15,064.75	20,394.52	23,729.74
ASPEN INSPECTION SERVICES	Repairs/maintenance	-	-	-	-	-	-	-	300.00
AT&T	Fax Service	-	-	-	-	-	-	-	2,413.05
AVANAN, INC.	COVID Capital	-	-	-	16,800.00	16,800.00	16,800.00	16,800.00	16,800.00
BARRY DAVENPORT	1099 Provider	-	-	-	-	-	-	-	-
BIO-RAD LABORATORIES INC	Lab Supplies	1,396.32	-	-	-	1,396.32	1,568.45	1,550.42	1,550.42
BRIGGS HEALTHCARE	Supplies	-	-	-	-	-	-	-	-
CARNEGIE EMS	Patient Transport Svs	-	4,740.00	-	-	4,740.00	4,740.00	8,550.00	8,550.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	-	-	-	-	-	-	-	9,869.76
CDW-G LLC	Supplies	-	-	-	3,059.84	3,059.84	3,059.84	3,059.84	3,059.84
CITY OF MANGUM	Utilities	-	-	-	-	-	-	-	8,048.85
CliftonLarsonAllen LLP	Audit firm	5,512.50	-	-	-	5,512.50	-	-	-
COHESIVE HEALTHCARE MGMT	Mgmt Fees	226,282.50	225,000.00	225,000.00	797,477.88	1,473,760.38	1,347,477.88	1,253,494.64	1,195,925.60
COHESIVE HEALTHCARE RESOURCES	Payroll	450,122.77	388,743.73	451,000.32	3,984,593.20	5,274,460.02	4,790,954.17	5,216,906.53	5,145,201.55
COHESIVE MEDIRYDE LLC	Patient Transportation Service	-	-	-	-	-	-	-	794.75
COHESIVE STAFFING SOLUTIONS	Agency Staffing Service	114,221.86	243,744.07	312,367.41	3,476,096.21	4,146,429.55	4,148,926.00	4,216,879.78	4,755,205.67
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance	-	2,450.00	-	-	2,450.00	-	-	2,450.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	2,000.00	2,000.00	2,000.00	17,980.95	23,980.95	19,980.95	21,980.95	23,980.95
CPSI	EHR Software	-	-	-	-	-	-	6,132.00	4,411.00
CURBELL MEDICAL PRODUCTS INC	Supplies	-	-	-	-	-	-	-	-
DELL FINANCIAL SERVICES LLC	Server Lease	-	-	-	-	-	-	-	590.96
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch Svs	2,150.00	-	-	-	2,150.00	2,150.00	4,550.00	10,750.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	-	6,165.00	6,962.64	343,786.52	356,914.16	356,914.16	351,591.55	356,591.55
DR W. GREGORY MORGAN III	1099 Provider	-	-	-	-	-	-	-	4,766.67
DYNAMIC ACCESS	Vascular Consultant	1,125.00	-	-	-	1,125.00	-	-	-
eCLINICAL WORKS, LLC	RHC EHR	-	6,000.00	-	-	6,000.00	6,000.00	2,875.50	-
EMD MILLIPORE CORPORATION	Lab Supplies	-	-	-	-	-	-	-	5,831.05
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	2,928.00	-	-	-	2,928.00	-	-	2,928.00
FEDEX	Shipping	-	-	-	-	-	-	145.66	84.71
FFF ENTERPRISES INC	Pharmacy Supplies	-	592.56	-	-	592.56	-	-	-
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	-	-	-	-	-	-	-	-
FORVIS LLP	Finance Purch Svs(Formerly BKD)	-	6,642.00	-	-	6,642.00	6,642.00	-	-
FOX BUILDING SUPPLY	Repairs/maintenance	(477.72)	326.53	-	-	(151.19)	(151.19)		
GEORGE BROS TERMITE & PEST CON	Pest Control Service	160.00	-	-	-	160.00	-	760.00	320.00
GRAINGER	Maintenance Supplies	160.81	-	-	-	160.81	273.73	967.83	-
GREER COUNTY CHAMBER OF	Advertising	-	-	-	-	-	-	-	900.00
GREER COUNTY TREASURER	Insurance	-	11,300.00	-	-	11,300.00	-	-	-
HAC INC	Dietary Supplies	345.68	-	-	-	345.68	-	-	591.89
HEALTH CARE LOGISTICS	Pharmacy Supplies	-	-	-	-	-	100.38	-	2,473.18
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	-	-	-	-	-	-	1,050.00	-
HENRY SCHEIN	Lab Supplies	-	-	-	-	-	-	-	-
HILL-ROM COMPANY, INC	Rental Equipment	-	-	-	-	-	-	-	-
HOBART SERVICE	Repairs/maintenance	2,060.38	-	-	-	2,060.38	-	-	-
ICU MEDICAL SALES INC.	Supplies	-	-	-	-	-	-	-	-
HSI	Materials Purch svs	-	-	-	-	-	-	2,500.00	-
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	-	-	-	-	-	-	-	204.30
INQUISEEK LLC	RHC purch svs	-	-	-	225.00	225.00	225.00	225.00	225.00

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	11/30/2023	10/31/2023	9/30/2023	8/31/2023
INSIGHT DIRECT USA INC.	IT Minor Equipment	-	-	-	1,007.36	1,007.36	1,007.36	1,007.36	1,007.36
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	-	-	-	-	-	-	691.17	656.41
JIMALL & KANISHA' LOFTIS	Rent House	-	-	-	-	-	-	-	-
KCI USA	Rental Equipment	-	-	-	-	-	-	-	234.96
KING GUIDE PUBLICATIONS INC	Advertising	-	-	-	-	-	-	100.00	100.00
LABCORP	Lab purch svs	-	-	-	-	-	-	-	2,135.18
LAMPTON WELDING SUPPLY	Patient Supplies	-	-	-	-	-	-	-	-
LANGUAGE LINE SERVICES INC	Translation service	135.00	-	-	-	135.00	-	130.00	260.00
LOCKE SUPPLY	Plant Ops supplies	59.36	-	-	-	59.36	663.80	-	-
MANGUM STAR NEWS	Advertising	-	-	-	-	-	-	-	-
MARK CHAPMAN	Employee Reimbursement	-	-	-	-	-	-	-	-
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	-	-	-	-	-	-	11,904.45	20,321.61
MEDLINE INDUSTRIES	Patient Care/Lab Supplies	(32.98)	-	-	-	(32.98)	-	3,125.41	18,533.28
MYHEALTH ACCESS NETWORK, INC	Compliance purch svs	-	-	-	-	-	-	758.92	758.92
NATIONAL RECALL ALERT CENTER	Safety and Compliance	-	-	-	-	-	-	-	1,290.00
NEXTIVA, INC.	Phone Svs	-	-	-	-	-	-	-	-
NUANCE COMMUNICATIONS INC	RHC purch svs	-	-	-	-	-	-	246.00	369.00
OFMQ	Quality purch svs	350.00	-	-	-	350.00	-	350.00	350.00
OHERI	Education/Training	-	-	-	-	-	-	-	-
OKLAHOMA BLOOD INSTITUTE	Blood Bank	-	-	-	-	-	6,475.90	10,217.80	11,788.30
OPTUM	Pharmacy Supplies	-	-	-	-	-	114.95	-	-
ORTHO-CLINICAL DIAGNOSTICS INC	Lab purch svs	-	-	-	1,203.96	1,203.96	1,203.96	1,203.96	1,203.96
PARA REV LOCKBOX	CDM purch svs	-	-	-	-	-	-	6,827.00	6,827.00
PHARMA FORCE GROUP LLC	340B purch svs	-	-	-	-	-	-	-	-
PHARMACY CONSULTANTS, INC.	PHARMACY CONSULTANTS, INC.	-	-	-	-	-	-	2,530.00	-
PHILADELPHIA INSURANCE COMPANY	OHA Insurance	-	-	-	-	-	-	-	2,116.00
PHILIPS HEALTHCARE	Supplies	-	-	-	-	-	-	-	504.88
PIPETTE COM	Lab maintenance	-	-	-	-	-	-	-	-
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	-	-	-	-	-	-	-	359.76
PORT53 TECHNOLOGIES, INC.	Software license	-	-	-	-	-	-	200.88	200.88
PRESS GANEY ASSOCIATES, INC	Purchased Service	-	-	-	-	-	738.48	738.48	1,448.44
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	-	-	-	-	-	-	-	4.00
PURCHASE POWER	Postage Fees	-	-	-	-	-	-	100.00	-
RADIATION CONSULTANTS	Radiology maintenance	-	-	-	-	-	-	3,200.00	3,200.00
RESPIRATORY MAINTENANCE INC	Repairs/maintenance	-	-	-	-	-	-	1,330.00	1,330.00
REYES ELECTRIC LLC	COVID Capital	-	-	-	25,000.00	25,000.00	25,000.00	29,780.00	20,670.00
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	-	-	-	-	-	-	770.00	-
SBM MOBILE PRACTICE, INC	1099 Provider	-	-	-	-	-	-	-	-
SCHAPEN LLC	Clinic Rent	-	-	-	-	-	-	-	-
SECURITY CHECK	Security	280.00	-	-	-	280.00	-	-	-
SHERWIN-WILLIAMS	Supplies	-	-	-	(11.78)	(11.78)	(11.78)	(11.78)	(11.78)
SHRED-IT USA LLC	Secure Doc disposal service	-	-	-	-	-	2,544.75	2,384.32	4,984.78
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract	3,912.29	-	-	-	3,912.29	-	12,600.00	12,600.00
SIZEWISE	Rental Equipment	-	-	2,473.50	-	2,473.50	2,473.50	2,473.50	4,604.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	-	-	-	-	-	-	1,735.00	5,205.00
SOMSS LLC	1099 Provider	-	-	-	-	-	-	-	-
SPACELABS HEALTHCARE LLC	Telemetry Supplies	-	1,566.30	-	-	1,566.30	-	-	405.98
SPARKLIGHT BUSINESS	Cable service	-	-	-	-	-	445.94	-	451.94
STANDLEY SYSTEMS LLC	Printer lease	-	-	-	-	-	-	2,245.75	4,301.14
STAPLES ADVANTAGE	Office Supplies	-	-	-	-	-	-	298.94	-
STERICYCLE INC	Waste Disposal Service	1,335.19	-	-	-	1,335.19	-	-	3,255.57
STRYKER INSTRUMENTS	Patient Supplies	-	-	-	-	-	-	-	-

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	11/30/2023	10/31/2023	9/30/2023	8/31/2023
SUMMIT UTILITIES	Utilities	-	-	-	-	-	-	32.33	843.30
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	-	-	-	-	-	-	1,755.00	4,950.00
TIGER ATHLETIC BOOSTERS	Advertising	-	-	-	-	-	-	-	-
TOUCHPOINT MEDICAL, INC	Med Dispense Monitor Support	-	-	-	3,285.00	3,285.00	3,285.00	3,285.00	3,285.00
TRIOSE INC	Freight	56.11	-	-	-	56.11	-	-	-
TRS MANAGED SERVICES	Agency Staffing-old	-	-	-	55,383.73	55,383.73	63,463.18	78,989.68	103,999.01
ULINE	Patient Supplies	-	-	-	-	-	-	-	-
ULTRA-CHEM INC	Housekeeping Supplies	-	-	-	-	-	-	-	-
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	-	-	-	-	-	-	1,161.47	2,486.53
US MED-EQUIP LLC	Swing bed eq rental	-	-	-	-	-	-	1,154.20	-
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	-	1,600.00	5,655.00	-	7,255.00	7,255.00	13,655.00	5,130.00
WELCH ALLYN, INC.	Supplies	-	-	-	-	-	-	-	(628.66)
WORTH HYDROCHEM	semi-annual water treatment	-	-	-	482.00	482.00	482.00	482.00	482.00
Grand Total		**827,184.87**	**906,896.09**	**1,005,458.87**	**8,726,369.87**	**11,465,909.70**	**10,836,167.96**	**11,329,072.42**	**11,843,072.41**
			Reconciling Items:		Conversion Variance	13,340.32	13,340.32	13,340.32	13,340.32
					AP Control	12,944,811.83	12,748,174.36	12,967,260.42	12,722,455.85
					Accrued AP	592,194.01	719,663.51	484,826.47	486,089.34
AHSO Related AP	**Description**	**11/30/2023**			AHSO Related AP	(892,723.76)	(892,723.76)	(892,723.76)	(892,723.76)
ADP INC	QMI Payroll Service Provider	4,276.42			**TOTAL AP**	**12,644,282.08**	**12,575,114.11**	**12,559,363.13**	**12,315,821.43**
ADP SCREENING AND SELECTION	QMI Payroll Service Provider	1,120.00				-			
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees	698,000.00							
AMERICAN HEALTH TECH	Rental Equipment-Old	22,025.36							
C.R. BARD INC.	Surgery Supplies-Old	3,338.95							
COMPLIANCE CONSULTANTS	Lab Consultant-Old	1,000.00							
ELISE ALDUINO	1099 AHSO consultant	12,000.00							
HEADRICK OUTDOOR MEDIA INC	AHSO Advertising	25,650.00							
HERC RENTALS-DO NOT USE	Old Rental Service	7,653.03							
IMEDICAL INC	Surgery Supplies-Old	1,008.29							
MEDSURG CONSULTING LLC	Equipment Rental Agreement	98,670.36							
MICROSURGICAL MST	Surgery Supplies-Old	2,233.80							
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies-Old	3,607.60							
NINJA RMM	IT Service-Old	2,625.00							
QUARTZ MOUNTAIN RESORT	Alliance Travel	9,514.95							
SUBTOTAL-AHSO Related AP		**892,723.76**							

Mangum Board Meeting Financial Reports
December 31, 2023

	REPORT TITLE
1	Financial Summary (Overview)
2	Cash Receipts - Cash Disbursements - NET
3	Financial Update (page 1)
4	Financial Update (page 2)
5	Stats
6	Balance Sheet Trend
7	Cash Collections Trend
8	Medicare Payables (Receivables)
9	Current Month Income Statement
10	Income Statement Trend
11	RHC YTD Income Statement
12	AP Aging Summary

Mangum Regional Medical Center
Financial Summary
December 31, 2023

	Prior Month	Current Month	**Dec-23** Year-to-Date	**Mthly Avg** Year-to-Date
ADC (Average Daily Census)	**8.07**	**8.19**	**11.32**	**11.32**
Payer Mix % (Acute):				
MCR	50.00%	55.56%	56.51%	
MCR Mgd Care	25.00%	31.75%	22.06%	
All Others	25.00%	12.70%	21.43%	
Total	100.00%	100.00%	100.00%	
Payer Mix % (SWB):				
MCR	92.70%	78.53%	90.29%	
MCR Mgd Care	7.30%	21.47%	9.71%	
All Others	0.00%	0.00%	0.00%	
Total	100.00%	100.00%	100.00%	
Operating margin	(143,439)	(225,342)	(2,035,600)	*(169,633)*
Operating Margin (Current Month vs Mthly Avg)	*26,194*	*(55,709)*		
NPR (Net Patient Revenue)	1,230,041	1,173,539	15,929,078	*1,327,423*
NPR (Current Month vs Mthly Avg)	*(97,383)*	*(153,885)*		
Operating Expenses	1,392,672	1,447,901	18,189,918	*1,515,827*
Oper Exp (CM vs Mthly Avg)	*(123,154)*	*(67,925)*		
NPR % of Oper Exp	**88.3%**	**81.1%**	**87.6%**	
Patient Days	242	254	4,131	*344*
Oper Exp / PPD	$ 5,755	$ 5,700	$ 4,403	
# of Months	**1**	**1**	**12**	
Cash Receipts (rnd)	**985,475**	**929,990**	**17,290,925**	*1,440,910*
Cash Receipts (CM vs Mthly Avg)	*(455,435)*	*(510,921)*		
Cash as a % of NPR (s/b 100% min)	**80.1%**	**79.2%**	**108.5%**	
Calendar Days	30	31	365	
Operating Exp / Day	$ 46,422	$ 46,706	$ 49,835	
Cash - (unrestricted)	335,731	80,298	80,298	
Days Cash-On-Hand	**7.2**	**1.7**	**1.6**	
Cash - (including restricted)	1,147,920	892,487	892,487	
Days Cash-On-Hand	**24.7**	**19.1**	**17.9**	
MCR Rec (Pay) - "as stated - but to be adjusted"	(2,349,751)	(2,218,453)		
AP & Accrued Liab	13,537,006	13,769,120		
Accounts Receivable (at net)	1,314,243	1,410,015		

Per AP aging schedule (incl. accruals)	**Nov-23**	**Dec-23**	Net Change
Account Payable - Cohesive	10,894,650	11,279,970	385,319
Account Payable - Other	1,749,632	1,596,426	(153,206)
Total	12,644,282	12,876,396	232,114
Cohesive Loan	5,241,832	5,272,849	31,017

Mangum Regional Medical Center
Cash Receipts - Cash Disbursements Summary
December 2023

	Current Month	COVID	Total Less COVID	Year-To-Date	COVID	Year-To-Date Less COVID
Cash Receipts	$ 929,990	$ -	$ 929,990	$ 17,290,925	$ -	$ 17,290,925
Cash Disbursements	$ (1,191,570)	$ -	$ (1,191,570)	$ (17,743,359)	$ 139,447	$ (17,603,912)
NET	$ (261,580)	$ -	$ (261,580)	$ (452,434)	$ 139,447	$ (312,987)

January 23, 2024

Board of Directors
Mangum Regional Medical Center

December 2023 Financial Statement Overview

- Statistics
  - The average daily census (ADC) for December 2023 was **8.19** – (Year-To-Date **11.32** vs PY fiscal year end of **9.86**).
  - Year-To-Date Acute payer mix was approximately **78%** MCR/MCR Managed Care combined & slightly higher than **71%** for the prior fiscal year end.
  - Year-To-Date Swing Bed payer mix was **90%** MCR & **10%** MCR Managed Care. For the prior year end those percentages were **93% & 7%,** respectively.

- Balance Sheet Highlights
  - The cash balance as of December 31, 2023, inclusive of both operating & reserves, was **$892K**. This decrease of **$255K** from November 30, 2023, balance was primarily due to a decrease in patient cash receipts which decreased by **$55K** from the prior month.
  - Days cash on hand, inclusive of reserves, was **19.1** based on December YTD expenses.
  - Net AR increased by **$96K** from November.
  - Payments of approximately **$1.2M** were made on AP (prior 3-month avg was **$1.3M**).
  - Cash receipts were **$55K** less than in the previous month **($930K vs $985K).**
  - The Medicare principal balance decreased by **$131K** due to ERS loan payments**.** The FY17 loan should be paid-in-full in March 2024.

- Income Statement Highlights

  - Net patient revenue for November was **$1.17M**, which is approximately a decrease of **$168K** over the prior month year-to-date average due to the decrease in ADC.
  - Operating expenses, exclusive of interest & depreciation, were **$1.39M** and decreased from the prior month year-to-date average **of $1.47M by -$71K.**
  - 340B revenues reached an all-time "monthly" high of **$49K** in December & YTD increased to **$192K**. Net profit from this service line YTD increased to **$70K**.

- Clinic (RHC) Income Statement Highlights - actual & projected (includes swing bed rounding):

  - Current month average visits per day = 8.75
  - Year-To-Date average visits per day = 7.20
  - Projected operating revenues (YTD) = $397K
  - Projected operating expenses (YTD) = $875K
  - Projected operating loss (YTD) = -($478K)

MANGUM REGIONAL MEDICAL CENTER
Admissions, Discharges & Days of Care
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	December	12/31/2023 YTD	12/31/2022 PY Comparison
Admissions														
Inpatient	13	16	19	11	16	12	13	19	13	11	16	19	178	138
Swingbed	14	14	15	5	12	7	10	15	8	17	8	12	137	95
Observation	0	1	1	1	2	1	2	6	0	3	1	3	21	6
	27	31	35	17	30	20	25	40	21	31	25	34	336	239
Discharges														
Inpatient	15	16	20	10	16	12	10	18	16	11	14	20	178	136
Swingbed	10	11	14	11	6	12	12	14	9	12	7	14	132	98
Observation	0	1	1	1	2	1	2	6		3	1	3	21	6
	25	28	35	22	24	25	24	38	25	26	22	37	331	240
Days of Care														
Inpatient-Medicare	23	31	43	22	35	27	25	39	24	20	32	35	356	274
Inpatient-Other	33	29	32	13	19	11	8	21	30	18	32	28	274	183
Swingbed-Medicare	371	356	386	289	328	240	222	281	171	202	165	150	3,161	2,414
Swingbed-Other	0	2	42	51	30	39	40	28	31	23	13	41	340	204
Observation	0	1	1	1	2	1	2	6	0	3	1	3	21	6
	427	419	504	376	414	318	297	375	256	266	243	257	4,152	3,081
Calendar days	31	28	31	30	31	30	31	31	30	31	30	31	365	304
ADC - (incl OBS)	13.77	14.96	16.26	12.53	13.35	10.60	9.58	12.10	8.53	8.58	8.10	8.29	11.38	10.13
ADC	13.77	14.93	16.23	12.50	13.29	10.57	9.52	11.90	8.53	8.48	8.07	8.19	11.32	10.12
ER	158	119	169	136	148	132	152	154	162	160	87	100	1,677	1,446
Outpatient	176	132	182	141	177	152	171	190	158	165	96	92	1,832	2,426
RHC	170	123	167	162	164	125	142	196	159	196	199	175	1,978	1,723

MANGUM REGIONAL MEDICAL CENTER
Comparative Balance Sheet - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	December	Prior Month Variance
Cash And Cash Equivalents	980,584	677,752	684,122	724,967	556,140	627,470	566,073	654,397	850,824	712,301	335,731	80,298	**(255,433)**
Reserved Funds	-	-	800,000	1,400,000	768,400	968,400	662,189	812,189	812,189	812,189	812,189	812,189	**-**
Patient Accounts Receivable, Net	1,696,258	1,823,404	2,265,664	2,231,841	2,003,361	1,480,786	1,551,449	1,915,345	1,399,933	1,318,350	1,314,243	1,410,015	**95,771**
Due From Medicare	74,934	74,956	-	-	-	-	-	-	-	-	-	-	**-**
Inventory	243,297	235,738	244,725	260,940	270,700	234,397	228,685	239,652	246,453	247,888	246,327	259,367	**13,040**
Prepaids And Other Assets	1,990,291	1,968,284	1,941,610	1,993,890	1,977,854	1,958,215	1,941,193	1,550,814	1,891,626	1,899,170	1,885,591	1,897,615	**12,024**
Capital Assets, Net	2,325,712	2,274,924	2,224,332	2,174,390	2,126,662	2,104,656	2,056,492	2,008,327	2,004,456	1,936,608	1,889,335	1,859,246	**(30,089)**
Total Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,725	7,205,480	6,926,505	6,483,416	6,318,729	(164,687)
Accounts Payable	16,893,910	16,526,357	11,418,965	11,562,124	11,770,040	11,703,708	12,099,854	12,315,821	12,559,363	12,575,114	12,644,282	12,876,396	**232,114**
AHSO Related AP	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	**-**
Due To Medicare	2,586,010	2,840,280	3,653,730	4,246,353	3,336,103	3,256,838	2,720,743	2,880,235	2,761,845	2,680,074	2,349,751	2,218,453	**(131,298)**
Covid Grant Funds	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Due To Cohesive - PPP Loans	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Notes Payable - Cohesive	-	-	5,552,000	5,520,983	5,489,966	5,458,950	5,427,933	5,396,916	5,365,899	5,334,882	5,303,866	5,272,849	**(31,017)**
Notes Payable - Other	23,565	23,565	23,565	95,369	88,382	81,409	74,366	67,281	60,197	52,990	45,362	38,045	**(7,317)**
Alliantz Line Of Credit	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Leases Payable	273,074	269,075	265,054	261,011	256,946	280,019	276,961	276,057	275,582	274,465	274,615	272,789	**(1,826)**
Total Liabilities	20,669,282	20,552,001	21,806,037	22,578,564	21,834,161	21,673,647	21,492,580	21,829,034	21,915,610	21,810,250	21,510,600	21,571,256	60,655
Net Assets	(13,358,207)	(13,496,944)	(13,645,584)	(13,792,536)	(14,131,044)	(14,299,723)	(14,486,500)	(14,648,309)	(14,710,130)	(14,883,745)	(15,027,184)	(15,252,526)	**(225,342)**
Total Liablities and Net Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,725	7,205,480	6,926,505	6,483,416	6,318,729	(164,687)

Mangum Regional Medical Center
Cash Receipts & Disbursements by Month

2021				2022				2023		
Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Disbursements
Jan-21	830,598		695,473	Jan-22	2,163,583		1,435,699	Jan-23	1,290,109	1,664,281
Feb-21	609,151		1,472,312	Feb-22	1,344,463	254,626	1,285,377	Feb-23	1,506,708	1,809,690
Mar-21	910,623	49,461	866,387	Mar-22	789,800		1,756,782	Mar-23	1,915,435	1,109,683
Apr-21	742,500		999,127	Apr-22	1,042,122		1,244,741	Apr-23	2,005,665	1,365,533
May-21	816,551		1,528,534	May-22	898,311		1,448,564	May-23	1,436,542	2,237,818
Jun-21	936,092		1,455,892	Jun-22	1,147,564		1,225,070	Jun-23	1,777,525	1,506,459
Jul-21	1,009,037		1,774,932	Jul-22	892,142		979,914	Jul-23	1,140,141	1,508,702
Aug-21	1,292,886	100,000	2,156,724	Aug-22	890,601		1,035,539	Aug-23	1,600,786	1,352,905
Sep-21	278,972		753,559	Sep-22	2,225,347		1,335,451	Sep-23	1,490,569	1,295,680
Oct-21	1,954,204		1,343,425	Oct-22	1,153,073		1,233,904	Oct-23	1,211,980	1,345,813
Nov-21	1,113,344	316,618	1,800,166	Nov-22	935,865		1,476,384	Nov-23	985,475	1,355,224
Dec-21	1,794,349	305,543	1,325,063	Dec-22	1,746,862		1,073,632	Dec-23	929,990	1,191,570
	12,288,308	771,623	16,171,592		15,229,733	254,626	15,531,057		17,290,925	17,743,359
Subtotal FY 2021	13,059,930			Subtotal FY 2022	15,484,359			Subtotal FY 2023	17,290,925	

Mangum Regional Medical Center
Medicare Payables by Year

	Original Balance	Balance as of 12/31/23	Total Interest Paid as of 12/31/2023
2016 C/R Settlement	1,397,906.00	-	205,415.96
2017 Interim Rate Review - 1st	723,483.00	-	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	-	20,332.88
2017 6/30/17-C/R Settlement	1,614,760.00	-	7,053.79
2017 12/31/17-C/R Settlement	(535,974.00)	253,074.37	262,600.59
2017 C/R Settlement Overpayment	3,539,982.21	-	-
2018 C/R Settlement	1,870,870.00	-	241,040.31
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	-	277,488.75
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement	(3,145,438.00)	-	-
FY21 MCR pay (rec) estimate	(1,631,036.00)	-	-
FY22 MCR pay (rec) estimate	(318,445.36)	-	-
2016 C/R Audit - Bad Debt Adj	348,895.00	-	16,927.31
2018 MCR pay (rec) Audit est.	(34,322.00)	-	-
2019 MCR pay (rec) Audit est.	(40,612.00)	-	-
2020 MCR pay (rec) Audit	(74,956.00)	-	-
FY23 (8-month IRR) L4315598	95,225.46	92,943.94	-
FY23 (8-month IRR) L4315599	1,918,398.00	1,872,434.86	-
FY23 MCR pay (rec) remaining estimate	-	-	-
FY24 MCR pay (rec) estimate	-	-	
Total	**7,009,696.31**	**2,218,453.17**	**1,185,922.21**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended December 31, 2023
Unaudited

MTD					YTD			
Actual	Budget	Variance	% Change		Actual	Budget	Variance	% Change
446,368	194,077	252,291	130%	Inpatient revenue	3,509,811	2,255,686	1,254,125	56%
919,447	673,437	246,010	37%	Swing Bed revenue	13,839,893	7,947,953	5,891,940	74%
668,384	602,742	65,642	11%	Outpatient revenue	7,213,007	7,084,114	128,892	2%
200,901	164,014	36,887	22%	Professional revenue	2,027,431	1,918,914	108,517	6%
2,235,099	1,634,269	600,830	37%	Total patient revenue	26,590,141	19,206,667	7,383,474	38%
955,776	230,958	724,818	314%	Contractual adjustments	6,888,643	2,548,289	4,340,354	170%
-	-	-	#DIV/0!	Contractual adjustments: MCR Settlement	2,680,967		2,680,967	#DIV/0!
105,784	110,150	(4,365)	-4%	Bad debts	1,091,452	1,294,529	(203,077)	-16%
1,061,560	341,108	720,452	211%	Total deductions from revenue	10,661,063	3,842,819	6,818,244	177%
1,173,539	1,293,161	(119,623)	-9%	Net patient revenue	15,929,078	15,363,848	565,230	4%
383	3,618	(3,235)	-89%	Other operating revenue	33,461	43,405	(9,944)	-23%
48,637	52,452	(3,815)	-7%	340B REVENUES	191,779	661,169	(469,390)	-71%
1,222,559	1,349,231	(126,672)	-9%	Total operating revenue	16,154,318	16,068,422	85,896	1%
				Expenses				
437,276	365,385	71,891	20%	Salaries and benefits	4,901,402	4,323,468	577,934	13%
135,840	142,008	(6,168)	-4%	Professional Fees	1,721,614	1,686,494	35,121	2%
279,182	433,274	(154,092)	-36%	Contract labor	4,251,985	5,100,948	(848,963)	-17%
102,201	109,796	(7,594)	-7%	Purchased/Contract services	1,548,024	1,297,683	250,341	19%
225,000	225,000	-	0%	Management expense	2,700,000	2,700,000	-	0%
101,612	88,519	13,092	15%	Supplies expense	1,145,809	1,044,729	101,080	10%
27,975	29,926	(1,951)	-7%	Rental expense	353,388	356,596	(3,208)	-1%
17,887	16,788	1,099	7%	Utilities	214,336	201,461	12,874	6%
142	1,219	(1,077)	-88%	Travel & Meals	11,645	14,501	(2,855)	-20%
9,799	12,130	(2,331)	-19%	Repairs and Maintnenance	140,155	145,135	(4,980)	-3%
14,788	12,596	2,192	17%	Insurance expense	139,491	151,146	(11,655)	-8%
15,378	21,829	(6,452)	-30%	Other Expense	266,705	261,875	4,830	2%
27,445	33,672	(6,227)	-18%	340B EXPENSES	121,444	396,459	(275,014)	-69%
1,394,524	1,492,141	(97,616)	-7%	Total expense	17,516,000	17,680,495	(164,494)	-1%
(171,965)	(142,909)	(29,056)	20%	EBIDA	(1,361,682)	(1,612,072)	250,390	-16%
-14.1%	-10.6%	-3.47%		EBIDA as percent of net revenue	-8.4%	-10.0%	1.60%	
23,288	2,994	20,295	678%	Interest	98,686	79,553	19,132	24%
30,089	48,039	(17,950)	-37%	Depreciation	575,232	573,827	1,406	0%
(225,342)	(193,942)	(31,400)	16%	Operating margin	(2,035,600)	(2,265,452)	229,852	-10%
-	-	-		Other	-	-	-	
-	-	-		Total other nonoperating income	-	-	-	
(225,342)	(193,942)	(31,400)	16%	Excess (Deficiency) of Revenue Over Expenses	(2,035,600)	(2,265,452)	229,852	-10%
-18.43%	-14.37%	-4.06%		Operating Margin %	-12.60%	-14.10%	1.50%	

MANGUM REGIONAL MEDICAL CENTER
Statement of Revenue and Expense Trend - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	November	December	YTD
Inpatient revenue	**248,170**	**273,130**	**272,704**	**168,264**	**292,654**	**256,424**	**217,685**	**346,918**	**329,664**	**245,590**	**412,239**	**446,368**	3,509,811
Swing Bed revenue	**857,835**	**848,580**	**1,159,897**	**1,415,031**	**1,815,525**	**1,219,155**	**1,228,096**	**1,406,639**	**971,812**	**1,128,584**	**869,292**	**919,447**	13,839,893
Outpatient revenue	**569,774**	**479,203**	**655,242**	**450,232**	**596,547**	**566,829**	**643,187**	**672,465**	**707,757**	**618,323**	**585,065**	**668,384**	7,213,007
Professional revenue	**165,566**	**172,559**	**183,040**	**122,822**	**164,587**	**152,378**	**159,248**	**182,030**	**183,508**	**178,118**	**162,673**	**200,901**	2,027,431
Total patient revenue	1,841,345	1,773,472	2,270,883	2,156,349	2,869,312	2,194,786	2,248,217	2,608,052	2,192,741	2,170,615	2,029,270	2,235,099	26,590,141
Contractual adjustments	**(121,100)**	**19,061**	**(134,294)**	**(23,053)**	**1,539,024**	**831,011**	**916,605**	**836,330**	**624,540**	**820,169**	**624,573**	**955,776**	6,888,643
Contractual adjustments: MCR Settlement	**533,168**	**285,044**	**920,000**	**702,755**	**-**	**-**	**-**	**240,000**	**-**	**-**	**-**	**-**	2,680,967
Bad debts	**25,723**	**134,415**	**12,093**	**118,358**	**49,948**	**41,945**	**53,383**	**99,904**	**117,963**	**157,280**	**174,657**	**105,784**	1,091,452
Total deductions from revenue	437,792	438,520	797,799	798,060	1,588,972	872,957	969,988	1,176,234	742,503	977,449	799,230	1,061,560	10,661,063
Net patient revenue	1,403,553	1,334,952	1,473,084	1,358,289	1,280,341	1,321,829	1,278,229	1,431,818	1,450,237	1,193,166	1,230,041	1,173,539	15,929,078
Other operating revenue	**643**	**481**	**1,746**	**782**	**4,037**	**14,751**	**920**	**1,035**	**2,826**	**3,737**	**2,119**	**383**	33,461
340B REVENUES	**17,199**	**11,534**	**9,264**	**6,654**	**7,518**	**25,149**	**6,901**	**12,515**	**20,071**	**9,265**	**17,073**	**48,637**	191,779
Total operating revenue	1,421,395	1,346,967	1,484,094	1,365,725	1,291,895	1,361,730	1,286,050	1,445,369	1,473,134	1,206,168	1,249,233	1,222,559	16,154,318
	89.8%	89.9%	90.2%	89.8%	78.5%	86.4%	86.8%	89.1%	94.5%	86.5%	88.3%	81.1%	87.6%
Expenses													
Salaries and benefits	**361,005**	**411,948**	**411,789**	**381,508**	**403,854**	**366,863**	**401,488**	**441,681**	**457,827**	**429,806**	**396,357**	**437,276**	4,901,402
Professional Fees	**149,199**	**131,495**	**159,564**	**139,183**	**153,226**	**141,955**	**140,784**	**141,126**	**143,727**	**157,258**	**128,259**	**135,840**	1,721,614
Contract labor	**467,147**	**361,407**	**425,232**	**351,293**	**409,120**	**355,927**	**361,836**	**396,420**	**308,448**	**248,085**	**287,889**	**279,182**	4,251,985
Purchased/Contract services	**107,498**	**115,260**	**160,858**	**144,976**	**166,564**	**132,525**	**102,698**	**144,927**	**143,947**	**117,485**	**109,083**	**102,201**	1,548,024
Management expense	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	2,700,000
Supplies expense	**85,209**	**77,055**	**109,037**	**83,909**	**96,572**	**145,554**	**92,679**	**108,407**	**95,857**	**63,012**	**86,906**	**101,612**	1,145,809
Rental expense	**25,693**	**25,335**	**22,200**	**40,587**	**37,323**	**28,670**	**21,353**	**36,558**	**34,038**	**29,191**	**24,466**	**27,975**	353,388
Utilities	**19,305**	**20,759**	**20,147**	**17,598**	**17,253**	**19,058**	**18,169**	**15,749**	**18,780**	**16,761**	**12,869**	**17,887**	214,336
Travel & Meals	**721**	**1,537**	**2,377**	**1,470**	**2,279**	**1,610**	**101**	**170**	**535**	**52**	**652**	**142**	11,645
Repairs and Maintnenance	**14,713**	**10,390**	**11,618**	**10,943**	**11,837**	**10,109**	**12,289**	**10,891**	**14,871**	**9,927**	**12,767**	**9,799**	140,155
Insurance expense	**13,940**	**13,997**	**5,518**	**6,394**	**12,379**	**12,386**	**12,384**	**12,384**	**12,384**	**12,384**	**10,556**	**14,788**	139,491
Other	**14,963**	**25,844**	**14,797**	**47,046**	**32,512**	**22,132**	**23,495**	**8,940**	**15,970**	**11,484**	**34,146**	**15,378**	266,705
340B EXPENSES	**9,702**	**6,242**	**5,693**	**5,170**	**7,268**	**13,332**	**5,975**	**10,877**	**10,871**	**6,909**	**11,961**	**27,445**	121,444
Total expense	1,494,096	1,426,270	1,573,830	1,455,077	1,575,186	1,475,120	1,418,248	1,553,130	1,482,254	1,327,353	1,340,912	1,394,524	17,516,000
EBIDA	$ (72,701)	$ (79,303)	$ (89,736)	$ (89,352)	$ (283,290)	$ (113,390)	$ (132,198)	$ (107,762)	$ (9,120)	$ (121,185)	$ (91,679)	$ (171,965)	$ (1,361,682)
EBIDA as percent of net revenue	-5.1%	-5.9%	-6.0%	-6.5%	-21.9%	-8.3%	-10.3%	-7.5%	-0.6%	-10.0%	-7.3%	-14.1%	-8.4%
Interest	**10,509**	**9,096**	**8,824**	**7,659**	**7,489**	**7,125**	**6,414**	**5,883**	**4,536**	**4,265**	**3,596**	**23,288**	98,686
Depreciation	**58,070**	**50,338**	**50,080**	**49,942**	**47,728**	**48,164**	**48,164**	**48,164**	**48,164**	**48,164**	**48,164**	**30,089**	575,232
Operating margin	$ (141,280)	$ (138,737)	$ (148,640)	$ (146,952)	$ (338,508)	$ (168,680)	$ (186,776)	$ (161,810)	$ (61,821)	$ (173,615)	$ (143,439)	$ (225,342)	$ (2,035,600)
Other	-	-	-	-	-	-	-	-	-	-	-		-
Total other nonoperating income	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess (Deficiency) of Revenue Over Expenses	(141,280)	(138,737)	(148,640)	(146,952)	(338,508)	(168,680)	(186,776)	(161,810)	(61,821)	(173,615)	(143,439)	(225,342)	(2,035,600)
Operating Margin % (excluding other misc. reve	-9.94%	-10.30%	-10.02%	-10.76%	-26.20%	-12.39%	-14.52%	-11.20%	-4.20%	-14.39%	-11.48%	-18.43%	-12.60%

	12/31/2023	"Annualized"
On-Site Visits -->	1,850	1,850
On-Site Visit / Bus Day -->	7.20	7.14

Mangum Family Clinic

Twelve Months Ended 12/31/2023

Description	YTD FS Per General Ledger	Eliminate Rev Deduct & Other Inc	Adj Rev Deduct to RHC Calc	Cost Report Allocations	12 RHC Financial Statements	FY 2023 "Annualized" RHC Financial Statements
Gross Patient Revenue	242,221	-	-	-	242,221	242,221
Less: Revenue deductions	252,923	(252,923)	155,261	-	155,261	155,261
Net Patient Revenue	495,144	(252,923)	155,261	-	397,482	397,482
Other Income (if any)	3,143	(3,143)	-	-	-	-
Operating revenue	498,288	(256,067)	155,261	-	397,482	397,482
Operating Expenses:						
Salaries	136,302	-	-	-	136,302	136,302
Benefits	-	-	-	-	-	-
Prof Fees	162,730	-	-	41,522	204,252	204,252
Contract Labor	41,167	-	-	-	41,167	41,167
Purch Serv	74,298	-	-	-	74,298	74,298
Supplies	7,098	-	-	-	7,098	7,098
Rent	28,241	-	-	-	28,241	28,241
Utilities	10,299	-	-	-	10,299	10,299
Repairs	1,441	-	-	-	1,441	1,441
Other	6,282	-	-	-	6,282	6,282
Insurance	2,588	-	-	-	2,588	2,588
Travels & Meals	4,586	-	-	-	4,586	4,586
Management Fee Direct Exp	-	-	-	138,484	138,484	138,484
Critical Access Hospital Overhead Allocation (a)	-	-	-	220,936	220,936	220,936
Total Operating Expenses	475,032	-	-	400,942	875,974	875,974
Net Income (loss)	**23,256**	**(256,067)**	**155,261**	**(400,942)**	**(478,491)**	**(478,492)**

MGMT Fee Allocation est. 2023	1 months	11,540
IP Rounding allocation based on 8/31/22 IRR estimate	8 months	27,681
CAH Overhead Allocation - from Chris based on last filed cost report -------->	12 months	220,936
Total allocation ------->		260,157

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	12/31/2023	11/30/2023	10/31/2023	9/30/2023
ALCO SALES & SERVICE CO	Patient Supplies	-	-	-	-	-	-	299.80	-
AMERICAN HEART ASSOCIATION INC	Supplies	-	-	-	-	-	-	-	242.22
AMERICAN PROFICIENCY INSTITUTE	Lab Supplies	-	-	-	-	-	-	-	50.00
ANESTHESIA SERVICE INC	Patient Supplies	-	-	-	-	-	1,050.00	-	914.14
APEX MEDICAL GAS SYSTEMS, INC	Supplies	-	-	-	-	-	-	-	-
ARAMARK	Linen Services	3,012.95	-	-	-	3,012.95	18,077.70	15,064.75	20,394.52
ASPEN INSPECTION SERVICES	Repairs/maintenance	-	-	-	-	-	-	-	-
AT&T	Fax Service	-	-	-	-	-	-	-	-
AVANAN, INC.	COVID Capital	-	-	-	16,800.00	16,800.00	16,800.00	16,800.00	16,800.00
BARRY DAVENPORT	1099 Provider	-	-	-	-	-	-	-	-
BIO-RAD LABORATORIES INC	Lab Supplies	-	-	-	-	-	1,396.32	1,568.45	1,550.42
BRIGGS HEALTHCARE	Supplies	-	-	-	-	-	-	-	-
CARNEGIE EMS	Patient Transport Svs	-	-	4,740.00	-	4,740.00	4,740.00	4,740.00	8,550.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	-	-	-	-	-	-	-	-
CDW-G LLC	Supplies	-	-	-	3,059.84	3,059.84	3,059.84	3,059.84	3,059.84
CITY OF MANGUM	Utilities	-	-	-	-	-	-	-	-
CliftonLarsonAllen LLP	Audit firm	-	-	-	-	-	5,512.50	-	-
COHESIVE HEALTHCARE MGMT	Mgmt Fees	225,382.50	226,282.50	-	1,227,445.19	1,679,110.19	1,473,760.38	1,347,477.88	1,253,494.64
COHESIVE HEALTHCARE RESOURCES	Payroll	592,699.72	447,967.42	443,340.43	4,088,761.42	5,572,768.99	5,274,460.02	4,790,954.17	5,216,906.53
COHESIVE MEDIRYDE LLC	Patient Transportation Service	-	-	-	-	-	-	-	-
COHESIVE STAFFING SOLUTIONS	Agency Staffing Service	191,539.58	236,713.42	243,744.07	3,356,093.46	4,028,090.53	4,146,429.55	4,148,926.00	4,216,879.78
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance	-	-	2,450.00	-	2,450.00	2,450.00	-	-
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	2,000.00	2,000.00	2,000.00	15,980.95	21,980.95	23,980.95	19,980.95	21,980.95
CPSI	EHR Software	-	-	-	-	-	-	-	6,132.00
CURBELL MEDICAL PRODUCTS INC	Supplies	-	-	-	-	-	-	-	-
DELL FINANCIAL SERVICES LLC	Server Lease	-	-	-	-	-	-	-	-
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch Svs	-	-	-	-	-	2,150.00	2,150.00	4,550.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	1,386.00	258.00	6,165.00	350,749.16	358,558.16	356,914.16	356,914.16	351,591.55
DR W. GREGORY MORGAN III	1099 Provider	-	-	-	-	-	-	-	-
DYNAMIC ACCESS	Vascular Consultant	1,000.00	-	-	-	1,000.00	1,125.00	-	-
eCLINICAL WORKS, LLC	RHC EHR	-	-	6,000.00	-	6,000.00	6,000.00	6,000.00	2,875.50
EMD MILLIPORE CORPORATION	Lab Supplies	-	-	-	-	-	-	-	-
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	-	-	-	-	-	2,928.00	-	-
FEDEX	Shipping	-	-	-	-	-	-	-	145.66
FFF ENTERPRISES INC	Pharmacy Supplies	-	-	-	-	-	592.56	-	-
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	-	-	-	-	-	-	-	-
FORVIS LLP	Finance Purch Svs(Formerly BKD)	-	-	-	-	-	6,642.00	6,642.00	-
FOX BUILDING SUPPLY	Repairs/maintenance	-	-	(151.19)	-	(151.19)	(151.19)	(151.19)	
GEORGE BROS TERMITE & PEST CON	Pest Control Service	-	-	-	-	-	160.00	-	760.00
GLOBAL EQUIPMENT COMPANY INC.	Patient Supplies	-	1,518.74	-	-	1,518.74	-	-	-
GRAINGER	Maintenance Supplies	551.73	-	-	-	551.73	160.81	273.73	967.83
GREER COUNTY CHAMBER OF	Advertising	-	-	-	-	-	-	-	-
GREER COUNTY TREASURER	Insurance	-	-	5,650.00	-	5,650.00	11,300.00	-	-
HAC INC	Dietary Supplies	22.23	-	-	-	22.23	345.68	-	-
HEALTH CARE LOGISTICS	Pharmacy Supplies	-	-	-	-	-	-	100.38	-
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	-	-	-	-	-	-	-	1,050.00
HENRY SCHEIN	Lab Supplies	-	-	-	-	-	-	-	-
HEWLETT-PACKARD FINANCIAL SERV	Computer Services	307.10	307.10	-	-	614.20	-	-	-
HILL-ROM COMPANY, INC	Rental Equipment	-	-	-	-	-	-	-	-
HOBART SERVICE	Repairs/maintenance	-	-	-	-	-	2,060.38	-	-
ICU MEDICAL SALES INC.	Supplies	-	-	-	-	-	-	-	-
HSI	Materials Purch svs	-	-	-	-	-	-	-	2,500.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	-	-	-	-	-	-	-	-

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	12/31/2023	11/30/2023	10/31/2023	9/30/2023
INQUISEEK LLC	RHC purch svs	-	-	-	225.00	225.00	225.00	225.00	225.00
INSIGHT DIRECT USA INC.	IT Minor Equipment	-	-	-	-	-	1,007.36	1,007.36	1,007.36
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	-	-	-	-	-	-	-	691.17
JIMALL & KANISHA' LOFTIS	Rent House	-	-	-	-	-	-	-	-
KCI USA	Rental Equipment	-	-	-	-	-	-	-	-
KING GUIDE PUBLICATIONS INC	Advertising	-	-	-	-	-	-	-	100.00
LABCORP	Lab purch svs	-	-	-	-	-	-	-	-
LAMPTON WELDING SUPPLY	Patient Supplies	-	-	-	-	-	-	-	-
LANGUAGE LINE SERVICES INC	Translation service	135.00	-	-	-	135.00	135.00	-	130.00
LOCKE SUPPLY	Plant Ops supplies	-	-	-	-	-	59.36	663.80	-
MANGUM STAR NEWS	Advertising	244.50	-	-	-	244.50	-	-	-
MARK CHAPMAN	Employee Reimbursement	-	-	-	-	-	-	-	-
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	4,911.97	-	-	-	4,911.97	-	-	11,904.45
MEDLINE INDUSTRIES	Patient Care/Lab Supplies	8,430.85	-	-	-	8,430.85	(32.98)	-	3,125.41
MYHEALTH ACCESS NETWORK, INC	Compliance purch svs	-	-	-	-	-	-	-	758.92
NATIONAL RECALL ALERT CENTER	Safety and Compliance	-	-	-	-	-	-	-	-
NEXTIVA, INC.	Phone Svs	3,707.22	-	-	-	3,707.22	-	-	-
NUANCE COMMUNICATIONS INC	RHC purch svs	-	-	-	-	-	-	-	246.00
OFMQ	Quality purch svs	350.00	-	-	-	350.00	350.00	-	350.00
OHERI	Education/Training	-	-	-	-	-	-	-	-
OKLAHOMA BLOOD INSTITUTE	Blood Bank	7,618.30	-	-	-	7,618.30	-	6,475.90	10,217.80
OPTUM	Pharmacy Supplies	104.95	-	-	-	104.95	-	114.95	-
ORTHO-CLINICAL DIAGNOSTICS INC	Lab purch svs	-	-	-	1,203.96	1,203.96	1,203.96	1,203.96	1,203.96
PARA REV LOCKBOX	CDM purch svs	-	-	-	-	-	-	-	6,827.00
PHARMA FORCE GROUP LLC	340B purch svs	-	-	-	-	-	-	-	-
PHARMACY CONSULTANTS, INC.	PHARMACY CONSULTANTS, INC.	-	-	-	-	-	-	-	2,530.00
PHILADELPHIA INSURANCE COMPANY	OHA Insurance	-	-	-	-	-	-	-	-
PHILIPS HEALTHCARE	Supplies	-	-	-	-	-	-	-	-
PIPETTE COM	Lab maintenance	-	-	-	-	-	-	-	-
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	-	-	-	-	-	-	-	-
PORT53 TECHNOLOGIES, INC.	Software license	-	-	-	-	-	-	-	200.88
PRESS GANEY ASSOCIATES, INC	Purchased Service	738.48	-	-	-	738.48	-	738.48	738.48
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	-	-	-	-	-	-	-	-
PURCHASE POWER	Postage Fees	-	-	-	-	-	-	-	100.00
RADIATION CONSULTANTS	Radiology maintenance	-	-	-	-	-	-	-	3,200.00
RESPIRATORY MAINTENANCE INC	Repairs/maintenance	-	-	-	-	-	-	-	1,330.00
REYES ELECTRIC LLC	COVID Capital	-	-	-	20,000.00	20,000.00	25,000.00	25,000.00	29,780.00
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	-	-	-	-	-	-	-	770.00
SBM MOBILE PRACTICE, INC	1099 Provider	-	-	-	-	-	-	-	-
SCHAPEN LLC	Clinic Rent	-	-	-	-	-	-	-	-
SECURITY CHECK	Security	-	-	-	-	-	280.00	-	-
SHERWIN-WILLIAMS	Supplies	-	-	-	(11.78)	(11.78)	(11.78)	(11.78)	(11.78)
SHRED-IT USA LLC	Secure Doc disposal service	-	-	-	-	-	-	2,544.75	2,384.32
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract	-	-	-	-	-	3,912.29	-	12,600.00
SIZEWISE	Rental Equipment	-	-	-	-	-	2,473.50	2,473.50	2,473.50
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	-	-	-	-	-	-	-	1,735.00
SOMSS LLC	1099 Provider	-	-	-	-	-	-	-	-
SPACELABS HEALTHCARE LLC	Telemetry Supplies	-	-	-	-	-	1,566.30	-	-
SPARKLIGHT BUSINESS	Cable service	-	-	-	-	-	-	445.94	-
STANDLEY SYSTEMS LLC	Printer lease	2,175.57	-	-	-	2,175.57	-	-	2,245.75
STAPLES ADVANTAGE	Office Supplies	257.36	-	-	-	257.36	-	-	298.94
STERICYCLE INC	Waste Disposal Service	-	-	-	-	-	1,335.19	-	-
STRYKER INSTRUMENTS	Patient Supplies	-	-	-	-	-	-	-	-

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	12/31/2023	11/30/2023	10/31/2023	9/30/2023
SUMMIT UTILITIES	Utilities	-	-	-	-	-	-	-	32.33
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	-	-	-	-	-	-	-	1,755.00
TIGER ATHLETIC BOOSTERS	Advertising	-	-	-	-	-	-	-	-
TOUCHPOINT MEDICAL, INC	Med Dispense Monitor Support	-	-	-	3,285.00	3,285.00	3,285.00	3,285.00	3,285.00
TRIOSE INC	Freight	-	-	-	-	-	56.11	-	-
TRS MANAGED SERVICES	Agency Staffing-old	-	-	-	46,203.53	46,203.53	55,383.73	63,463.18	78,989.68
ULINE	Patient Supplies	-	-	-	-	-	-	-	-
ULTRA-CHEM INC	Housekeeping Supplies	-	-	-	-	-	-	-	-
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	-	-	-	-	-	-	-	1,161.47
US MED-EQUIP LLC	Swing bed eq rental	-	964.51	-	-	964.51	-	-	1,154.20
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	-	-	1,600.00	5,655.00	7,255.00	7,255.00	7,255.00	13,655.00
WELCH ALLYN, INC.	Supplies	-	-	-	-	-	-	-	-
WORTH HYDROCHEM	semi-annual water treatment	-	-	-	482.00	482.00	482.00	482.00	482.00
Grand Total		**1,046,576.01**	**916,011.69**	**715,538.31**	**9,135,932.73**	**11,814,058.74**	**11,465,909.70**	**10,836,167.96**	**11,329,072.42**
			Reconciling Items:		Conversion Variance	13,340.32	13,340.32	13,340.32	13,340.32
					AP Control	13,355,032.85	12,944,811.83	12,748,174.36	12,967,260.42
					Accrued AP	414,086.98	592,194.01	719,663.51	484,826.47
AHSO Related AP	**Description**	**12/31/2023**			AHSO Related AP	(892,723.76)	(892,723.76)	(892,723.76)	(892,723.76)
ADP INC	QMI Payroll Service Provider	4,276.42			**TOTAL AP**	**12,876,396.07**	**12,644,282.08**	**12,575,114.11**	**12,559,363.13**
ADP SCREENING AND SELECTION	QMI Payroll Service Provider	1,120.00				12,876,396.07			
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees	698,000.00				-			
AMERICAN HEALTH TECH	Rental Equipment-Old	22,025.36							
C.R. BARD INC.	Surgery Supplies-Old	3,338.95							
COMPLIANCE CONSULTANTS	Lab Consultant-Old	1,000.00							
ELISE ALDUINO	1099 AHSO consultant	12,000.00							
HEADRICK OUTDOOR MEDIA INC	AHSO Advertising	25,650.00							
HERC RENTALS-DO NOT USE	Old Rental Service	7,653.03							
IMEDICAL INC	Surgery Supplies-Old	1,008.29							
MEDSURG CONSULTING LLC	Equipment Rental Agreement	98,670.36							
MICROSURGICAL MST	Surgery Supplies-Old	2,233.80							
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies-Old	3,607.60							
NINJA RMM	IT Service-Old	2,625.00							
QUARTZ MOUNTAIN RESORT	Alliance Travel	9,514.95							
SUBTOTAL-AHSO Related AP		**892,723.76**							

Mangum Regional Medical Center

FY24 Budget

Assumptions

1	Budgeted ADC of 11.00 vs Curent Year (CY) 11.33 - (-3% decrease)
2	Budgeted payer mix allocation consistent with CY
3	All other stats budgeted based on calendar and / or business days
4	2024 = leap year; accordingly, both calendar & business days increased over CY
5	SHOPP estimate 2024 - $827,727 vs CY $693,875 - $133,852 increase
6	Salaries/Benefits & all expenses were reviewed & budgeted at the department level
7	
8	
9	
10	

Mangum Regional Medical Center

CASH BASIS

FY 2024 BUDGET - Income Statement Summary

	CY Annualized	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	FY24	Budget vs CY Incr (Decr)	% Incr (Decr)
Patient service revenue, gross	26,790,926	2,273,698	1,986,356	2,310,452	2,107,607	2,230,778	2,097,891	2,239,141	2,273,155	2,219,312	2,192,724	2,160,324	2,247,657	26,339,096	(451,830)	-1.7%
Contractual adjustments	(9,587,114)	(811,935)	(578,835)	(846,535)	(677,735)	(774,835)	(669,835)	(783,135)	(816,635)	(787,735)	(740,135)	(731,735)	(793,935)	(9,013,017)	574,097	-6.0%
Provision for bad debts	(973,213)	(82,595)	(72,595)	(84,595)	(76,595)	(80,595)	(75,595)	(81,595)	(82,595)	(80,595)	(79,595)	(78,595)	(81,595)	(957,137)	16,076	-1.7%
Patient service revenue, net	16,230,599	1,379,169	1,334,926	1,379,323	1,353,278	1,375,348	1,352,462	1,374,412	1,373,926	1,350,983	1,372,995	1,349,994	1,372,128	16,368,942	138,343	0.9%
340B revenue	151,283	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	151,283	-	0.0%
Other revenue	37,150	3,098	3,089	3,099	3,089	3,098	3,093	3,097	3,102	3,094	3,099	3,095	3,096	37,151	1	0.0%
Total operating revenue	16,419,032	1,394,874	1,350,623	1,395,029	1,368,974	1,391,053	1,368,161	1,390,116	1,389,635	1,366,684	1,388,701	1,365,696	1,387,831	16,557,376	138,344	
Salaries and benefits	4,881,323	393,394	372,079	393,394	389,736	400,394	389,736	400,394	400,394	389,736	400,394	389,736	400,394	4,719,779	(161,544)	-3.3%
Contract labor	4,421,897	368,478	345,347	368,478	349,581	361,146	349,581	361,146	361,146	349,581	361,146	349,581	361,146	4,286,356	(135,541)	-3.1%
Professional fees	1,749,018	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	1,727,934	(21,084)	-1.2%
Purchase Services	1,604,087	141,523	141,304	141,523	141,413	141,523	141,413	141,523	141,523	141,413	141,523	141,413	141,523	1,697,615	93,528	5.8%
Management fees	699,818	67,679	73,149	67,627	70,856	68,148	71,054	68,231	68,268	71,130	68,385	71,205	68,589	834,319	134,501	19.2%
Supplies expense	1,148,749	97,944	94,132	100,444	95,038	97,944	95,038	97,944	97,944	95,038	97,944	95,038	97,944	1,162,390	13,640	1.2%
Rental expense	361,136	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	363,605	2,468	0.7%
Utilities	220,295	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	220,295	-	0.0%
Travel & Meals	13,022	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	13,021	(1)	0.0%
Repairs & Maintenance	141,108	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	145,560	4,452	3.2%
Insurance expense	136,977	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	136,977	-	0.0%
340B expenses	98,446	8,187	8,084	8,187	8,135	8,187	8,135	8,187	8,187	8,135	8,187	8,135	8,187	97,934	(512)	-0.5%
Other expense	260,618	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	249,279	(11,339)	-4.4%
Total operating expenses	15,736,496	1,315,260	1,272,150	1,317,708	1,292,815	1,315,397	1,293,013	1,315,480	1,315,517	1,293,089	1,315,634	1,293,164	1,315,838	15,655,064	(81,431)	-0.5%
EBIDA	682,536	79,614	78,472	77,321	76,159	75,656	75,149	74,636	74,118	73,595	73,066	72,533	71,993	902,312	219,776	
Interest expense	86,161	29,916	28,774	27,623	26,461	25,958	25,451	24,938	24,420	23,897	23,368	22,835	22,295	305,937	219,776	255.1%
Depreciation	596,375	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	596,375	-	0.0%
Net income (loss)	0	0	-	-	0	-	(0)	0	0	-	-	(0)	(0)	0	0	16.3%
Non-Operating Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0%
Change in net assets	**0**	**0**	**-**	**-**	**0**	**-**	**(0)**	**0**	**0**	**-**	**-**	**(0)**	**(0)**	**0**	**0**	16.3%

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. **Name of Contract:** Pharmacy Consultants
3. **Contract Parties: MRMC/Pharmacy Consultants**

4. **Contract Type Services:** Consulting Agreement

5. **Impacted Hospital Departments: Hospital Pharmacy**

6. **Contract Summary:** Consulting services for 340B compliance. This agreement includes a yearly audit. Policy and procedure review with recommendations. Data Submission monitor and resolving data submission issues.

7. **Cost: $2,600.00/month and travel for annual onsite 340B audit**

8. **Prior Cost: $2,600.00/month and travel for annual onsite 340B audit**

9. **Term: The term of the Agreement shall expire on January 31, 2025**

10. **Termination Clause: None**

11. **Other:**

CONSULTING AGREEMENT

THIS CONSULTING AGREEMENT (the "Agreement") is dated this _____ day of _____, _____.

CLIENT	CONSULTANT
Mangum Regional Medical Center 1 Wickersham Drive; Mangum, OK 73554 (the "Client")	Pharmacy Consultants, Inc. DBA 340B Compliance Partners 1310 Cove Lane Road; Roaring Spring, PA 16673 (the "Consultant")

BACKGROUND

A. The Consultant has the necessary qualifications, experience and abilities to provide consulting services to the Client.

B. The Consultant is agreeable to providing such consulting services to the Client on the terms and conditions set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the Client and the Consultant (individually the "Party" and collectively the "Parties" to this Agreement) agree as follows:

SERVICES PROVIDED

1. The Client hereby agrees to engage the Consultant to provide the Client with the following consulting services (the "Services"):

- 1. The Client hereby agrees to engage the Consultant to provide the Client with the following consulting services (the “Services”):
  340B Compliance Partners Platinum Plan (Monthly Maintenance)
  a. Includes annual independent audit, as described in attached proposal.
  b. Includes having a resource available via phone/email (experienced pharmacist) for questions and guidance throughout the term. This includes reaching out to HRSA/Apexus anonymously on your behalf.
  c. Fee is parsed over 12 months for ease of budgeting
  d. Policy & Procedure review with recommendations for edits if gaps identified compared to HRSA expectations, as well as guidance on industry best-practices

e. Originate (if needed) a facility 340B oversight committee, as well as facilitate meetings with agenda/minutes generation.
f. Assist with vendor review, negotiation, and selection
g. Review Contract Pharmacy agreements
h. Analyze TPA functionality
i. Review the ongoing monthly audits performed by your staff
j. Provide written reports to leadership
k. 340B Compliance Partners assigned analyst for your account to complete monthly internal audits of all relevant universes on your behalf
l. Analysis of missed opportunities for increased 340B savings
m. 25% discount provided for annual independent audit.

2. Referral Prescription Capture Services

a. Referral Strategist assigned to your account to review potential queue created by TPA(s).
b. View access to your EHR to determine required elements of the medical record.
c. Will reach out to specialist offices to request care notes be sent to your medical records department, if needed.
d. Auditable records readily available.
e. Charged as a percent of net CE benefit

3. 340B Data Management Services

a. 340B ESP Data Submission includes submission of data on a bi-monthly basis. This encompasses generating data extracts from source systems, performing necessary file manipulations, such as NDC filtering, and ensuring the data is submitted on time.
b. 340B ESP Data Monitoring including monitoring and resolving issues arising from data submission. This encompasses ensuring all contracted pharmacies are in the appropriate and expected status within the 340B ESP platform and auditing contract loads at the wholesale level.
c. 340B ESP Data Analytics including aggregating and data analysis to provide a summarized quarterly report.
d. TPA Data File Creation including the generation of data files from source systems to meet the required specifications for the destination Third Party Administrator.
e. TPA Data File Automation including the creation of automated processes to generate the needed data files and submit them to the source systems for ingestion.
f. TPA Data File Maintenance including any needed file edits secondary to changes in the source or destination system to maintain continuous operation.
g. TPA Data File Monitoring including monthly verification of file transmission from source system and ingestion of file at destination system.
h. Monthly report of financial performance for each CE
i. Monthly review of outlier accumulations in the contract pharmacy space (both large positive accumulations and negative accumulations) and corrective action

taken as applicable..

2. The Services will also include any other consulting tasks which the Parties may agree on. The Consultant hereby agrees to provide such Services to the Client.

TERM OF AGREEMENT

3. The term of this Agreement (the "Term") will begin on the date of this Agreement and will remain in full force and effect until January 31, 2024 or for one year from start of agreement. The Term may be extended with the written consent of the Parties.

PERFORMANCE

4. The Parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

CURRENCY

5. Except as otherwise provided in this Agreement, all monetary amounts referred to in this Agreement are in USD (US Dollars).

COMPENSATION

6. The Consultant will charge the Client for the Services as follows (the "Compensation"):
    - The Client will pay the Consultant a monthly flat fee of $2600.00 and travel reimbursement will be billed at completion of annual onsite 340B audit. For Platinum Plan, the referral prescription capture service is billed at 10% of CE net benefit as defined in proposal.

7. Invoices submitted by the Consultant to the Client are due within 30 days of receipt.

8. In the event that this Agreement is terminated by the Client prior to completion of the Services but where the Services have been partially performed, the Consultant will be entitled to pro rata payment of the Compensation to the date of termination provided that there has been no breach of contract on the part of the Consultant.

9. The Consultant will not be reimbursed for any expenses incurred in connection with providing the Services of this Agreement.

INTEREST ON LATE PAYMENTS

10. Interest payable on any overdue amounts under this Agreement is charged at a rate of 2.00% per annum or at the maximum rate enforceable under applicable legislation, whichever is lower.

CONFIDENTIALITY

11. Confidential information (the "Confidential Information") refers to any data or information relating

to the business of the Client which would reasonably be considered to be proprietary to the Client including, but not limited to, accounting records, business processes, and client records and that is not generally known in the industry of the Client and where the release of that Confidential Information could reasonably be expected to cause harm to the Client.

12. The Consultant agrees that they will not disclose, divulge, reveal, report or use, for any purpose, any Confidential Information which the Consultant has obtained, except as authorized by the Client or as required by law. The obligations of confidentiality will apply during the Term and will survive indefinitely upon termination of this Agreement.

13. All written and oral information and material disclosed or provided by the Client to the Consultant under this Agreement is Confidential Information regardless of whether it was provided before or after the date of this Agreement or how it was provided to the Consultant.

OWNERSHIP OF INTELLECTUAL PROPERTY

14. All intellectual property and related material (the "Intellectual Property") that is developed or produced under this Agreement, will be the property of the Consultant. The Client is granted a non-exclusive limited-use license of this Intellectual Property.

15. Title, copyright, intellectual property rights and distribution rights of the Intellectual Property remain exclusively with the Consultant.

RETURN OF PROPERTY

16. Upon the expiration or termination of this Agreement, the Consultant will return to the Client any property, documentation, records, or Confidential Information which is the property of the Client.

CAPACITY/INDEPENDENT CONTRACTOR

17. In providing the Services under this Agreement it is expressly agreed that the Consultant is acting as an independent contractor and not as an employee. The Consultant and the Client acknowledge that this Agreement does not create a partnership or joint venture between them, and is exclusively a contract for service. The Client is not required to pay, or make any contributions to, any social security, local, state or federal tax, unemployment compensation, workers' compensation, insurance premium, profit-sharing, pension or any other employee benefit for the Consultant during the Term. The Consultant is responsible for paying, and complying with reporting requirements for, all local, state and federal taxes related to payments made to the Consultant under this Agreement.

AUTONOMY

18. Except as otherwise provided in this Agreement, the Consultant will have full control over working time, methods, and decision making in relation to provision of the Services in accordance with the Agreement. The Consultant will work autonomously and not at the direction

of the Client. However, the Consultant will be responsive to the reasonable needs and concerns of the Client.

EQUIPMENT

19. Except as otherwise provided in this Agreement, the Consultant will provide at the Consultant's own expense, any and all equipment, software, materials and any other supplies necessary to deliver the Services in accordance with the Agreement.

NO EXCLUSIVITY

20. The Parties acknowledge that this Agreement is non-exclusive and that either Party will be free, during and after the Term, to engage or contract with third parties for the provision of services similar to the Services.

NOTICE

21. All notices, requests, demands or other communications required or permitted by the terms of this Agreement will be given in writing and delivered to the Parties at the following addresses:

a. Mangum Regional Medical Center
1 Wickersham Drive; Mangum, OK 73554

b. Pharmacy Consultants, Inc. DBA 340B Compliance Partners
1310 Cove Lane Road; Roaring Spring, PA 16673

or to such other address as either Party may from time to time notify the other, and will be deemed to be properly delivered (a) immediately upon being served personally, (b) two days after being deposited with the postal service if served by registered mail, or (c) the following day after being deposited with an overnight courier.

INDEMNIFICATION

22. Except to the extent paid in settlement from any applicable insurance policies, and to the extent permitted by applicable law, each Party agrees to indemnify and hold harmless the other Party, and its respective directors, shareholders, affiliates, officers, agents, employees, and permitted successors and assigns against any and all claims, losses, damages, liabilities, penalties, punitive damages, expenses, reasonable legal fees and costs of any kind or amount whatsoever, which result from or arise out of any act or omission of the indemnifying party, its respective directors, shareholders, affiliates, officers, agents, employees, and permitted successors and assigns that occurs in connection with this Agreement. This indemnification will survive the termination of this Agreement.

ADDITIONAL CLAUSE

23. Consultant may agree to additional tasks outside scope of agreement for agreed upon fees, and

an amendment will be created to delineate those services.

MODIFICATION OF AGREEMENT

24. Any amendment or modification of this Agreement or additional obligation assumed by either Party in connection with this Agreement will only be binding if evidenced in writing signed by each Party or an authorized representative of each Party.

TIME OF THE ESSENCE

25. Time is of the essence in this Agreement. No extension or variation of this Agreement will operate as a waiver of this provision.

ASSIGNMENT

26. The Consultant will not voluntarily, or by operation of law, assign or otherwise transfer its obligations under this Agreement without the prior written consent of the Client.

ENTIRE AGREEMENT

27. It is agreed that there is no representation, warranty, collateral agreement or condition affecting this Agreement except as expressly provided in this Agreement.

ENUREMENT

28. This Agreement will enure to the benefit of and be binding on the Parties and their respective heirs, executors, administrators and permitted successors and assigns.

TITLES/HEADINGS

29. Headings are inserted for the convenience of the Parties only and are not to be considered when interpreting this Agreement.

GENDER

30. Words in the singular mean and include the plural and vice versa. Words in the masculine mean and include the feminine and vice versa.

GOVERNING LAW

31. This Agreement will be governed by and construed in accordance with the laws of the State of Oklahoma.

SEVERABILITY

32. In the event that any of the provisions of this Agreement are held to be invalid or unenforceable in whole or in part, all other provisions will nevertheless continue to be valid and enforceable with the invalid or unenforceable parts severed from the remainder of this Agreement.

WAIVER

33. The waiver by either Party of a breach, default, delay or omission of any of the provisions of this Agreement by the other Party will not be construed as a waiver of any subsequent breach of the same or other provisions.

IN WITNESS WHEREOF the Parties have duly affixed their signatures under hand and seal on this _____ day of _____, _____.

Mangum Regional Medical Center
Per: _____
Officer's Name: _____

Date:_____

Pharmacy Consultants, Inc. DBA 340B Compliance Partners
Per: _____ (Seal)
Officer's Name: _____

Date:_____

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. **Name of Contract:** Memorandum of Understanding
3. **Contract Parties: MRMC/Oklahoma Department of Mental Health and Substance Abuse Services**

4. **Contract Type Services:** MOU

5. **Impacted Hospital Departments: Hospital Pharmacy**

6. **Contract Summary:** To provide access to overdose reversal kits for distribution to persons of risk.

7. **Cost: None**

8. **Prior Cost: None**

9. **Term: The term of the Agreement shall remain in effect for 1 year from date of agreement and as funding allows.**
10.
11. **Termination Clause: None**

12. **Other:**

MEMORANDUM OF UNDERSTANDING
Between Mangum Regional Medical Center and
The Oklahoma Department of Mental Health and Substance Abuse Services

AGREEMENT TO PROVIDE OVERDOSE EDUCATION & NALOXONE DISTRIBUTION TRAINING & OVERDOSE REVERSAL KITS

This Agreement is entered into this _____ day of _____(Month), _____ (Year), by the **Mangum Regional Medical Center** (hereinafter referred to as "MHMC") and the Oklahoma Department of Mental Health and Substance Abuse Services (hereinafter referred to as "ODMHSAS") and will remain in effect for up to 1 year from this date as funding allows. This agreement may be terminated by either party by providing at least 30 days written notice.

Purpose and Objectives of Agreement/Project

This Agreement reflects the understanding of MHMC and ODMHSAS regarding the ODMHSAS's sponsorship of an overdose education and naloxone distribution (OEND) training course for MHMC and provision of overdose reversal kits. This Agreement will:

- Build a working relationship between the organizations with a common goal of reducing the number of opioid overdose injuries and deaths.
- Provide MHMC access to overdose reversal kits for distribution to persons at risk of witnessing or experiencing opioid overdose.
- Provide MHMC training in OEND.
- Provide MHMC appropriate forms for documenting the utilization of any other harm reduction tools provided by the ODMHSAS.

Responsibilities of ODMHSAS

1.) Sponsor and conduct OEND training courses as mutually agreed for MHMC staff.

2.) Provide all necessary equipment and materials for trainings.

3.) Provide MHMC appropriate access to data collection systems for documenting staff training and the distribution of each overdose reversal kit and/or other harm reductions tools; and technical assistance with integrating the service into the electronic medical record and billing systems for sustainability.

4.) Aid in the development of an overdose risk assessment and kit distribution workflow and provide naloxone for distribution to people at risk of experiencing or witnessing an overdose as determined by brief screening and/or known overdose injury.

Responsibilities of MRMC

1.) Properly train all identified personnel for the distribution of overdose reversal kits.

2.) Document the training of personnel and report into the ODMHSAS data collection system.

3.) Develop and adopt a workflow or policy for risk assessment, overdose education, and naloxone kit distribution for people at risk of experiencing or witnessing overdose.

4.) Distribute overdose reversal kits for their intended purposes.

5.) Document the distribution of each overdose reversal kit using the data collection system provided by the ODMHSAS; develop method to document services in electronic medical record and billing system for sustainability.

6.) Document the utilization/distribution of additional harm reduction tools using forms provided by the ODMHSAS and remit completed forms to the ODMHSAS for managing data.

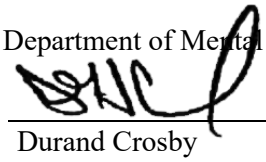
7.) Return all undistributed overdose reversal kits upon termination or expiration of this agreement to ODMHSAS.

8.) Identify methods to coordinate the project in accordance with all relevant laws/rules and sustain the project in the event the ODMHSAS is unable to renew the agreement.

Contact Personnel

- The ODMHSAS liaison for this Agreement is Gary Shepherd, (405) 985-9796, gary.shepherd@odmhsas.org
- The MHMC liaison for this Agreement is Kelley Martinez, (580) 782-3353, kmartinez@chmcok.com

Oklahoma Department of Mental Health and Substance Abuse Services

Signature:  Date: _____11/21/2023____

Durand Crosby

Title: Senior Deputy Commissioner

Mangum Regional Medical Center

Signature: _____ Date: _____

Print name: _____

Title: _____

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. **Name of Contract:** CliftonLarsonAllen LLP

3. **Contract Parties: MRMC/CliftonLarsonnAllen LLP**

4. **Contract Type Services:** Service Agreement

5. **Impacted Hospital Departments: Hospital Financials**

6. **Contract Summary:** Agreed upon Procedures for years 2018 and 2019

7. **Cost: $30,000.00 to $36,000.00 total for both years audits**

8. **Prior Cost: None**

9. **Term: The term of the Agreement shall be 5 years from 12/6/2023**

10. **Termination Clause: Agreement can be terminated with a 30-day written notice.**

11. **Other:**

CliftonLarsonAllen LLP
https://www.claconnect.com

Master Services Agreement

Mangum Regional Medical Center
2510 E. Independence, Suite 100, Shawnee, OK, 74804, USA
MSA Date: December 6, 2023

This master service agreement ("MSA") documents the terms, objectives, and the nature and limitations of the services CliftonLarsonAllen LLP ("CLA," "we," "us," and "our") will provide for Mangum Regional Medical Center ("you," or "your"). The terms of this MSA will apply to the initial and each subsequent statement of work ("SOW"), unless the MSA is changed in a communication that you and CLA both sign or is terminated as permitted herein.

1. Scope of Professional Services

CLA will provide services as described in one or more SOW that will reference this MSA. The SOW will describe the scope of professional services; the nature, limitations, and responsibilities related to the specific services CLA will provide; and the fees for such services.

If modifications or changes are required during CLA's performance of requested services, or if you request that we perform any additional services, we will provide you with a separate SOW for your signature. Such SOW will advise you of the additional fee and time required for such services to facilitate a clear understanding of the services.

Our services cannot be relied upon to disclose all errors, fraud, or noncompliance with laws and regulations. Except as described in the scope of professional services section of this MSA or any applicable SOW, we have no responsibility to identify and communicate deficiencies in your internal controls as part of any services.

2. Management responsibilities

You acknowledge and understand that our role is to provide the services identified in an SOW and that management, and any other parties engaging CLA, have responsibilities that are fundamental to our undertaking to perform the identified services.

3. Fees and terms

See the applicable SOW for the fees for the services.

Work may be suspended if your account becomes 60 days or more overdue and will not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagements will be deemed to have been completed even if we have not completed the services. You

will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

Payments may be made utilizing checks, Bill.com, your online banking platform, CLA's electronic payment platform, or any other client-initiated payment method approved by CLA. CLA's electronic online bill pay platform claconnect.com/billpay accepts credit card and Automated Clearing House (ACH) payments. Instructions for you to make direct bank to bank wire transfers or ACH payments will be provided upon request.

4. Other Fees

You agree to compensate us for reasonable time and expenses, including time and expenses of outside legal counsel, we may incur in responding to a subpoena, a formal third-party request for records or information, or participating in a deposition or any other legal, regulatory, or other proceeding relating to services we provide pursuant to a SOW.

5. Finance charges and collection expenses

You agree that if any statement is not paid within 30 days from its billing date, the unpaid balance shall accrue interest at the monthly rate of one and one-quarter percent (1.25%), which is an annual percentage rate of 15%. In the event that any collection action is required to collect unpaid balances due us, reasonable attorney fees and expenses shall be recoverable.

6. Dispute Resolution

Any disagreement, controversy, or claim ("Dispute") that may arise out of any aspect of our services or relationship with you shall be submitted to non-binding mediation by written notice ("Mediation Notice") to the other party. In mediation, we will work with you to resolve any differences voluntarily with the aid of an impartial mediator.

The mediation will be conducted as specified by the mediator and agreed upon by the parties (i.e., you and CLA). The parties agree to discuss their differences in good faith and to attempt, with the assistance of the mediator, to reach an amicable resolution of the Dispute.

Each party will bear its own costs in the mediation. The fees and expenses of the mediator will be shared equally by the parties.

7. Limitation of remedies

These limitation of remedies provisions are not applicable for any audit or examination services provided to you.

Our role is strictly limited to the services described in an SOW, and we offer no assurance as to the results or ultimate outcomes of any services or of any decisions that you may make based on our communications with you. You agree that it is appropriate to limit the liability of CLA, its partners, principals, directors, officers, employees, and agents (each a "CLA party").

You further agree that you will not hold CLA or any other CLA party liable for any claim, cost, or damage, whether based on warranty, tort, contract, or other law, arising from or related to this MSA,

the services provided under an SOW, the work product, or for any plans, actions, or results of an SOW, except to the extent authorized by this MSA. In no event shall any CLA party be liable to you for any indirect, special, incidental, consequential, punitive, or exemplary damages, or for loss of profits or loss of goodwill, costs, or attorney fees.

The exclusive remedy available to you shall be the right to pursue claims for actual damages that are directly caused by acts or omissions that are breaches by a CLA party of our duties owed under this MSA and the specific SOW thereunder, but any recovery on any such claims shall not exceed the fees actually paid by you to CLA pursuant to the SOW that gives rise to the claim.

8. Governing Laws, Jurisdiction, and Venue

The MSA is made under and shall be governed by the laws of the state of Minnesota, without giving effect to choice-of-law principles. This includes dispute resolution and limitation of remedies.

9. Time limitations

The nature of our services makes it difficult, with the passage of time, to gather and present evidence that fully and fairly establishes the facts underlying any dispute that may arise between you and any CLA party. The parties (you and CLA) agree that, notwithstanding any statute or law of limitations that might otherwise apply to a dispute, including one arising out of this MSA or the services performed under an SOW, for breach of contract or fiduciary duty, tort, fraud, misrepresentation or any other cause of action or remedy, any action or legal proceeding by you against any CLA party must be commenced as provided below, or you shall be forever barred from commencing a lawsuit or obtaining any legal or equitable relief or recovery. An action to recover on a dispute shall be commenced within these periods ("Limitation Period"), which vary based on the services provided, and may be modified as described in the following paragraph:

Service	Time after the date we deliver the services or work product*
Tax Consulting Services	36 months
Tax Return Preparation	36 months
Examination, compilation, and preparation services related to prospective financial statements	12 months
Audit, review, examination, agreed-upon procedures, compilation, and preparation services other than those related to prospective financial information	24 months
All Other Services	12 months

* pursuant to the SOW on which the dispute is based

If the MSA is terminated or your ongoing relationship with CLA is terminated, then the applicable Limitation Period is the lesser of the above periods or 12 months after termination of MSA or your ongoing relationship with CLA. The applicable Limitation Period applies and begins to run even if you have not suffered any damage or loss, or have not become aware of the existence or possible existence of a dispute.

10. Confidentiality

Except as permitted by the "Consent" section of this MSA, CLA will not disclose any of your confidential, proprietary, or privileged information to any person or party, unless you authorize us to do so, it is published or released by you, it becomes publicly known or available other than through disclosure by us, or disclosure is required by law, regulation, or professional standard. This confidentiality provision does not prohibit us from disclosing your information to one or more of our affiliated companies in order to provide services that you have requested from us or from any such affiliated company. Any such affiliated company shall be subject to the same restrictions on the use and disclosure of your information as apply to us. You also consent to our disclosure of information regarding the nature of services we provide to you to another independent network member of CLA Global, for the limited purpose of complying with professional obligations regarding independence and conflicts of interest.

The Internal Revenue Code contains a limited privilege for confidentiality of tax advice between you and our firm. In addition, the laws of some states likewise recognize a confidentiality privilege for some accountant-client communications. You understand that CLA makes no representation, warranty or promise, and offers no opinion with respect to the applicability of any confidentiality privilege to any information supplied or communications you have with us, and, to the extent that we follow instructions from you to withhold such information or communications in the face of a request from a third party (including a subpoena, summons or discovery demand in litigation), you agree to hold CLA harmless should the privilege be determined not to apply to particular information or communications.

The workpapers and files supporting the services we perform are the sole and exclusive property of CLA and constitute confidential and proprietary information. We do not provide access to our workpapers and files to you or anyone else in the normal course of business. Unless required by law or regulation to the contrary, we retain our workpapers and files in accordance with our record retention policy that typically provides for a retention period of seven years. After this period expires, our workpapers and files will be destroyed. Furthermore, physical deterioration or catastrophic events may shorten the time our records are available. The workpapers and files of our firm are not a substitute for your records.

Pursuant to authority given by law, regulation, or professional standards we may be requested to make certain workpapers and files available to a regulator for its regulatory oversight purposes. We will notify you of any such request, if permitted by law. Access to the requested workpapers and files will be provided to the regulator under the supervision of CLA personnel and at a location designated by our firm. Furthermore, upon request, we may provide copies of selected workpapers and files to such regulator. The regulator may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

11. Other provisions

You agree that CLA will not be assuming any fiduciary responsibility on your behalf during the course of this MSA, except as may be assumed in an SOW.

CLA may, at times, utilize external web applications to receive and process information from our clients; however, any sensitive data, including protected health information and personally identifiable information, must be redacted by you to the maximum extent possible prior to uploading the document or file. In the event that you are unable to remove or obscure all sensitive data, please contact us to discuss other potential options for transmitting the document or file.

CLA and certain owners of CLA are licensed by the California State Board of Accountancy. However, CLA has owners not licensed by the California State Board of Accountancy who may provide services under this MSA. If you have any questions regarding licensure of the personnel performing services under this MSA, please do not hesitate to contact us.

During the course of the engagement, there may be communication via fax or email. You are responsible to ensure that communications received by you or your personnel are secured and not shared with unauthorized individuals.

12. HIPAA Business Associate Agreement

To protect the privacy and provide for the security of any protected health information, as such is defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the regulations and policy guidances thereunder (HIPAA), we acknowledge that Mangum Regional Medical Center and CLA have entered into a HIPAA Business Associate Agreement (BAA) as attached hereto as Exhibit 1. If the attached HIPAA Business Associate Agreement is acceptable but has not yet been executed, please sign, date, and return it to us.

13. Consent to use financial information

We regularly aggregate anonymized client data and perform a variety of analyses using that aggregated data. Some of these analyses are published to clients or released publicly. However, we are always careful to preserve the confidentiality of the separate information that we obtain from each client, as required by the AICPA Code of Professional Conduct and various laws. Your acceptance of this MSA will serve as your consent to our use of Mangum Regional Medical Center anonymized data in performing and reporting on these cost comparison, performance indicator and/or benchmarking analyses.

Unless authorized by law or the client consents, we cannot use a client's tax return information for purposes other than the preparation and filing of the client's tax return. By signing and dating this MSA, you authorize CLA to use any and all information furnished to CLA for or in connection with the preparation of the tax returns under this MSA, for a period of up to six (6) years from the date of this MSA, in connection with CLA's preparation of the types of reports described in the foregoing paragraph.

14. Consent to send you publications and other materials

For your convenience, CLA produces a variety of publications, hard copy and electronic, to keep you

informed about pertinent business and personal financial issues. This includes published articles, invitations to upcoming seminars, webinars and webcasts, newsletters, surveys, and press releases. To determine whether these materials may be of interest to you, CLA will need to use your tax return information. Such tax information includes your name and address as well as the business and financial information you provided to us.

By signing and dating this MSA, you authorize CLA to use the information that you provide to CLA during the preparation of your tax returns to determine whether to offer you relevant materials. Your consent is valid until further notice.

15. Subcontractors

CLA may, at times, use subcontractors to perform services under this MSA, and they may have access to your information and records. Any such subcontractors will be subject to the same restrictions on the use of such information and records as apply to CLA under this MSA.

16. Technology

CLA may, at times, use third-party software applications to perform services under this MSA. You acknowledge the software vendor may have access to your data.

17. Termination of MSA

This MSA shall continue for five years from December 6, 2023, unless terminated earlier by giving appropriate notice. Either party may terminate this MSA at any time by giving 30 days written notice to the other party.

Upon termination of the MSA, the provisions of this MSA shall continue to apply to all services rendered prior to termination.

18. Agreement

We appreciate the opportunity to be of service to you and believe this MSA accurately summarizes the significant terms of our relationship. This MSA, along with the applicable addendum(s) and SOW(s), constitute the entire agreement regarding services to be performed and supersedes all prior agreements (whether oral or written), understandings, negotiations, and discussions between you and CLA. If you have any questions, please let us know. If you agree with the terms of our relationship as described in this MSA, please sign, date, and return.

CliftonLarsonAllen LLP
Greg Thelen
Principal
612-397-3043
greg.thelen@claconnect.com

Response:

This MSA correctly sets forth the understanding of Mangum Regional Medical Center.

CLA
CLA

Greg Thelen, Principal

SIGNED 12/13/2023, 11:18:41 AM CST

Client
Mangum Regional Medical Center

SIGN:

Kelley Martinez

DATE:

HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is made by and between Mangum Regional Medical Center (hereinafter referred to as "Client") and CliftonLarsonAllen LLP (hereinafter referred to as "CLA"). This Agreement is effective as of the date signed by Client.

RECITALS

WHEREAS, Client is a "covered entity" within the meaning of 45 CFR § 160.103;

WHEREAS, CLA provides accounting, consulting, or other services to Client and, in connection therewith, Client wishes to disclose "protected health information" within the meaning of 45 CFR § 160.103 to CLA and CLA wishes to receive protected health information and, on behalf of Client, create, maintain, or transmit protected health information (collectively, "Client's PHI");

WHEREAS, CLA is a "business associate" within the meaning of 45 CFR § 160.103;

WHEREAS, Client and CLA intend to protect the privacy and provide for the security of Client's PHI in compliance with the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the regulations and policy guidance thereunder ("HIPAA Rules");

WHEREAS, the HIPAA Rules require that Client receive adequate assurances that CLA will comply with certain obligations with respect to Client's PHI and, accordingly, the parties hereto desire to enter into this Agreement for the purpose of setting forth in writing the terms and conditions for the use, disclosure, and safeguarding of Client's PHI, including provisions required by the HIPAA Rules as the same may be amended from time to time;

NOW, THEREFORE, in consideration of the foregoing recitals and mutual covenants herein contained and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

TERMS OF AGREEMENT

1. Obligations and Activities of CLA

a. Permitted and Required Uses and Disclosures.
CLA shall not use or disclose Client's PHI except as permitted or required by this Agreement or as required by law. Specifically, CLA agrees as follows:

i. CLA may only use or disclose Client's PHI as necessary to perform the services set forth in the service agreement, if any, between Client and CLA, to perform functions, activities, or services for, or on behalf of, Client as requested by Client from time to time, or as required by law.

ii. CLA shall use or disclose only the "Minimum Necessary" amount of information, as such term is defined in the HIPAA Rules, required to conduct the authorized activities herein, except that CLA will limit disclosures to a limited data set as set forth in 45 CFR § 164.514(e)(2) as required by the HIPAA Rules.

iii. CLA may not use or disclose Client's PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by Client, except that CLA may use or disclose Client's PHI for the proper management and administration of CLA or to carry out the legal responsibilities of CLA, provided the use or disclosures are required by law or CLA obtains reasonable assurances from the person to whom the information is disclosed that Client's PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies CLA of any instances of which it is aware in which the confidentiality of Client's PHI has been breached.

iv. CLA may use Client's PHI to provide "data aggregation services" relating to the health care operations of Client within the meaning of 45 CFR § 164.501.

v. CLA shall not disclose Client's PHI in a manner that would violate any restriction thereof which has been duly communicated to CLA.

vi. Except as permitted by the HIPAA Rules, CLA shall not directly or indirectly receive remuneration in exchange for any of Client's PHI unless authorized in writing by Client.

b. Safeguards

CLA shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of Client's PHI other than as provided in this Agreement.

i. Administrative Safeguards.

CLA shall implement all required administrative safeguards pursuant to 45 CFR § 164.308 as such are made applicable to business associates pursuant to the HIPAA Rules. Additionally, CLA shall either implement or properly document the reasons for non-implementation of all administrative safeguards of 45 CFR § 164.308 that are designated as "addressable" as such are made applicable to business associates pursuant to the HIPAA Rules.

ii. Physical Safeguards.

CLA shall implement all required physical safeguards pursuant to 45 CFR § 164.310 as such are made applicable to business associates pursuant to the HIPAA Rules. Additionally, CLA shall either implement or properly document the reasons for non-implementation of all physical safeguards of 45 CFR § 164.310 that are designated as "addressable" as such are made applicable to business associates pursuant to the HIPAA Rules.

iii. Technical Safeguards.

CLA shall implement all required technical safeguards pursuant to 45 CFR § 164.312 as such are made applicable to business associates pursuant to the HIPAA Rules. Additionally, CLA shall either implement or properly document the reasons for non-implementation of all technical safeguards of 45 CFR § 164.312 that are designated as "addressable" as such are made applicable to business associates pursuant to the HIPAA Rules.

c. Reporting of Disclosures

CLA shall report to Client any use or disclosure of Client's PHI not provided for by this Agreement of which CLA becomes aware, including any acquisition, access, use or disclosure (i.e., "breach") of "unsecured protected health information," within the meaning of 45 CFR § 164.403, and any security incident of which CLA becomes aware. CLA shall make such report to Client without unreasonable delay and in no case later than sixty (60) calendar days following discovery of the breach. CLA's notice to Client shall include all information needed by Client to provide notice to affected individuals and otherwise satisfy the requirements of 45 CFR § 164.410.

d. CLA's Subcontractors.

CLA may disclose Client's PHI to one or more subcontractors and may allow its subcontractors to create, receive, maintain, or transmit Client's PHI on behalf of CLA. CLA shall obtain satisfactory assurances from any such subcontractor that it will appropriately safeguard Client's PHI in accordance with 45 CFR § 164.314(a) and shall ensure that the subcontractor agrees in writing to the same or more stringent restrictions, conditions, and requirements that apply to CLA with respect to Client's PHI. Upon CLA contracting with a subcontractor regarding Client's PHI, CLA shall provide Client written notice of such executed agreement and copy of agreement.

e. Satisfying Requests for Access.

CLA shall make available to Client Client's PHI in a "designated record set," within the meaning of 45 CFR § 164.501, as Client may require to satisfy its obligations to respond to a request for access pursuant to 45 CFR § 164.524. If CLA receives a request for access directly from an individual or an individual's designee, CLA shall forward such request within five (5) calendar days to Client for Client to fulfill. Alternatively, if directed by Client and agreed to by CLA, CLA shall make available to the individual or the individual's designee Client's PHI in a designated record set, as necessary to satisfy the requirements of 45 CFR § 164.524. CLA shall provide such access within thirty (30) calendar days of receiving a request for access and shall confirm to Client in writing that such request has been fulfilled.

f. Satisfying Requests for Amendment.

CLA shall make any amendments to Client's PHI in a designated record set, as Client may require to satisfy its obligations to respond to a request for amendment pursuant to 45 CFR § 164.526. If CLA receives a request for amendment directly from an individual or an individual's designee, CLA shall forward such request within ten (10) calendar days to Client for Client to fulfill. Alternatively, if directed by Client and agreed to by CLA, CLA shall make an amendment

to Client's PHI in a designated record set, as necessary to satisfy the requirements of 45 CFR § 164.526. CLA shall make such amendment within sixty (60) calendar days of receiving a request for amendment and shall confirm to Client in writing that such request has been fulfilled.

g. Internal Practices.
CLA shall make its internal practices, books and records relating to the use and disclosure of Client's PHI available to the Secretary of the United States Department of Health and Human Services or his or her designee for purposes of determining compliance with the HIPAA Rules.

h. Accounting.
CLA shall document disclosures of Client's PHI and information related to such disclosures and otherwise maintain and make available the information required to provide an accounting of disclosures to the Client as necessary to permit the Client to respond to a request for an accounting pursuant to 45 CFR § 164.528. If CLA receives a request for an accounting directly from an individual or an individual's designee, CLA shall forward such request within ten (10) calendar days to Client for Client to fulfill. Alternatively, if directed by Client and agreed to by CLA, CLA shall provide an accounting as necessary to satisfy the requirements of 45 CFR § 164.528. CLA shall satisfy such request within sixty (60) calendar days of receiving a request for an accounting and shall confirm to Client in writing that such request has been fulfilled.

i. Policies and Procedures; Documentation.
CLA shall develop appropriate policies and procedures relating to its compliance with the administrative, physical, and technical safeguards set forth in Section 1.b. and shall document, retain, and update such policies and procedures as required by 45 CFR § 164.316.

j. Compliance as if Covered Entity.
To the extent CLA is to carry out one or more of the obligations imposed on the Client as a "covered entity" under Subpart E of 45 CFR Part 164, CLA shall comply with the requirements of said Subpart E that apply to the Client in the performance of such obligations.

2. Client Obligations.
Client shall provide notice to CLA of any of the following:

a. Any limitations in the notice of privacy practices of Client under 45 CFR § 164.520, as well as any changes to such limitations, to the extent that such limitation may affect CLA's use or disclosure of Client's PHI.

b. Any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect CLA's use or disclosure of Client's PHI.

c. Any restriction on the use or disclosure of protected health information that Client has agreed to or is required to abide by under 45 CFR § 164.522, to the extent that such restriction may affect CLA's use or disclosure of Client's PHI.

Client shall not request CLA to use or disclose Client's PHI in any manner that would not be permissible under the HIPAA Rules if done by Client, except that Client may request CLA to provide to Client "data aggregation services" relating to the health care operations of the Client within the meaning of 45 CFR § 164.501, as permitted by 45 CFR § 164.504(e)(2)(i)(B).

3. Termination of Agreement

a. This Agreement shall terminate on the earliest to occur of the date either party terminates the Agreement "for cause," as described in Section 3.b., the date CLA terminates as described in Section 3c., or pursuant to Section 5 upon either party's failure to negotiate or enter into an amendment to this Agreement.

b. Termination for Cause.
A breach of any provision of this Agreement by either party, as determined by the non-breaching party, shall constitute a material breach of the Agreement and shall provide grounds for termination of the Agreement for cause if the breaching party is unable to cure such breach to the other party's satisfaction within ten (10) days following written notice of such breach. The breaching party shall cooperate with the other party as necessary to mitigate the extent of any unauthorized disclosures of Client's PHI or any damages or potential damages and liability under the HIPAA Rules caused by any violation of this Agreement or other unauthorized use of Client's PHI.

c. Termination by CLA.
Upon thirty (30) days' advance written notice, CLA shall have the right to terminate this Agreement if Client imposes additional restrictions or requirements regarding the use, disclosure, or maintenance of Client's PHI that CLA reasonably determines will materially affect CLA's ability to perform its responsibilities under this Agreement or will materially increase CLA's costs to perform its responsibilities under this Agreement.

4. Treatment of Client's PHI after Termination.
Upon termination of this Agreement for any reason, CLA, with respect to Client's PHI, shall:

a. Retain only that portion of Client's PHI which is necessary for CLA to continue its proper management and administration or to carry out its legal responsibilities;

b. Return to Client or, if agreed to by Client, destroy remaining Client's PHI that CLA still maintains in any form and retain no copies of such Client's PHI;

c. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of Client's PHI, other than as provided for in this Section, for as long as CLA retains any Client's PHI;

d. Not use or disclose Client's PHI retained by CLA other than for the purposes for which Client's PHI was retained and subject to the same conditions, as set forth in Section 2, which applied prior to termination;

e. Return to Client or, if agreed to by Client, destroy remaining Client's PHI retained by CLA when it is no longer needed by CLA for its proper management and administration or to carry out its legal responsibilities and retain no copies of such Client's PHI;

f. Obtain or ensure the destruction of any Client's PHI created, received, or maintained by any of CLA's subcontractors; and

g. Within thirty (30) calendar days after termination of this Agreement, certify in a written statement signed by a senior officer of CLA, that all Client's PHI has been returned or disposed of as required above.

If the parties mutually agree that return or destruction is not feasible, this Agreement shall continue to apply to Client's PHI and, without limitation to the foregoing, the obligations of CLA under this Agreement shall survive the termination of this Agreement with respect to any Client's PHI retained by CLA. CLA shall limit further use and disclosure of Client's PHI to those purposes that make the return or destruction of Client's PHI infeasible.

5. Amendment to Comply with Law.

The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties agree to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the HIPAA Rules or other applicable law upon the written request of either party. Either party may terminate this Agreement upon thirty (30) days' written notice in the event (i) the other party does not promptly enter into negotiations to amend this Agreement upon the request of the party giving notice or (ii) the other party fails to execute an amendment to this Agreement upon the request of the party giving notice.

6. No Third Party Beneficiaries.

Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Client, CLA, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

7. Indemnification.

Client shall indemnify, hold harmless, and defend (with counsel of CLA's choosing) CLA, its subsidiaries, affiliates, partners, and employees from and against all claims, suits, administrative proceedings, demands, losses, damages, or penalties, including reasonable attorneys' fees, arising out of Client's misuse or improper disclosure of Client's PHI, breach of this Agreement, or violation of the HIPAA Rules or any other law or regulation.

8. Interpretation.

This Agreement shall be interpreted as broadly as necessary to implement and comply with the HIPAA Rules. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules. There shall be no presumption for or against either party, by reason of one of the parties causing this Agreement to be drafted, with respect

to the interpretation or enforcement of this Agreement.

9. Notices.

All notices and other communications required or permitted hereunder or necessary or convenient in connection herewith shall be in writing and shall be deemed to have been given when hand delivered or mailed by registered or certified mail, as follows (provided that notice of change of address shall be deemed given only when received):

If to Client:
Mangum Regional Medical Center
2510 E. Independence, Suite 100, Shawnee, OK, 74804, USA
Attention: Kelley Martinez

If to CLA:
CliftonLarsonAllen LLP
220 South Sixth Street, Suite 300
Minneapolis, MN 55402-1436
Attention: Legal

or to such other names or addresses as Client or CLA, as the case may be, shall designate by notice to the other in the manner specified in this Section 9.

10. Survival.

The obligations contained in this Agreement which by their nature or context survive or are expressly intended to survive the termination of this Agreement will so survive and continue in full force and effect. Without limiting the generality of the foregoing, Sections 2, 4, and 7 shall survive the termination of this Agreement.

11. Severability.

If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid, illegal, or unenforceable, the remaining provisions of this Agreement shall remain in full force, if the essential terms and conditions of this Agreement for each party remain valid, binding, and enforceable.

12. Entire Agreement.

This Agreement constitutes the entire agreement between the parties on the matters contained herein. All prior and contemporaneous negotiations and agreements between the parties on the matters contained in this Agreement are superseded by this Agreement.

13. Non-Waiver.

No failure or delay in exercising any right or remedy under this Agreement and no course of dealing between the parties operates as a waiver or estoppel of any right, remedy, or condition. A waiver made in writing on one occasion is effective only in that instance and only for the purpose that it is given and is not to be construed as a waiver on any future occasion.

14. Governing Law.

This Agreement shall be governed, construed, and interpreted in accordance with the laws of the State of Minnesota without regard to such state's conflict of laws provisions.

Signatures

IN WITNESS WHEREOF, the parties have signed this Agreement.

CLA
CLA

Greg Thelen, Principal

SIGNED 12/13/2023, 11:18:50 AM CST

Client
Mangum Regional Medical Center

SIGN:

Kelley Martinez

DATE:

CliftonLarsonAllen LLP
https://www.claconnect.com

Statement of Work - Agreed-upon Procedures

December 13, 2023

This document constitutes a statement of work ("SOW") under the master service agreement ("MSA") dated December 6, 2023, or superseding MSA, made by and between CliftonLarsonAllen LLP ("CLA," "we," "us," and "our") and Mangum Regional Medical Center ("you," "your," or "the entity"). We are pleased to confirm our understanding of the terms and objectives of our engagement and the nature and limitations of the services CLA will provide for the entity as of and for the years ended December 31, 2018 and 2019.

Greg Thelen is responsible for the performance of the agreed-upon procedures engagement.

Scope, objective, and responsibilities
We will apply the agreed-upon procedures which Mangum Regional Medical Center has specified and agreed to, listed in the attached schedule, to procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits of Mangum Regional Medical Center as of or for the years ended December 31, 2018 and 2019. Mangum Regional Medical Center is responsible for procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits.

Our engagement to apply agreed-upon procedures will be conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require us to be independent of the entity or responsible party, as applicable, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our engagement. Mangum Regional Medical Center agrees to and acknowledges the procedures performed or to be performed are appropriate for the intended purpose of satisfy the requirements in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits. The intended users of the agreed-upon procedures report is the State of Oklahoma. Intended users in addition to Mangum Regional Medical Center will be requested to agree to the procedures and acknowledge that the procedures performed are appropriate for the intended purpose. Consequently, we make no representation regarding the appropriateness of the procedures enumerated in the attached schedule either for the purpose for which this report has been requested or for any other purpose. The intended users assume the risk that such procedures might be inappropriate for the intended purpose and the risk that they might misunderstand or otherwise inappropriately use findings properly reported by CLA.

This engagement is performed pursuant to regulation.

Our responsibility is to perform the specified procedures and report the findings in accordance with the attestation standards. For purposes of reporting findings, you specified a threshold of $0.00 for reporting exceptions. Because the agreed-upon procedures listed in the attached schedule do not constitute an examination, audit, or review, we will not express an opinion or conclusion on procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits or the Mangum Regional Medical Center's financial statements or any elements, accounts, or items thereof. Also, we will not express an opinion or conclusion on the effectiveness of Mangum Regional Medical Center's internal control over financial reporting or any part thereof. In addition, we have no obligation to perform any procedures beyond those listed in the attached schedule.

At the conclusion of the engagement, you agree to provide a written representation letter that includes your agreement and acknowledgement that the procedures performed are appropriate for the intended purpose of the engagement and, if applicable, that you have obtained from necessary other parties their agreement to the procedures and acknowledgement that the procedures performed are appropriate for their purposes.

We will issue a written report upon completion of our engagement that lists the procedures performed and our findings. This report is intended solely for the information and use of State of Oklahoma, and should not be used by anyone other than the specified parties. If, for any reason, we are unable to complete the procedures, we will describe any restrictions on the performance of the procedures in our report, or will not issue a report and withdraw from this engagement. Our report will include a statement indicating that had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

An agreed-upon procedures engagement is not designed to detect instances of fraud or noncompliance with laws or regulations; however, we will communicate to you any known and suspected fraud and noncompliance with laws or regulations affecting the procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits that come to our attention, unless they are clearly inconsequential. In addition, if, in connection with this engagement, matters come to our attention that contradict the procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits, we will disclose those matters in our report. Such disclosures, if any, may not necessarily include all matters that might have come to our attention had we performed additional procedures or an examination or review.

Management is responsible for providing us with (1) access to all information of which you are aware that is relevant to the procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits and the agreed-upon procedures, such as records, documentation, and other matters, and for the accuracy and completeness of that information; (2) additional information that we may request for the purpose of performing the agreed-upon procedures; and (3) unrestricted access to persons within the entity from whom we determine it necessary to obtain evidence relating to performing the procedures. You agree to inform us of events occurring or facts discovered subsequent to the date of the procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter 4- Uses and Trusts, Section 180.1- Annual Audits that may affect the procedures as outlined in accordance with Oklahoma Statutes Citationized, Tile 60. Property, Chapter

4- Uses and Trusts, Section 180.1- Annual Audits.

Engagement administration and other matters
A list of information we expect to need for the engagement and the dates required will be provided in a separate communication.

CLA will not disclose any of your confidential, proprietary, or privileged information to any persons without the authorization of your management or unless required by law. This confidentiality provision does not prohibit us from disclosing your information to one or more of our affiliated companies in order to provide services that you have requested from us or from any such affiliated company. Any such affiliated company shall be subject to the same restrictions on the use and disclosure of your information as apply to us.

Our engagement ends on delivery of our signed report. Any additional services that might be requested will be a separate, new engagement. The terms and conditions of that new engagement will be governed by a new, specific SOW for that service.

Fees
We estimate that our professional fees will range from $30,000.00 to $36,000.00. We will also bill for expenses (including travel, other costs such as report production, word processing, postage, etc., and internal and administrative charges) plus a technology and client support fee of five percent (5%) of all professional fees billed. This estimate is based on anticipated cooperation from your personnel and their assistance with locating requested documents and preparing requested schedules. If the requested items are not available on the dates required or are not accurate, the fees and expenses will likely be higher. Our invoices, including applicable state and local taxes, will be rendered each month as work progresses and are payable on presentation.

Agreement
We appreciate the opportunity to be of service to you and believe this SOW accurately summarizes the significant terms of our engagement. This SOW constitutes the entire agreement regarding these services and supersedes all prior agreements (whether oral or written), understandings, negotiations, and discussions between you and CLA. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this SOW, please sign, date, and return the enclosed copy to us.

Sincerely,

CliftonLarsonAllen LLP

CLA
CLA

Greg Thelen, Principal

SIGNED 12/13/2023, 11:14:51 AM CST

Client
Mangum Regional Medical Center

SIGN:

Kelley Martinez

DATE:

Procedures in accordance with Oklahoma Statutes Citationized, Title 60. Property, Chapter - Uses and Trusts, Section 180.1- Annual Audits

1.) Prepare a schedule of revenues, expenditures/expenses and changes in fund balances/net assets for each fund and determine compliance with any applicable trust or other prohibitions for creating fund balance deficits;

2.) Agree material bank account balances to bank statements, and trace significant reconciling items to subsequent clearance;

3.) Compare uninsured deposits to fair value of pledged collateral;

4.) Compare use of material☒ restricted revenues and resources to their restrictions;

5.) Determine compliance with requirements for separate funds; and

6.) Determine compliance with reserve account and debt service coverage requirements of bond indentures.

LifeShare Network

4705 NW Expressway • Oklahoma City, OK 73132
405.840.5551 • Fax 405.840.9748
LifeShareNetwork.org

December 27, 2023

Kelley Martinez
Hospital Administrator
Mangum Regional Medical Center
1 Wickersham Drive
Mangum, OK 73554

Re: New Organ and Tissue Donor Agreements

Dear Sir or Madam,

I hope that this email finds you well. My thanks to you, on behalf of all of us at LifeShare, for your support of organ and tissue donation in the state of Oklahoma. Thanks to your hospital's collaboration with LifeShare, Oklahoma is among not only the nation's but the world's leaders in lives saved and touched by donation.

The end of the year represents a time for renewal of agreements between your hospital and LifeShare as your CMS-designated organ procurement organization. With this cycle, we are also taking the opportunity to reflect LifeShare's restructuring with the creation of LifeShare Tissue Services and the separation of organ and tissue recovery services into two parallel, collaborative organizations. As a result, you will find attached or enclosed the following:

- An OPO/Donor Hospital agreement between your hospital and LifeShare Transplant Donor Services of Oklahoma which meets all CMS requirements for both of our organizations.

- A tissue recovery agreement between LifeShare Tissue Services, our non-profit tissue recovery organization, and your hospital which again meets all applicable requirements.

Please review, complete contact information, sign and return to my attention at LifeShare. If you have any questions, please reach out to your LifeShare Hospital Liaison, to Kim Gillespie who is LifeShare's Director of Hospital Development and Family Services, or to me.

LifeShare Network

LifeShareNetwork.org

In closing, thank you again for your support. As a result of you and your colleagues throughout the state as well as the generosity of Oklahoma's donor families, LifeShare each year is able to coordinate in excess of 600 lifesaving organ transplants and tissue donations which touch nearly 80,000 lives.

Sincerely,

Jeffrey P. Orlowski
President and Chief Executive Officer

ORGAN RECOVERY AGREEMENT

This ORGAN RECOVERY AGREEMENT (this "**Agreement**") is made and entered into effective as of January 1, 2024 (the "**Effective Date**"), between Mangum Regional Medical Center with its principal place of business at 1 Wickersham Drive, Mangum, OK 73554 ("**Hospital**") and LifeShare Transplant Donor Services of Oklahoma, Inc., an Oklahoma not-for-profit 501(c)(3) corporation, with its principal place of business at 4705 NW Expressway, Oklahoma City, Oklahoma 73132-5213, ("**LifeShare**"), with respect to the following circumstances:

WHEREAS, LifeShare, being the Organ Procurement Organization ("**OPO**") designated by the Secretary of the Department of Health and Human Services for procurement of transplantable organs in Oklahoma,

WHEREAS, Hospital, being required by 42 CFR Part 482.45 (the "**COP**"), to have a written agreement with an OPO to notify the OPO designated by the Secretary of the Department of Health and Human Services or third party designated by LifeShare, in a timely manner, of individuals for whom death is imminent or who have died at Hospital,

WHEREAS, Hospital and LifeShare, desiring to facilitate the procurement of organs for transplantation and are committed to maximizing donation from suitable donors,

NOW THEREFORE, Hospital and LifeShare do agree as follows:

Section 1: Definitions

1.1 Imminent Death: Imminent Death occurs: a) when a patient is on a ventilator with Glasgow Coma Score ("**GCS**") of five (5) or less and no sedation or paralytics, b) when a brain death test is ordered on a patient, c) immediately prior to decelerating care or withdrawal of support on a ventilator patient, and/or d) when a patient experiences cardiac death.

1.2 Timely Referral: A referral by a Hospital is considered timely when made within sixty (60) minutes of determination that a patient meets clinical triggers for imminent death as described in Section 1.1 above.

Section 2: Responsibilities of Hospital

2.1 Make a timely referral of all patients meeting clinical triggers for imminent death using the toll-free referral number (800) 241-4483;

2.2 Grant to LifeShare the exclusive right to coordinate organ donation for deaths referred during the term of this Agreement;

2.3 Provide initial information to allow LifeShare to screen patients for medical suitability for organ donation;

2.4 Work collaboratively with LifeShare in assuring all appropriate Hospital staff participate in training provided or approved by LifeShare on organ donation;

2.5 Allow LifeShare to have the responsibility to verify that employees and physicians functioning in roles for the purpose of organ recovery are qualified and have the appropriate licensure and credentialing as defined in paragraph 3.9 below;

2.6 Allow LifeShare to serve as and not interfere with LifeShare in serving as the designated requester for organ donation, recognizing and acknowledging that LifeShare staff are the only personnel trained according to CMS regulation to approach families of medically suitable patients regarding the option of organ donation and that Hospital's staff will not be trained or designated as requestors;

2.7 In cooperation with LifeShare protect the rights of every individual having made an anatomical gift through first person authorization (a right protected by state law: "…in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part…") by honoring the deceased's first person authorization to donate in every case where said authorization is appropriately documented through a state or national donor registry;

2.8 In cooperation with LifeShare, protect the right of the legal next of kin to make or decline to make an anatomical gift in the absence of a first person authorization to make or decline to make an anatomical gift;

2.9 In keeping with patient or family wishes, require that reasonable efforts be made to maintain physiological support and management of organ viability for a patient who is brain dead or for whom brain-death is considered imminent, to allow evaluation for organ donation;

2.10 Allow LifeShare staff full access (i.e., 24/7/365) to all medical records including the Electronic Medical Record ("**EMR**") for evaluation of medical suitability and to order any lab tests or diagnostic procedures on patients who are authorized donors;

2.11 Encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors;

2.12 Make medical records of deceased patients available electronically and remotely, when possible, for death record review as required by Centers for Medicare and Medicaid Services ("**CMS**") and the Organ Procurement and Transplant Network ("**OPTN**");

2.13 Ensure Hospital has a Donation after Circulatory Death Policy ("**DCD**") or a transfer policy to a facility that supports DCD, and permit LifeShare to perform evaluations of patients for DCD in collaboration with Hospital healthcare team;

2.14 Assure that Hospital and nursing service policies for organ donation are current and available to Hospital staff and LifeShare personnel and notify LifeShare of any change in credentials of any Hospital organ recovery surgeon or other recovery personnel from the hospital routinely recovering organs for LifeShare;

2.15 Provide LifeShare access to all Hospital testing services (e.g., laboratory and radiology) and ensure Hospital's operating rooms and anesthesia services are made available 24/7/365 on a priority basis when organ recovery is planned;

2.16 Work cooperatively with, and actively participate in, LifeShare's comprehensive QAPI program related to donor referral/recovery, including facilitating follow-up on occurrences identified and tracked by the LifeShare and Hospital's QAPI programs; and,

2.17 In the event of a natural or man-made disaster in the Hospital's service area, Hospital shall, to the best of its ability under such circumstances, notify LifeShare of Hospital's status and provide LifeShare with continued access to referral sources and appropriate contacts at Hospital.

Section 3: Responsibilities of LifeShare

3.1 In consultation with LifeShare's Medical Director(s) determine medical suitability of potential donors for organ donation;

3.2 Work collaboratively with Hospital by providing programming and resource materials to educate members of Hospital staff regarding organ donation, including DCD donation protocols, and provide orientation training for new Hospital staff, as well as on-going training to current Hospital staff;

3.3 Make available to Hospital the services of appropriately trained LifeShare staff for timely communication and prompt response by LifeShare on a 24/7/365 basis;

3.4 Ensure that a member of LifeShare staff will be available, with respect for family wishes, to discuss all options for donation of organs with the legal next-of-kin ("**NOK**") in a sensitive, caring, and informative manner, to answer all questions the NOK may have, and when appropriate assure appropriate documentation of the NOK's authorization of donation. In cases of first person authorization, ensure that LifeShare's staff will verify the first person authorization by accessing the appropriate donor registry, will inform the NOK of the donor's pre-existing authorization for donation, and in a sensitive, caring, and informative manner discuss the process with the NOK, including answering questions the NOK may have;

3.5 Provide, upon request, sample protocols for organ donation including DCD;

3.6 Meet all legal requirements regarding the use and disclosure of confidential patient information ("**HIPAA**"), including adherence to the HI TECH ACT of 2013, which addresses patient data security;

3.7 Following declaration of brain-death, LifeShare staff will oversee medical management of the potential organ donor, coordinate the allocation of organs through the UNOS DonorNet system, and coordinate the retrieval of suitable organs;

3.8 For DCD donation, LifeShare staff, working with the LifeShare Medical Director, shall determine whether the patient has the medical potential to become a candidate for DCD. If the patient is deemed a candidate, LifeShare will present the option of donation to the family, as applicable. Upon obtaining authorization for DCD, LifeShare will notify Hospital staff. Hospital staff and physicians then are responsible for the withdrawal of care, comfort care, and pronouncement of death per hospital policy and with no involvement from LifeShare staff or transplant surgeons. Following asystole, the attending physician or his/her designee, pronounces the patient dead and the organ recovery team enters to coordinate the retrieval of suitable organs;

3.9 Ensure employees and physicians functioning in roles for the purpose of organ recovery are qualified and have the appropriate licensure, competency, and the proper composition and credentials in the recovery teams;

3.10 Ensure organ recovery services are in compliance with all applicable standards, rules and regulations and provide these services with discretion, sensitivity, and respect for the views and beliefs of the families of potential donors;

3.11 Notify Hospital of any LifeShare policy changes that affect recovery, perfusion or transport and provide timely communication and prompt response on a 24x7 basis;

3.12 Provide to Hospital administration a summary of deaths referred to LifeShare's toll-free referral number, 800-241-4483 and the number of referrals that result in anatomical donation;

3.13 LifeShare will provide data reports on referral/conversion rate/timeliness of referral/donor activity with trends on a monthly, quarterly, or annual basis with frequency dependent upon volume of referrals (the more referrals, the more frequent the reporting). These reports will include reports/data generated by the LifeShare QAPI process;

3.14 Upon pronouncement of death and authorization for organ donation, LifeShare will assume and pay the donor evaluation, maintenance and surgical recovery costs associated with donor organs based on the Hospital's CMS-determined Cost-to-Charge Ratio ("**CCR**") and Hospital shall send invoices to LifeShare calculated based on the Hospital's CMS-determined CCR;

3.15 LifeShare will cooperate with Hospital's designated tissue and eye/cornea bank to facilitate tissue and ocular donation;

3.16 LifeShare will cooperate with the Oklahoma State Medical Examiner's Office to assure appropriate release for donation is obtained in cases where medicolegal investigation is to occur;

3.17 If pharmaceuticals are not readily available at Hospital, LifeShare shall provide those necessary for donor support;

3.18 LifeShare will ensure that proper documentation is prepared for the transplant program regarding the recovered organ(s) including blood type and other identifying information; and,

3.19 In the event of a natural or man-made disaster in the Hospital's service area, LifeShare shall, to the best of its abilities under such circumstances, do as follows: i) provide notification to the Hospital of the status of the donor referral and recovery process and ii) provide donor referral services for screening and evaluation; including a) laboratory testing for infectious diseases and HLA, b) donor management as part of continued organ and tissue recovery services, c) adequate protection of potential donor PHI, d) resources for patient triage and care, and e) any other services that LifeShare can provide to serve the community. In the event of a natural or man-made disaster affecting LifeShare's corporate office functions and operations, LifeShare shall communicate with Hospital regarding the procedure LifeShare has adapted to deal with the impact such disaster has had on LifeShare's functions and operations and shall update Hospital as any of such disaster-response procedures are adjusted.

Section 4: Term and Termination

4.1 This Agreement shall become effective as of the Effective Date set forth above and shall remain in effect until December 31, 2027 (the "**Initial Term**"), unless terminated as provided herein. Either party may terminate this Agreement at the end of the Initial Term by providing written notice of its intent to terminate to the other party within ninety (90) days of the expiration of the Initial Term.

4.2 Unless either party hereto provides the other party written notice of its intent to terminate this Agreement ninety (90) days prior to expiration of the Initial Term, this Agreement shall automatically renew for an additional three (3) year term (the "**Renewal Term**").

4.3 If at any time during the Initial Term or Renewal Term of this Agreement LifeShare fails to meet federal requirements as an OPO, Hospital shall have the right to terminate this Agreement at that time.

4.4 If at any time during the Initial Term or Renewal Term of this Agreement Hospital loses its state license or is debarred as an eligible provider under any Federal Healthcare Program, LifeShare shall have the right to terminate this Agreement at that time.

Section 5: Indemnify and Hold Harmless

5.1 Hospital agrees to defend, hold harmless, and indemnify LifeShare, its directors, officers, employees, or agents against any legal liability with respect to bodily injury, death, and property damage arising from the negligence of Hospital, its directors, officers, employees, or agents during Hospital's performance of its responsibilities under this Agreement.

5.2 LifeShare agrees to defend, hold harmless, and indemnify Hospital, its directors, officers, employees or agents against any legal liability in respect to bodily injury, death, and property damage arising from the negligence of LifeShare, its directors, officers, or employees or agents during LifeShare's performance of its responsibilities under this Agreement.

Section 6: Insurance

6.1 LifeShare and Hospital shall maintain malpractice and general liability insurance with minimum limits of $1,000,000 per occurrence and $3,000,000 in the aggregate throughout the term of this Agreement. Upon reasonable request of either party, the other party shall furnish the requesting party proof of adequate insurance. Such insurance shall be obtained from a reputable insurance company authorized to sell insurance policies in the State of Oklahoma and be satisfactory to the other party.

Section 7: Force Majeure

7.1 Neither party shall be responsible to the other for nonperformance or delayed performance of the terms and conditions hereof due to acts of God, acts of government, wars, riots, accidents and transportation, fuel shortages, or other causes (except strikes), in the nature of force majeure which is beyond its control.

Section 8: Independent Contractor

8.1 LifeShare is providing its services hereunder as an independent contractor. Nothing herein shall create any affiliation, partnership or joint venture between the parties hereto, or any employer/employee relationship. Neither is LifeShare, as an OPO, considered a Business Associate of Hospital as described in HIPAA.

Section 9: Notices

9.1 All notices and other communications provided for hereunder shall be in writing and shall be mailed by certified U.S. mail return receipt requested, by overnight delivery, or by hand delivery with a copy sent by electronic mail as follows:

If to Hospital: Name: _____ (Please print)
Title: _____
Hospital: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Email: _____

If to LifeShare: Jeffrey P. Orlowski, President and CEO
LifeShare Transplant Donor Services of Oklahoma, Inc.
4705 NW Expressway
Oklahoma City, Oklahoma 73132-5213
Telephone: (405) 840-5551
Email: LSHospitalDevelopment@lifeshareok.org

Section 10: Applicable Law

10.1 This Agreement shall be construed in accordance with the laws of the State of Oklahoma, without giving effect to any conflict of laws principles.

Section 11: Addenda

11.1 To the extent that the parties hereto agree to expand or modify the terms of this Agreement, the parties agree that they may from time to time enter into separate Addenda relating to this Agreement and expanding or modifying the terms of this Agreement. Any such Addenda relating to this Agreement will reference this Agreement and shall be made a part of this Agreement when fully executed by both parties hereto. Any such addenda so executed by the parties hereto shall specifically provide that the terms of this Agreement shall control if there is language that is in conflict in the Addenda.

Section 12: Entire Agreement

12.1 This Agreement and any addenda hereto set forth the entire Agreement between the parties. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect. The obligations in these provisions shall survive the termination or expiration of this Agreement for a period of one (1) year.

(Signatures on next page)

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized officers as of the date first written above.

"HOSPITAL" Mangum Regional Medical Center

By: _____
Name: Kelley Martinez, MSN, RN
Title: Hospital Administrator

Date: _____

"LIFESHARE" LifeShare Transplant Donor Services of Oklahoma, Inc.

By: _____
Name: Jeffrey P. Orlowski
Title: President and Chief Executive Officer

Date: _____

TISSUE RECOVERY AGREEMENT

This TISSUE RECOVERY AGREEMENT (this "Agreement") is made and entered into effective as of January 1, 2024 (the "**Effective Date**"), by and between Mangum Regional Medical Center with its principal place of business at 1 Wickersham Drive, Mangum, OK 73554, ("**Hospital**") and LifeShare Tissue Services, Inc., an Oklahoma not-for-profit corporation exempt from taxation under 501(c)(3) of the Internal Revenue Code, with its principal place of business at 4705 NW Expressway, Oklahoma City, Oklahoma 73132-5213, ("**LifeShare**"), with respect to the following circumstances:

WHEREAS, Hospital, being required by 42 CFR Part 482.45 (the "COP"), to have a written agreement with a tissue bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissue and that such written agreement does not interfere with the organ procurement process at Hospital;

WHEREAS, LifeShare is a tissue bank regulated by the Food and Drug Administration (the "**FDA**") and accredited by the American Association of Tissue Banks (the "**AATB**") that serves as an accredited Tissue Recovery Agency; and

WHEREAS, Hospital and LifeShare desire to enter into this Agreement to facilitate the procurement of tissues for transplantation and are committed to maximizing donation from suitable donors.

NOW THEREFORE, Hospital and LifeShare agree as follows:

Section 1: Definitions

1.1 Timely Referral: A referral by a Hospital is considered timely when made within sixty (60) minutes of following cardiac death.

1.2 Tissue: For purposes of this Agreement, the term "tissue" means bone, bone marrow, heart valves, skin, fascia, pericardium, nerve, tendon, cartilage, corneas/eyes, blood vessel and all other tissues as specified by applicable federal, state and local laws and/or regulations, and Joint Commission Standards or Det Norske Veritas Healthcare, Inc. ("**DNV**").

Section 2: Responsibilities of Hospital

2.1 Make a timely referral of all Hospital deaths using the toll-free referral number (800) 241-4483, with deaths that occur during transport from one hospital to another being reported by the receiving hospital;

2.2 Provide initial information to allow LifeShare to screen patients for medical suitability for tissue donation;

2.3 Grant to LifeShare the exclusive right to coordinate tissue donation for deaths referred during the term of this Agreement;

2.4 Work collaboratively with LifeShare to assure that all appropriate Hospital staff participate in training provided or approved by LifeShare relating to tissue donation;

2.5 Allow LifeShare to serve as and not interfere with LifeShare in serving as the designated requester for tissue donation, recognizing and acknowledging that LifeShare staff are the only personnel trained according to the regulation of the Centers for Medicare and Medicaid Services ("**CMS**") and the FDA to approach families of medically suitable patients regarding the option of tissue donation and that Hospital's staff will not be trained or designated as requestors;

2.6 In cooperation with LifeShare protect the rights of every individual having made an anatomical gift through first person authorization (a right protected by state law: "…in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part…") by honoring the deceased's first person authorization to donate in every case where said authorization is appropriately documented through a state donor registry;

2.7 In cooperation with LifeShare, protect the right of the legal next of kin to make or decline to make an anatomical gift in the absence of a first person authorization to make or decline to make an anatomical gift;

2.8 Allow LifeShare staff full access (i.e., 24/7/365) to all medical records, including Electronic Medical Record ("**EMR**") for evaluation of medical suitability of potential donors;

2.9 Encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of potential donors;

2.10 Make medical records of deceased patients available, electronically and remotely, when possible, for death record review as required by CMS, the FDA, the AATB, the Association of Organ Procurement Organizations (the "**AOPO**"), and United Network for Organ Sharing ("**UNOS**");

2.11 Assure that Hospital and nursing service policies for tissue donation are current and available to Hospital staff and LifeShare personnel;

2.12 Work cooperatively with, and actively participate in, LifeShare's comprehensive Quality Assurance and Performance Improvement (QAPI) program related to donor referral/recovery including facilitating follow-up on occurrences identified and tracked by the LifeShare and Hospital's QAPI programs; and,

2.13 In the event of a natural or man-made disaster in the Hospital's service area, Hospital shall, to the best of its ability under such circumstances notify, LifeShare of Hospital's status and provide LifeShare with continued access to referral sources and appropriate contacts at Hospital.

Section 3: Responsibilities of LifeShare

3.1 In consultation with LifeShare's Medical Director(s) determine medical suitability of potential donors for tissue donation;

3.2 Work collaboratively with Hospital by providing programming and resource materials to educate members of Hospital's staff regarding tissue donation and provide orientation training for new Hospital staff as well as on-going training to current Hospital staff;

3.3 Make available to Hospital the services of appropriately trained LifeShare staff for timely communication and prompt response by LifeShare on a 24/7/365 basis; Ensure that a member of LifeShare's staff will be available, with respect for family wishes, to discuss all options for donation of tissue with the legal next-of-kin ("**NOK**") in a sensitive, caring, and informative manner, to answer all questions the NOK may have, and when appropriate assure appropriate documentation of the NOK's authorization of donation. In cases of first person authorization, LifeShare will verify the first person authorization by accessing the appropriate donor registry, will inform the NOK of the donor's pre-existing authorization for donation, and in a sensitive, caring, and informative manner discuss the process with the NOK including answering questions the NOK may have;

3.4 Meet all legal requirements regarding the use and disclosure of confidential patient information of the Health Insurance Portability and Accountability Act ("**HIPAA**"), including adherence to the HI TECH ACT of 2013, which addresses patient data security;

3.5 Ensure employees and physicians functioning in roles for the purpose of tissue recovery are qualified and have the appropriate licensure, competency, and the proper composition and credentials in the recovery teams;

3.6 Ensure tissue recovery services are in compliance with all applicable standards and rules and regulations, and provide these services with discretion, sensitivity, and respect for the views and beliefs of the families of potential donors;

3.7 Notify Hospital of any LifeShare policy changes that affect recovery, or transport and provide timely communication and prompt response on a 24x7 basis;

3.8 Provide to Hospital administration a summary of deaths referred to LifeShare's toll-free referral number, 800-241-4483 and the number of referrals that result in anatomical donation;

3.9 Provide data reports on referral/conversion rate/timeliness of referral/donor activity with trends on a monthly, quarterly, or annual basis with frequency dependent upon volume of referrals (the more referrals, the more frequent the reporting). These reports will include reports/data generated by the LifeShare QAPI process;

3.10 Cooperate with the Hospital's designated eye/cornea bank to facilitate ocular donation;

3.11 Cooperate with the Oklahoma State Medical Examiner's Office to assure appropriate release for donation is obtained in cases where medicolegal investigation is to occur; and,

3.12 In the event of a natural or man-made disaster in the Hospital's service area, LifeShare shall, to the best of its abilities under such circumstances, do as follows: i) provide notification to the Hospital of the status of the donor referral and recovery process, and ii) provide donor referral services for screening and evaluation; including a) laboratory testing for infectious diseases and HLA, b) donor management as part of continued organ and tissue recovery services, c) adequate protection of potential donor PHI, d) resources for patient triage and care, and e) any other services that LifeShare can provide to serve the community. In the event of a natural or man-made disaster affecting LifeShare's corporate office functions and operations, LifeShare shall communicate with Hospital regarding the procedure LifeShare has adapted to deal with the impact such disaster has had on LifeShare's functions and operations and shall update Hospital as any of such disaster-response procedures are adjusted.

Section 4: Term and Termination

4.1 This Agreement shall become effective as of the Effective Date set forth above and shall remain in effect until December 31, 2027 (the "**Initial Term**"), unless terminated as provided herein. Either party may terminate this Agreement at the end of the Initial Term by providing written notice of its intent to terminate to the other party within ninety (90) days of the expiration of the Initial Term.

4.2 Unless either party hereto provides the other party written notice of its intent to terminate this Agreement ninety (90) days prior to expiration of the Initial Term, this Agreement shall automatically renew each year for an additional one (1) year term (the "**Renewal Term**").

4.3 If at any time during the Initial Term or Renewal Term of this Agreement LifeShare fails to meet federal requirements as a Tissue Bank, Hospital shall have the right to terminate this Agreement at that time.

4.4 If at any time during the Initial Term or Renewal Term of this Agreement Hospital loses its state license or is debarred as an eligible provider under any Federal Healthcare Program, LifeShare shall have the right to terminate this Agreement at that time.

Section 5: Indemnify and Hold Harmless

5.1 Hospital agrees to defend, hold harmless, and indemnify LifeShare, its directors, officers, employees or agents against any legal liability with respect to bodily injury, death, and property damage arising from the negligence of Hospital, its directors, officers, employees or agents during Hospital's performance of its responsibilities under this Agreement.

5.2 LifeShare agrees to defend, hold harmless, and indemnify Hospital, its directors, officers, employees or agents against any legal liability in respect to bodily injury, death, and property damage arising from the negligence of LifeShare, its directors, officers, or employees or agents during LifeShare's performance of its responsibilities under this Agreement.

Section 6: Insurance

6.1 LifeShare and Hospital shall maintain malpractice and general liability insurance with minimum limits of $1,000,000 per occurrence and $3,000,000 in the aggregate throughout the term of this Agreement. Upon reasonable request of either party, the other party shall furnish the requesting party proof of adequate insurance. Such insurance shall be obtained from a reputable insurance company authorized to sell insurance policies in the State of Oklahoma and be satisfactory to the other party.

Section 7: Force Majeure

7.1 Neither party shall be responsible to the other for nonperformance or delayed performance of the terms and conditions hereof due to acts of God, acts of government, wars, riots, accidents and transportation, fuel shortages, or other causes (except strikes), in the nature of force majeure which is beyond its control.

Section 8: Independent Contractor

8.1 LifeShare is providing its services hereunder as an independent contractor. Nothing herein shall create any affiliation, partnership or joint venture between the parties hereto, or any employer/employee relationship.

Section 9: Notices

9.1 All notices and other communications provided for hereunder shall be in writing and shall be mailed by certified mail, return receipt requested, or emailed to Hospital Development, with a copy sent promptly thereafter by U.S. mail, overnight delivery or hand delivery, as follows:

If to Hospital: Name: _____ (Please print)
Title: _____
_____
_____
_____
Telephone: _____
Email: _____

If to LifeShare: Jeffrey P. Orlowski, President and CEO
LifeShare Tissue Services, Inc.
4705 NW Expressway
Oklahoma City, Oklahoma 73132-5213
Telephone: (405) 840-5551
Email: LSHospitalDevelopment@lifeshareok.org

Section 10: Applicable Law

10.1 This Agreement shall be construed in accordance with the laws of the State of Oklahoma, without giving effect to any conflict of laws principles.

Section 11: Addenda

11.1 To the extent that the parties hereto agree to expand or modify the terms of this Agreement, the parties agree that they may from time to time enter into separate Addenda relating to this Agreement and expanding or modifying the terms of this Agreement. Any such Addenda relating to this Agreement will reference this Agreement and shall be made a part of this Agreement when fully executed by both parties hereto. Any such addenda so executed by the parties hereto shall specifically provide that the terms of this Agreement shall control if there is language that is in conflict in the Addenda.

Section 12: Entire Agreement

12.1 This Agreement and any addenda hereto set forth the entire Agreement between the parties. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect. The obligations in these provisions shall survive the termination or expiration of this Agreement for a period of three (3) years.

(Signatures on next page)

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized officers as of the date first written above.

"HOSPITAL" Mangum Regional Medical Center

By: _____
Name: Kelley Martinez, MSN, RN
Title: Hospital Administrator

Date: _____

"LIFESHARE" LifeShare Tissue Services, Inc.

By: _____
Name: Jeffrey P. Orlowski
Title: President and Chief Executive Officer

Date: _____

HOSPITAL AGREEMENT

AETNA BETTER HEALTH ADMINISTRATORS, LLC, on behalf of itself and its Affiliates ("Company"), and, Mangum City Hospital Authority. d/b/a/ Mangum Regional Medical Center on behalf of itself and any and all of its Hospital Providers and locations ("Hospital" or "Provider"), are entering into this Hospital Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page, the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:

As of the Effective Date, Hospital agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: April 1, 2024 (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Hospital has read and understood this Agreement, has had the opportunity to review it with an attorney of Hospital's choice, and is authorized to bind Hospital, including all Hospital Providers and Hospital locations, to the terms of the Agreement.

HOSPITAL	**COMPANY**
By: _____	**By:** _____
Printed Name: _____	**Printed Name:** _____
Title: _____	**Title:** _____

FEDERAL TAX I.D. NUMBER: 82-2087512

NPI NUMBER: 1033635263

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Hospital:	**Company:**
Mangum Regional Medical Center	**Aetna Medicaid Administrators LLC c/o**
PO Box 280	**Aetna Inc.4500 E Cotton Center Blvd**
Mangum, OK 73554	**Phoenix, AZ 85040ATTN: Ld Director,**
Attn: Hospital Administrator	**Network Management**

GENERAL TERMS AND CONDITIONS

1.0 HOSPITAL OBLIGATIONS

1.1 **General Obligations**. Hospital agrees that it and all Hospital Providers will:

(a) provide Covered Services, including any related facilities, equipment, personnel and/or other resources necessary to provide the Covered Services, to Members according to generally accepted standards of care in the applicable geographic area, and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law and conduct all credentialing, privileging, and re-appointment in accordance with Applicable Law and its medical staff by-laws, regulations, and policies;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Hospital represents that neither it nor any Hospital Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Hospital understands that no Hospital Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Hospital locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Hospital's services to be made directly to Hospital instead of to the Member, unless the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Hospital further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Hospital agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Hospital will not accept any referral from persons or entities that have a financial interest in Hospital, or make any referrals to persons or entities in which Hospital has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Hospital or a Hospital Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Hospital renders to Members; (ii) claims against Hospital or a Hospital Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks, that could reasonably have a material impact on Hospital's ability to provide services to Members or to participate in Medicare or Medicaid programs; (iii) investigation or action taken by The Joint Commission (TJC) and/or other applicable accrediting organization that could adversely affect Hospital's accreditation status; (iv) change in the ownership or management of Hospital; (v) material change in services provided by Hospital (e.g., a significant decrease in medical staff or the closure of a service unit or a material decrease in beds or emergency services departments) or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Hospital or a Hospital Provider related to those services;

(n) mutually commit, together with Company, to the promotion of Member safety and clinical quality, including the prevention of potentially avoidable serious adverse events. Hospital agrees to comply with Company's Patient Safety Events and related policies, and any successor policies, including, but not limited to, notification to applicable reporting agencies; root cause analysis; corrective action; and the waiver of directly related charges for certain events. Hospital agrees to publicly report patient safety and quality information at least annually, to one or more external reporting entities, including but not limited to: CMS Quality Reporting Program; TJC; Leapfrog Hospital Survey; and March of Dimes 39-Week Initiative.

1.2 **Hospital Contact and Service Information**. Hospital agrees that it has provided Company with contact information that is complete and accurate as of the Effective Date. Hospital will notify Company within twenty (20) business days unless Applicable Law requires Company to update its directories in a shorter timeframe, of all changes to the list of Hospital Providers, the services it/they provide and all contact and billing information for Hospital and Hospital Providers. Hospital understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Hospital fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Hospital.

1.3 **Compliance with Company Policies**. Hospital agrees to comply with Company Policies of which Hospital knows or reasonably should have known, including, but not limited to, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Hospital's administration or rates under this Agreement, Company will send Hospital at least ninety (90) days advance written notice of the Policy change. Hospital understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Hospital objects to a Policy change that will have a significant impact on Hospital's administration or operations or will create a material adverse financial impact for Hospital, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Hospital is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Hospital agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Hospital Providers for services rendered, and that it will require all Hospital Providers to look solely to Hospital for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Hospital and Hospital Providers, containing all information needed to process the claims, within one hundred and eighty (180) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Hospital provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Hospital's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) Subject to Applicable law, to notify Company of any underpayment or payment/claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Hospital's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Hospital acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Hospital with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

1.5 **Member Billing**. Hospital agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Hospital's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

1.6 **Utilization Management**. Hospital agrees that it shall be subject to utilization management (including prospective, concurrent and retrospective review) and that payment for Hospital services may be adjusted or denied for the inefficient delivery of services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Hospital and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Hospital.

1.7 **Precertification and Referrals**. Except when a Member requires emergency services, Hospital agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Hospital services. Hospital will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Hospital agrees to provide notice of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such

services. For the purpose of pre-admission testing, Hospital agrees to directly provide testing or accept test results and examinations performed outside Hospital, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a specialty program, Hospital agrees to work with Company in transferring the Member's care to a specialty program Hospital, as the case may be.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Hospital, (ii) provide Hospital with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Hospital with a means to check Member eligibility; and (iv) include Hospital in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Hospital of periodic updates to its Policies as required by this Agreement and make current Policies available to Hospital through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable Product Addendum(a) and Service and Rate Schedule(s), and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees to pay Hospital for Covered Services rendered to Members; and within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim.

3.0 NETWORK PARTICIPATION

Hospital agrees that it and Hospital Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company will notify Hospital of a new or revised Product Addendum and Service and Rate Schedule.; provided that such addition will not go into effect unless Hospital agrees to such addition, in writing, within the time period specified in Company's notice.

4.0 CONFIDENTIALITY

Company and Hospital agree that medical records do not belong to Company. Company and Hospital agree that the information contained in the claims Hospital submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Hospital/Hospital Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Hospital will keep the rates and the development of rates and other terms of this Agreement confidential. However, Hospital, through its staff, is encouraged

to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which Hospital is paid. In addition, Hospital and Hospital Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Hospitals, Facilities or Locations**. Company may terminate the participation of one or more of Hospital's individual hospitals, facilities or locations: (a) without cause, by providing Hospital with at least one hundred and twenty (120) days written notice prior to the date of termination; or (b) for breach, as specified below, without affecting the participation of other hospitals/facilities/locations.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Hospital or any Hospital Provider or location, with written notice to Hospital, due to: (a) Hospital's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) the bankruptcy or receivership of Hospital, or an assignment by Hospital for the benefit of creditors; (c) the exclusion, debarment or suspension of Hospital or a Hospital Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (d) change of control of Hospital to an entity not acceptable to Company; (e) the revocation orsuspension of Hospital's accreditation by TJC or any other applicable accrediting agency; or (f) a determination by Company that Hospital's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Hospital will provide immediate notice to Company of any of the events described in (a)-(e) above. Hospital may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Hospital agrees to provide services, at Company's discretion, to: (a) any Member under Hospital's care who, at the time of the effective date of termination, is a registered bed patient at Hospital, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Hospital will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Hospital are independent contractors, and not employees, agents or representatives of each other. Company and Hospital will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Hospital will be liable in any way for the activities of the other Party or the other Party's employees or agents. Hospital acknowledges that all Member care and related decisions are the responsibility of Hospital and/or Hospital Providers and that Policies do not dictate or control Hospital's and/or Hospital Providers' clinical decisions with respect to the care of Members. Hospital agrees to indemnify and

hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Hospital's and/or Hospital Providers' provision of care to Members. Company agrees to indemnify and hold harmless Hospital and Hospital Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Hospital agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Hospital will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Hospital will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Hospital will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Hospital and a Member, or a party designated by a Member determined by Hospital to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Hospital can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Hospital will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND HOSPITAL UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the

extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum (the most current version, which may be contained in the Provider Manual)** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Hospital is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by Company under this Agreement. Hospital agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by hospitals in the state or region in which the Hospital operates. Such insurance coverage shall cover the acts and omissions of Hospital as well as those of Hospital's agents and employees.

8.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.5 **Assignment**. Hospital may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Hospital participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Hospital.

8.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Company may amend the agreement for reasons other than Applicable Law by notifying Hospital in writing at least sixty (60) days prior to the effective date of the amendment. Hospital may reject the amendment upon Hospital's receipt of such notice of amendment, by notifying Company in writing of such rejection within thirty (30) days of notice of such amendment; provided, however, if Company has not received notice of such rejection within that thirty (30) day period, Hospital's silence shall constitute acceptance of such amendment.

8.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.8 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Hospital, applicable accreditation agency or organization (e.g., TJC) requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Hospital Provider. Any physician or other health care provider: (a) employed by Hospital; or (b) who, through a contract or arrangement with Hospital, provides services to Members for which Hospital is reimbursed under this Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Hospital, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Hospital serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria, Provider Manuals, clinical policy bulletins, credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, Institutes of Excellence™, complaint and appeals, and other policies and procedures (as modified from time to time) that are made available to Hospital electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Hospital participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company

obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products. Furthermore, the Parties understand and agree that if this Agreement is executed prior to execution of a State Contract and/or prior to issuance to Company of Government Approvals, the **State Compliance Addendum (Medicaid Products)** may need to be added to this Agreement after execution. After issuance of the State Contract and/or Government Approvals, Company may, in its discretion: (a) unilaterally amend the Agreement to add the **State Compliance Addendum (Medicaid Products);** and/or (b) incorporate the **State Compliance Addendum (Medicaid Products)** into the Provider Manual.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State.

B. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans: Reimbursement is based upon the contracted location where service is performed and is at a minimum an amount equal to 100% of the State's Medicaid reimbursement for Inpatient and Outpatient services.

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

C. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

D. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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Regulatory Compliance Addendum
Governing Oklahoma Medicaid (Provider)

Aetna Better Health of Oklahoma Inc., an Oklahoma corporation ("Company" or "CE") has contracted with the Oklahoma Health Care Authority ("OHCA" or "State Agency" or "Government Sponsor") to provide Medicaid managed care services to Enrollees as part of the SoonerSelect program ("SoonerSelect"). The provisions of this Addendum are required by the State Contract, state or federal law for all of Company's participating providers. Company and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company.

If there is any conflict between the terms of this Addendum and any term of the Agreement, including any Addendums, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict or ambiguity between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract shall govern and control. If any requirement in the Agreement or this Addendum is determined by OHCA to conflict with the State Contract, such requirement shall be null and void, and all other provisions shall remain in full force and effect. References to the State Contract are for convenience only.

Each provision contained herein shall apply to Provider only to the extent applicable to the services provided by Provider pursuant to the Agreement.

1. Definitions. Terms used in this Addendum and not defined herein will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract. Terms used in this Addendum that are not otherwise explicitly defined shall be understood to have the definition set forth in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

2. Incorporation of Terms and Conditions. Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents, the solicitation for the State Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Enrollees under this Addendum. (State Contract §1.14.1)

3. Approval of State Contract. Effectiveness of the Agreement is contingent upon approval of the State Contract by the OHCA Board and the Centers for Medicare and Medicaid Services (CMS). If CMS does not approve the State Contract under the terms and conditions, the Agreement and this Addendum, OHCA may terminate the Agreement. (State Contract§ 1.2.3)

4. Termination.

    4.1 Availability of Records. In the event of termination of this Addendum or the Agreement, Provider shall immediately make available to OHCA or its designated representative, in a usable form, any or all records, whether medically or financially related to the terminated Provider's activities undertaken pursuant to this Addendum, and that the provision of such records shall be at no expense to OHCA. (State Contract §1.14.1.11.14.1.1) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Enrollee records and information are provided to Company to facilitate an orderly transition of all Enrollees' care. (State Contract § 1.14.5.2.1)

4.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Addendum for cause upon 30 days advance written notice to the other party, and without cause upon 60 days advance written notice to the other party (State Contract §1.14.5.1).

4.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Addendum may be immediately terminated by Health Plan in the event of the following (State Contract§ 1.14.5.1):

a) To protect the health and safety of Enrollees;
b) Upon conviction of credible allegation of Fraud on the part of Provider;
c) Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way affected to make it unlawful for Provider to provide services under this Addendum;
d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (State Contract § 1.14.1.1 and State Contract § 1.12.6.1);
e) If Provider violates Section 1.24.1.7 of the State Contract (State Contract § 1.12.1.7).
f) DHS or OJA terminates or refuses to re-contract Provider.

4.4 Company's right to deny, refuse to renew or terminate the Agreement shall be in accordance with the terms of the State Contract and any applicable statutes and regulations;

5. Independent Contractor. Provider is not a third-party beneficiary to the State Contract. Provider is an independent contractor performing services as outlined in the State Contract. (State Contract §1.14.1.1)

6. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have a National Provider Identifier ("NPI"), to the extent such Provider is not an atypical provider as defined by CMS. (State Contract §1.14.1.1)

7. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Addendum be, enrolled as a contracted provider in good standing in SoonerCare, and Provider shall, upon request of Company or OHCA, provide any and all such documentary evidence, as reasonably required by Company or OHCA, to validate such status in accordance with 42 C.F.R. 438.602(b)(1) and 438.608(b) (State Contract §§1.13.1.4.1 and 1.20.8). In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Addendum pending the outcome of the of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days but will terminate Provider immediately upon notification from the State that Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of Provider with SoonerCare. (State Contract §1.13.1.4.2)

8. Credentialing and Recredentialing. Provider shall comply with OHCA's and Company's credentialing and re-credentialing processes as set forth in the Agreement and Provider Manual. (State Contract §§ 1.14.1 and 1.14.2) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

9. Enrollee Rights and Responsibilities. Provider shall abide by the Enrollee rights and responsibilities denoted in § 1.12.5.4 of the State Contract and in Company's Enrollee Handbook. (State § Contract 1.14.1.1)

10. Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings. Provider shall display notices in public areas of Provider's facility/facilities in accordance with all State requirements and any subsequent amendments. (State Contract § 1.14.1.1)

11. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (State Contract § 1.14.1.1)

12. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters. (State Contract §§ 1.14.1.1 1.12.1.1, and 1.12.1.2).

13. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (State Contract § 1.14.1.1)

14. Confidentiality. Provider shall keep all Enrollee information confidential, as defined by State and federal laws, regulations and policy. (State Contract § 1.14.1.1)

15. Records.

    15.1 Maintenance. Provider shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Enrollees and their representatives shall be given access to and can request copies of the Enrollees' medical records to the extent and in the manner provided under State or federal law. (State Contract § 1.14.1.1)

    15.2 Record Availability. Provider shall maintain all records related to services provided to Enrollees for a 10-year period (for minors, Provider shall retain all medical records during the period of minority, plus a minimum of 10 years after the age of majority.). In addition, Providers shall make all Enrollees' medical records or other service records available for any quality reviews that may be conducted by Company, OHCA or its designated agent(s) during and after the term of the Agreement. OHCA, its personnel, designees and contractors shall be provided with prompt access to Enrollees' records. Enrollees shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (State Contract §§ 1.14.1.1 and 1.11.9.1)

16. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Enrollees shall maintain and share Enrollees' health records in accordance with professional standards. (State Contract § 1.14.1.1)

17. Critical Incident Reporting. Consistent with the reporting and tracking system established by Company, Provider shall report adverse or Critical Incidents to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). Provider shall avail itself of training and take corrective action as needed to ensure compliance with Critical Incident requirements, in the manner and format required in the Reporting Manual. Provider shall ensure that any serious incident that harms or potentially harms a Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated and corrected, in a manner that ensures Company's compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39. Provider shall report abuse, neglect and/or Exploitation to Company within less than one Business Day. Provider shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all Enrollees and respond to any emergency needs of Enrollees. Provider shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c). Provider will cooperate with any investigations and implement any corrective actions as directed by Company and/or OHCA within applicable timeframes. (State Contract § 1.11.9.3)

18. Vaccines for Children. If Provider is eligible for participation in the Vaccines for Children program, Provider shall comply with all program requirements as defined by OHCA. (State Contract § 1.14.1.1)

19. Facility and Record Access for Evaluation, Inspection or Auditing Purposes. Authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Agreement (State Contract § 1.14.1.1). Provider shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which State of federal monies are expended, unless otherwise provided by law. Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2. (State Contract § 1.20.1.4)

20. Release of Information for Monitoring Purposes. Provider shall release to Company any information necessary to monitor Provider's performance on an ongoing and periodic basis. (State Contract § 1.14.1.1)

21. Cost Sharing.

21.1 Enrollee Charges. When the Covered Service provided requires a Co-payment, as allowed by Company, Provider may charge the Enrollee only the amount of the allowed Co-payment, which may not exceed the Co-payment amount allowed by OHCA. Provider shall accept payment made by Company as payment in full for Covered Services, and Provider shall not solicit or accept any surety or guarantee of payment from the Enrollee, OHCA or the State. (State Contract § 1.14.1.1)

21.2 Exemption from Cost Sharing. In accordance with 42 C.F.R. 447.56, Provider shall not seek cost sharing from "Exempt Populations," including, but not limited to, AI/AN Enrollees (State Contract §§1.19.2 and 1.17.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (State Contract § 1.19.3)

21.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Enrollee's Cost Sharing obligations, regardless of whether Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, Company shall not reduce payments to Provider, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing. (State Contract § 1.19.4)

21.4 Balance Billing. In accordance with §1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), Provider agrees to, and agrees that any of its Contracted Providers or subcontractors will, hold harmless Enrollee for the costs of Covered Services, except for any applicable Co-payment amount allowed by OHCA. (State Contract §1.16.1.3)

22. Third-Party Liability. Provider shall identify Enrollee Third-Party Liability coverage, including Medicare and long-term care insurance, as applicable; and except as otherwise required, Provider shall seek such Third-Party Liability payment before submitting claims to Company. (State Contract § 1.14.1.1)

23. Claims Submission and Payment. Provider shall comply with all claim submittal obligations of the State Contract. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to an Enrollee. Health Plan may not impose requirements to file claims within a shorter period. (State Contract 1.14.1.1). Except for those exceptions set forth in § 1.16.5 of the State Contract, resubmitted claims must be filed within an additional six months thereafter. (State Contract §§ 1.16.5 and 1.16.6)

24. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, may be set forth in the Agreement between Company and Provider (including any Amendments, Attachments, Exhibits or Appendices) or the Company's Provider Manual. (State Contract § 1.14.1.1)

25. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external Quality Management/Quality Improvement (QM/QI) monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or Company, and Provider shall participate in any corrective action processes taken to improve quality of care. (State Contract § 1.14.1.1)

26. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (State Contract § 1.14.1.1)

27. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (State Contract §1.8.5)

28. Indemnify and Hold Harmless. At all times during the term of the Agreement, Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by Provider or Contracted Providers pursuant to the Agreement. (State Contract § 1.14.1.1)

29. Non-discrimination. Provider agrees that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of Company's program or otherwise subjected to discrimination in the performance of the Agreement with Company or in the employment practices of Provider. Provider shall identify Enrollees in a manner which will not result in discrimination against the Enrollee in order to provide or coordinate the provision of Covered Services and shall not use discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients. (State Contract § 1.14.1.1)

30. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (State Contract § 1.14.1.1)

31. Timely Access to Care. Provider shall comply with State standards for timely access to care and services, as specified in the State Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. §438.206(c)(1)(i). Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, or if Provider serves only Medicaid Enrollees, hours of operation comparable to other State Medicaid populations, in accordance with 42 C.F.R. §438.206(c)(1)(ii). Provider shall comply with any corrective action directed by Company to remedy any failure to comply with timely access to care obligations. (State Contract § 1.13.1.2)

32. Database Screening and Criminal Background Check of Employees. Provider shall comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Enrollees and/or access to Enrollees' PHI. Provider is prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.20.10 of the State Contract, entitled "Prohibited Affiliations and Exclusions." Provider shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. Provider shall immediately report to Company any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate this Addendum as provided under State and/or federal law. (State Contract § 1.14.1.1)

33. Prohibited Payments. Provider acknowledges that Company will not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services (State Contract § 1.16.2.4):

33.1 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

33.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

33.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

33.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

33.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (State Contract § 1.7.15)

33.6 Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with § 1.20.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (State Contract § 1.16.2.2).

33.7 In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include: in accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to a Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include:

33.8 Health-acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of HHS under § 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of the Act; other than DVT/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients; and

33.9 Conditions meeting the following criteria:

a) Is identified in the State Plan;

b) Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

c) Has a negative consequence for the Enrollee;

d) Is auditable; and

e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

34. Prohibited Affiliations and Exclusions.

34.1 Provider acknowledges that Company may not contract with Providers excluded from participation in federal health care programs, and may not contract for the provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly: (i) with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in accordance with 42 C.F.R. § 438.808(a), and 438.808(b)(2); (ii) with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-

procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(a); or (iii) with any individual or entity that is excluded from participation in any federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(b). Moreover, Company may not employ or contract, directly or indirectly, for the furnishing of health care, services: (i) with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(a); or (ii) with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(b). Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (State Contract §1.20.10). Health Plan may immediately terminate this Addendum in the event that Provider comes within any such prohibition or exclusion. Provider shall not receive any payment hereunder using Medicaid funds for services or items as provided in §1.20.10 of the State Contract. (State Contract § 1.20.10.3)

34.2 No person who has been involved in any manner in the development of this State Contract while employed by the State of Oklahoma shall be employed by the Company to fulfill any of the services provided under the State Contract, in accordance with 74 O.S. § 85.42(B) (State Contract § 1.20.10.3)

34.3 Provider acknowledges that Company may not contract with: (i) any such person or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal, state, local department, or agency; (ii) any such person or entity that has been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property within three years of the Health Plan's contract with the person or entity; (iii) any such person or entity that is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in the previous paragraph; or (iv) Any such person or entity that has had one or more public (federal, state, or local) contracts terminated for cause or default within three years of the Health Plan's contract with the person or entity. (State Contract § 1.20.10.3)

35. Off-Shoring. In accordance with 42 C.F.R. § 438.602(i), Company shall not enter into any subcontract for the performance of any duty under this State Contract in which such services are to be transmitted or performed outside of the United States nor will any claims be paid by Company to a Network Provider, out-of-Network Provider, Subcontractor, or financial institution located outside of the U.S. The purchase of offshore services is expressly prohibited. (State Contract § 4.5.1)

36. Provider Right to Support Enrollee Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports an Enrollee's Appeal. (State Contract § 1.14.1.2)

37. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (State Contract § 1.23.1.18)

38. Grievances and Appeals System. Provider acknowledges that it has received the following information regarding Company's Grievance and Appeals system. In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), Company operates an Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances. In accordance with the requirements of 42 C.F.R. § 438.402, Company's Grievances and Appeals System allows a Enrollee (or his or her Authorized Representative) to file a Grievance with Company, either orally or in writing, at any time, and to subsequently to request an Appeal with Company, with the ability for the Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. An Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to Company, which may be filed either orally or in writing. Unless the Enrollee is requesting an expedited resolution, an Enrollee's oral request for an Appeal must be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made. Company will make assistance available to the Enrollee with filing Grievances and Appeals including: provision of reasonable assistance to Enrollees in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Enrollee care support staff; (iv) providing auxiliary aids and services upon request, such as providing interpreter services; and (v) providing toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 C.F.R. 438.406(a). An Enrollee may be represented by an Authorized Representative, may present evidence and testimony, may make legal and factual arguments and the Company shall make Enrollee's case file available to the Enrollee at no charge. Enrollee has the right to request a State Fair Hearing by filing a request within 120 Days after receiving notice that the Adverse Benefit Determination has been upheld on Appeal. Enrollee has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing., Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Enrollee, as specified in 42 § 438.420(b)(5). (State Contract § 1.18 et. seq.)

39. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall return overpayments within 60 Days after the date on which the Overpayment was identified and shall notify Company in writing of the reason for the Overpayment. Provider acknowledges that if an Overpayment is identified by OHCA rather than by Company, OHCA may recover the Overpayment directly from Provider, or OHCA may require Company to recover and send the Overpayment to OHCA as directed by the OHCA Program Integrity and Accountability Unit. (State Contract §1.20.11.6)

40. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect Program enrollment. Enrollees who become Dual Eligible Individuals will be disenrolled as of their Medicare eligibility effective date. In the event that an Enrollee becomes retroactively Medicare eligible, Company will recover any claims payments made to Provider during the months of retroactive Medicare eligibility. Provider shall submit the claim to Medicare for reimbursement in such instances. (State Contract § 1.6.10)

41. Electronic Visit Verification. If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (State Contract § 1.21.2)

42. Encounter Data. Provider shall cooperate with Company's Encounter Data submittal requirements and shall submit required Encounter Data in accordance with Company's automated Encounter Data system, and Provider shall accept and use the State-assigned Provider IDs for Encounter Data submissions and shall accept and use the State eMPI/Medicaid IDs for Enrollees. Provider shall submit complete Encounter Data and claims data timely and in sufficient detail to support detailed utilization and tracking and financial reporting. (State Contract §§ 1.21.7 et. seq.)

43. Provider Reconsiderations and Provider Appeals. Provider acknowledges: (A) receipt from Company of the link to Company's website containing, among other things, the Provider Manual(s) detailing, among other things, the policies and procedures for (i) Company's reconsideration of decisions adverse to Provider; and (ii) Provider appeals of such adverse decisions; and (B) the availability to Provider, at the time of entering into this Addendum and upon Provider's request, of a paper copy of the Provider Manual(s). Provider shall comply with such policies and procedures in pursuing Reconsiderations and Appeals. Appeals of Company decisions adverse to the Provider shall be made in writing within 30 Calendar Days. (State Contract § 1.15.6)

44. Health Information Exchange ("***HIE***"). Provider shall comply with 63 O.S. §§ 1-133, and all subsequently promulgated rules, relating to participation in the State's SDE-HIE for the submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery. Encounter Data will include servicing provider data as required by 42 CFR § 438.242(c) (State Contract § 1.21.8)

45. Compliance with Law.

45.1 Changes in Law/Interpretation of Laws. The Parties to this Addendum acknowledge that Medicaid managed care plans are highly regulated by federal statutes and regulations. The Parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The Parties acknowledge and expect that changes may occur over the term of this Addendum regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Addendum, the Parties shall be mutually bound by the amended requirements in effect at any given time following the effective date of this Addendum. The explicit inclusion of some statutory and regulatory duties in this Addendum shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Addendum shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed. If any portion of this Addendum is found to be in violation of State or federal statutes, that portion shall be stricken from this Addendum and the remainder of this Addendum and Agreement shall remain in full force and effect. (State Contract § 1.2.20.5)

45.2 Compliance with Specific Laws. In accordance with 42 C.F.R. § 438.3(f)(1), Provider shall comply, and shall ensure that its officers, employees, Contracted Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies and guidance including but not limited to:

a) Federal requirements within 42 C.F.R. §§ 438.1, et seq., as applicable to MCOs
b) Title VI of the Civil Rights Act of 1964;
c) The Age Discrimination Act of 1975;
d) The Rehabilitation Act of 1973;
e) Title IX of the Education Amendments of 1972 (regarding education programs and activities);
f) The Americans with Disabilities Act of 1990 as amended;
g) Section 1557 of the Patient Protection and Affordable Care Act (ACA);
h) Health Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2 (HIPAA);
i) Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2 MHPAEA);
j) Oklahoma Electronic and Information Technology Accessibility (EITA) Act (Oklahoma 2004 House Bill (HB) 2197) regarding information technology accessibility standards for persons with disabilities;

k) Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, et seq
l) Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
m) Oklahoma Worker's Compensation Act, 85A O.S. §§ 1 *et seq.*;
n) 74 O.S. §§ 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to Company's entity) purchased with monies received from OHCA pursuant to the State Contract;
o) Title 317 of the Oklahoma Administrative Code ("OAC");
p) Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
q) Deceptive Trade Practices; Unfair Business Practices. (State Contract § 1.2.20.5)

45.3 Deceptive Trade Practices Violations. Provider represents and warrants that neither Provider nor any of its Subcontractors: (i) have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.*; (ii) have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding; (iii) have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding. (State Contract § 1.2.20.5)

45.4 Enrollees' Rights. In accordance with 42 C.F.R. § 438.100(a)(2), Provider shall comply with any applicable federal and State laws that pertain to Enrollees' rights and shall ensure that its employees and Contracted Providers observe and protect those rights. (State Contract § 1.2.20.5)

46. Primary Care Providers ("***PCP***"). The following provisions shall apply if Provider is a PCP. (State Contract §1.14.1.3). Provider shall:

a) deliver primary care services and follow-up care;
b) utilize and practice evidence-based medicine and clinical decision supports;
c) screen Enrollees for behavioral health disorders and conditions;
d) make referrals for Behavioral Health Services, specialty care and other covered services and, when applicable, work with Company to allow Enrollees to directly access a specialist as appropriate for an Enrollee's condition and identified needs;
e) maintain a current medical record for the Enrollee;
f) use health information technology to support care delivery;
g) provide care coordination in accordance with the Enrollee's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Enrollee's Care Manager;
h) ensure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;
i) engage active participation by the Enrollee and the Enrollee's family, Authorized Representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;
j) provide access to medical care 24 hours per day, 7 days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
k) provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
l) participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.
m) maintain medical records documenting all referrals of Enrollees.

n) meet the following "Appointment Time" obligations for the applicable Provider-type category (State Contract §§ 1.14.3.1and 1.14.3.2):

Service Category	Appointment Time
Adult PCP Pediatric PCP	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCP shall allow for at least some same-day appointments to meet acute care needs.
OB/GYN	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. Maternity Care: • First Trimester – Not to exceed 14 Calendar Days • Second Trimester – Not to exceed seven Calendar Days • Third Trimester – Not to exceed three Business Days
Adult Specialty Pediatric Specialty	• Not to exceed 60 Days from date of the Enrollee's request for routine appointment. • Within 24 hours for Urgent Care.

For purposes of the "Appointment Time" chart above, "Specialty" includes, but is not limited to, the following specialty provider-types: anesthesiologist assistants; physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package; audiologists; nutritionists; opticians; optometrists; podiatrists; and therapists to provide specialty care services as required in the SoonerSelect Program benefit package. (State Contract §1.14.3.3)

47. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.
   a) Provider shall provide inpatient psychiatric services to Enrollees and schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven Calendar Days from the date of discharge.
   b) Provider shall complete the ODMHSAS Customer Data Core form located at odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the State Contract;
   c) Provider shall provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.
   d) Provider agrees that Company will obtain the appropriate Enrollee releases to share clinical information and Enrollee health records with community-based behavioral health Providers, as requested, consistent with all State and federal confidentiality requirements and in accordance with Company policy and procedures. (State Contract §1.14.1.3.2)
   e) Provider shall meet the following "Appointment Time" obligations (State Contract §1.14.3.4):

Service Category	Appointment Time
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within seven Days for residential care and hospitalization. • Within 24 hours for Urgent Care.

f) If requested by the Enrollee and to the extent possible for OHCA-defined services that are reimbursable through Telehealth, Provider shall provide for the delivery of Behavioral Health Services via Telehealth. (State Contract §1.14.3.4)

48. Laboratory Testing Sites. The following provisions shall apply if Provider is a laboratory testing site. Provider shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration, along with a CLIA identification number. Provider understands that Company will maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Enrollees. Any Provider performing laboratory tests is required to be certified under CLIA. OHCA will continue to update the Provider file with CLIA information, which Provider acknowledges will make laboratory certification information available to Company on the Medicaid Provider file. (State Contract §1.14.1.3.3)

50. Pharmacy Providers. In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the pharmacist in charge must also be licensed by the Oklahoma State Board of Pharmacy. (State Contract § 1.14.3.5)

STATE LAW REGULATORY REQUIREMENTS

This schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Enrollees enrolled in or covered by this Product may be set forth in the Provider Manual or another Addendum. To the extent that a Coverage Agreement, or an Enrollee, is subject to the law cited in the parenthetical at the end of a provision on this Schedule B, such provision will apply to the rendering of Covered Services to an Enrollee with such Coverage Agreement, or to such Enrollee, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, an Enrollee shall not be liable to Participating Provider for any sums owed by Payor. Neither Participating Provider nor the agent, trustee or assignee of Participating Provider may maintain an action at law against an Enrollee to collect sums owed by Payor. (OKLA. STAT. ANN. tit. 36, § 6913.D)

OK-2 Termination.

(a) If Provider terminates the Agreement or Participating Provider voluntarily chooses to discontinue participation with respect to a particular Product, Provider or Participating Provider will give Company written notice by the longer of 90 days or the number of days set forth in the Agreement prior to such termination. (OKLA. STAT. ANN. tit. 36, § 6913.F; OKLA. ADMIN. CODE 365:40-5-71(4)(C))

(b) If Health Plan terminates the Agreement without cause, Health Plan will give Provider at least 90 days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than 90 days' advance notice are set forth in the Agreement (OKLA. ADMIN. CODE 365:40-5-71(1).

OK-3 Continuation of Care.

(a) If Payor becomes insolvent, Participating Provider shall provide services for the duration of the period after Payor's insolvency for which premium payment has been made, for Enrollees confined on the date of insolvency in an inpatient facility, and for pregnant Enrollees, until Enrollee's discharge from inpatient facilities, Enrollee's delivery and discharge if pregnant, and/or expiration of benefits under the Coverage Agreement. (OKLA. STAT. ANN. tit. 36, § 6913.E.2; OKLA. ADMIN. CODE 365:40-5-72(b))

(b) Following termination, Participating Provider will continue to provide services, at the terms and price under the Agreement, for up to 90 days from the date of notice for an Enrollee who: (i) has a degenerative and disabling condition or disease; (ii) has entered the third trimester of pregnancy; or (iii) is terminally ill. With respect to Enrollees that have entered the third trimester of pregnancy, terminated Participating Provider shall continue to provide services, at the terms and price under the Agreement, through at least six weeks of postpartum evaluation. (OKLA. ADMIN. CODE 365:40-5-71(4)(A).

(c) If Company or Payor authorizes such continuation of care, Participating Provider will: (i) accept reimbursement set forth in the Agreement as payment in full, (ii) adhere to the quality assurance requirements and provide necessary medical information regulated to such care, and (iii) otherwise adhere to applicable policies and procedures regarding references, and obtaining preauthorization and treatment plan approval, from the Company or Payor. (OKLA. ADMIN. CODE 365:40-5-71(4)(d).

OK-4 Delegation of Claims Processing. If Company has delegated its claims processing functions to Provider, Provider shall comply with the requirements of applicable Oklahoma law, including without limitation Chapter 40, Subchapter 5, Part 23 of the Insurance Department Regulations. (OKLA. ADMIN. CODE 365:40-5-127(d))

OK-5 Network Lease. Participating Provider expressly authorizes Company to sell, lease and otherwise transfer information regarding the payment or reimbursement terms of the Agreement, and acknowledges that Participating Provider has received prior adequate notification of such other contracting parties. (OKLA. STAT. ANN. tit. 36, §§ 1219.3.B; 7302.B)

OK-6 Indemnification. If the Agreement requires indemnification by Participating Provider, such indemnification will not apply, to the extent required by law, with respect to liability imposed by the Oklahoma Managed Health Care Reform and Accountability Act. (OKLA. STAT. ANN. tit. 36, § 6593.E).

OK-7 Contract Disclosures. Participating Provider acknowledges and agrees that the Agreement (including the Provider Manual) discloses the following:

(a) the mailing address, including a physical address, where claims are to be sent for processing whether it be the address of the Payor, a delegated claims processor, or any other entity, including a clearing house or a repricing company designated by the Payor to receive claims;

(b) the telephone number to which Participating Provider's questions and concerns regarding claims may be directed; and

(c) the mailing address, including physical address, of any separate claims processing centers for specific types of services, if applicable. (OKLA. ADMIN. CODE 365:40-5-127(a)).

PROVIDER AGREEMENT

AETNA BETTER HEALTH ADMINISTRATORS, LLC, on behalf of itself and its Affiliates ("Company"), and Mangum City Hospital Authority d/b/a/ Mangum Regional Medical Center, on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:
As of the Effective Date, Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: April 1, 2024 (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider's choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER	**COMPANY**
By:_____	**By:**_____
Printed Name:_____	**Printed Name:**_____
Title:_____	**Title:**_____

FEDERAL TAX I.D. NUMBER: 82-2087512

GROUP NPI NUMBER: 1033635263

As required by Section 8.6 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:	**Company:**
Mangum Regional Medical Center	**Aetna Medicaid Administrators LLC**
PO Box 280	**c/o Aetna Inc.**
Mangum, OK 73554	**4500 E Cotton Center Blvd**
Attn: Hospital Administrator	**Phoenix, AZ 85040**
	ATTN: Ld Director, Network Management

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within twenty (20) business days unless Applicable Law requires Company to update its directories in a shorter timeframe, of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Provider objects to a Policy change that will have a significant impact on Provider's administration or operations or will create a material adverse financial impact for Provider, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and eighty (180) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) Subject to Applicable law, to notify Company of any underpayment or payment/claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for

resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable Product Addendum(a) and Service and Rate Schedule(s), and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees to pay Facility for Covered Services rendered to Members; and within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company will notify Provider of a new or revised Product Addendum and Service and Rate Schedule.; provided that such addition will not go into effect unless Provider agrees to such addition, in writing, within the time period specified in Company's notice.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination

of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR**

INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT. The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum (the most current version, which may be contained in the Provider Manual)** and any other part of the Agreement, the terms of the State Compliance Addendum will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign

this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Company may amend the agreement for reasons other than Applicable Law by notifying Provider in writing at least sixty (60) days prior to the effective date of the amendment. Hospital may reject the amendment upon Provider's receipt of such notice of amendment, by notifying Company in writing of such rejection within thirty (30) days of notice of such amendment; provided, however, if Company has not received notice of such rejection within that thirty (30) day period, Provider's silence shall constitute acceptance of such amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider: (a) employed by Provider; or (b) who, through a contract or arrangement with Provider, provides services to Members for which Provider is reimbursed under this Agreement or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.
   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.
   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government

Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products. Furthermore, the Parties understand and agree that if this Agreement is executed prior to execution of a State Contract and/or prior to issuance to Company of Government Approvals, the **State Compliance Addendum (Medicaid Products)** may need to be added to this Agreement after execution. After issuance of the State Contract and/or Government Approvals, Company may, in its discretion: (a) unilaterally amend the Agreement to add the **State Compliance Addendum (Medicaid Products)**; and/or (b) incorporate the **State Compliance Addendum (Medicaid Products)** into the Provider Manual.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State.

B. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans: Reimbursement is based upon the contracted location where service is performed and is at a minimum an amount equal to 100% of the State of Oklahoma's Medicaid fee schedule.

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

C. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

D. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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Regulatory Compliance Addendum
Governing Oklahoma Medicaid (Provider)

Aetna Better Health of Oklahoma Inc., an Oklahoma corporation ("Company" or "CE") has contracted with the Oklahoma Health Care Authority ("OHCA" or "State Agency" or "Government Sponsor") to provide Medicaid managed care services to Enrollees as part of the SoonerSelect program ("SoonerSelect"). The provisions of this Addendum are required by the State Contract, state or federal law for all of Company's participating providers. Company and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company.

If there is any conflict between the terms of this Addendum and any term of the Agreement, including any Addendums, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict or ambiguity between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract shall govern and control. If any requirement in the Agreement or this Addendum is determined by OHCA to conflict with the State Contract, such requirement shall be null and void, and all other provisions shall remain in full force and effect. References to the State Contract are for convenience only.

Each provision contained herein shall apply to Provider only to the extent applicable to the services provided by Provider pursuant to the Agreement.

1. Definitions. Terms used in this Addendum and not defined herein will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract. Terms used in this Addendum that are not otherwise explicitly defined shall be understood to have the definition set forth in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

2. Incorporation of Terms and Conditions. Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents, the solicitation for the State Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Enrollees under this Addendum. (State Contract §1.14.1)

3. Approval of State Contract. Effectiveness of the Agreement is contingent upon approval of the State Contract by the OHCA Board and the Centers for Medicare and Medicaid Services (CMS). If CMS does not approve the State Contract under the terms and conditions, the Agreement and this Addendum, OHCA may terminate the Agreement. (State Contract§ 1.2.3)

4. Termination.

    4.1 Availability of Records. In the event of termination of this Addendum or the Agreement, Provider shall immediately make available to OHCA or its designated representative, in a usable form, any or all records, whether medically or financially related to the terminated Provider's activities undertaken pursuant to this Addendum, and that the provision of such records shall be at no expense to OHCA. (State Contract §1.14.1.11.14.1.1) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Enrollee records and information are provided to Company to facilitate an orderly transition of all Enrollees' care. (State Contract § 1.14.5.2.1)

4.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Addendum for cause upon 30 days advance written notice to the other party, and without cause upon 60 days advance written notice to the other party (State Contract §1.14.5.1).

4.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Addendum may be immediately terminated by Health Plan in the event of the following (State Contract§ 1.14.5.1):

a) To protect the health and safety of Enrollees;
b) Upon conviction of credible allegation of Fraud on the part of Provider;
c) Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way affected to make it unlawful for Provider to provide services under this Addendum;
d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (State Contract § 1.14.1.1 and State Contract § 1.12.6.1);
e) If Provider violates Section 1.24.1.7 of the State Contract (State Contract § 1.12.1.7).
f) DHS or OJA terminates or refuses to re-contract Provider.

4.4 Company's right to deny, refuse to renew or terminate the Agreement shall be in accordance with the terms of the State Contract and any applicable statutes and regulations;

5. Independent Contractor. Provider is not a third-party beneficiary to the State Contract. Provider is an independent contractor performing services as outlined in the State Contract. (State Contract §1.14.1.1)

6. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have a National Provider Identifier ("NPI"), to the extent such Provider is not an atypical provider as defined by CMS. (State Contract §1.14.1.1)

7. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Addendum be, enrolled as a contracted provider in good standing in SoonerCare, and Provider shall, upon request of Company or OHCA, provide any and all such documentary evidence, as reasonably required by Company or OHCA, to validate such status in accordance with 42 C.F.R. 438.602(b)(1) and 438.608(b) (State Contract §§1.13.1.4.1 and 1.20.8). In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Addendum pending the outcome of the of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days but will terminate Provider immediately upon notification from the State that Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of Provider with SoonerCare. (State Contract §1.13.1.4.2)

8. Credentialing and Recredentialing. Provider shall comply with OHCA's and Company's credentialing and re-credentialing processes as set forth in the Agreement and Provider Manual. (State Contract §§ 1.14.1 and 1.14.2) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

9. Enrollee Rights and Responsibilities. Provider shall abide by the Enrollee rights and responsibilities denoted in § 1.12.5.4 of the State Contract and in Company's Enrollee Handbook. (State § Contract 1.14.1.1)

10. Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings. Provider shall display notices in public areas of Provider's facility/facilities in accordance with all State requirements and any subsequent amendments. (State Contract § 1.14.1.1)

11. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (State Contract § 1.14.1.1)

12. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters. (State Contract §§ 1.14.1.1 1.12.1.1, and 1.12.1.2).

13. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (State Contract § 1.14.1.1)

14. Confidentiality. Provider shall keep all Enrollee information confidential, as defined by State and federal laws, regulations and policy. (State Contract § 1.14.1.1)

15. Records.

    15.1 Maintenance. Provider shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Enrollees and their representatives shall be given access to and can request copies of the Enrollees' medical records to the extent and in the manner provided under State or federal law. (State Contract § 1.14.1.1)

    15.2 Record Availability. Provider shall maintain all records related to services provided to Enrollees for a 10-year period (for minors, Provider shall retain all medical records during the period of minority, plus a minimum of 10 years after the age of majority.). In addition, Providers shall make all Enrollees' medical records or other service records available for any quality reviews that may be conducted by Company, OHCA or its designated agent(s) during and after the term of the Agreement. OHCA, its personnel, designees and contractors shall be provided with prompt access to Enrollees' records. Enrollees shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (State Contract §§ 1.14.1.1 and 1.11.9.1)

16. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Enrollees shall maintain and share Enrollees' health records in accordance with professional standards. (State Contract § 1.14.1.1)

17. Critical Incident Reporting. Consistent with the reporting and tracking system established by Company, Provider shall report adverse or Critical Incidents to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). Provider shall avail itself of training and take corrective action as needed to ensure compliance with Critical Incident requirements, in the manner and format required in the Reporting Manual. Provider shall ensure that any serious incident that harms or potentially harms a Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated and corrected, in a manner that ensures Company's compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39. Provider shall report abuse, neglect and/or Exploitation to Company within less than one Business Day. Provider shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all Enrollees and respond to any emergency needs of Enrollees. Provider shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c). Provider will cooperate with any investigations and implement any corrective actions as directed by Company and/or OHCA within applicable timeframes. (State Contract § 1.11.9.3)

18. Vaccines for Children. If Provider is eligible for participation in the Vaccines for Children program, Provider shall comply with all program requirements as defined by OHCA. (State Contract § 1.14.1.1)

19. Facility and Record Access for Evaluation, Inspection or Auditing Purposes. Authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Agreement (State Contract § 1.14.1.1). Provider shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which State of federal monies are expended, unless otherwise provided by law. Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2. (State Contract § 1.20.1.4)

20. Release of Information for Monitoring Purposes. Provider shall release to Company any information necessary to monitor Provider's performance on an ongoing and periodic basis. (State Contract § 1.14.1.1)

21. Cost Sharing.

21.1 Enrollee Charges. When the Covered Service provided requires a Co-payment, as allowed by Company, Provider may charge the Enrollee only the amount of the allowed Co-payment, which may not exceed the Co-payment amount allowed by OHCA. Provider shall accept payment made by Company as payment in full for Covered Services, and Provider shall not solicit or accept any surety or guarantee of payment from the Enrollee, OHCA or the State. (State Contract § 1.14.1.1)

21.2 Exemption from Cost Sharing. In accordance with 42 C.F.R. 447.56, Provider shall not seek cost sharing from "Exempt Populations," including, but not limited to, AI/AN Enrollees (State Contract §§1.19.2 and 1.17.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (State Contract § 1.19.3)

21.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Enrollee's Cost Sharing obligations, regardless of whether Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, Company shall not reduce payments to Provider, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing. (State Contract § 1.19.4)

21.4 Balance Billing. In accordance with §1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), Provider agrees to, and agrees that any of its Contracted Providers or subcontractors will, hold harmless Enrollee for the costs of Covered Services, except for any applicable Co-payment amount allowed by OHCA. (State Contract §1.16.1.3)

22. Third-Party Liability. Provider shall identify Enrollee Third-Party Liability coverage, including Medicare and long-term care insurance, as applicable; and except as otherwise required, Provider shall seek such Third-Party Liability payment before submitting claims to Company. (State Contract § 1.14.1.1)

23. Claims Submission and Payment. Provider shall comply with all claim submittal obligations of the State Contract. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to an Enrollee. Health Plan may not impose requirements to file claims within a shorter period. (State Contract 1.14.1.1). Except for those exceptions set forth in § 1.16.5 of the State Contract, resubmitted claims must be filed within an additional six months thereafter. (State Contract §§ 1.16.5 and 1.16.6)

24. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, may be set forth in the Agreement between Company and Provider (including any Amendments, Attachments, Exhibits or Appendices) or the Company's Provider Manual. (State Contract § 1.14.1.1)

25. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external Quality Management/Quality Improvement (QM/QI) monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or Company, and Provider shall participate in any corrective action processes taken to improve quality of care. (State Contract § 1.14.1.1)

26. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (State Contract § 1.14.1.1)

27. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (State Contract §1.8.5)

28. Indemnify and Hold Harmless. At all times during the term of the Agreement, Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by Provider or Contracted Providers pursuant to the Agreement. (State Contract § 1.14.1.1)

29. Non-discrimination. Provider agrees that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of Company's program or otherwise subjected to discrimination in the performance of the Agreement with Company or in the employment practices of Provider. Provider shall identify Enrollees in a manner which will not result in discrimination against the Enrollee in order to provide or coordinate the provision of Covered Services and shall not use discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients. (State Contract § 1.14.1.1)

30. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (State Contract § 1.14.1.1)

31. Timely Access to Care. Provider shall comply with State standards for timely access to care and services, as specified in the State Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. §438.206(c)(1)(i). Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, or if Provider serves only Medicaid Enrollees, hours of operation comparable to other State Medicaid populations, in accordance with 42 C.F.R. §438.206(c)(1)(ii). Provider shall comply with any corrective action directed by Company to remedy any failure to comply with timely access to care obligations. (State Contract § 1.13.1.2)

32. Database Screening and Criminal Background Check of Employees. Provider shall comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Enrollees and/or access to Enrollees' PHI. Provider is prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.20.10 of the State Contract, entitled "Prohibited Affiliations and Exclusions." Provider shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. Provider shall immediately report to Company any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate this Addendum as provided under State and/or federal law. (State Contract § 1.14.1.1)

33. Prohibited Payments. Provider acknowledges that Company will not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services (State Contract § 1.16.2.4):

33.1 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

33.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

33.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

33.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

33.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (State Contract § 1.7.15)

33.6 Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with § 1.20.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (State Contract § 1.16.2.2).

33.7 In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include: in accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to a Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include:

33.8 Health-acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of HHS under § 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of the Act; other than DVT/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients; and

33.9 Conditions meeting the following criteria:

a) Is identified in the State Plan;

b) Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

c) Has a negative consequence for the Enrollee;

d) Is auditable; and

e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

34. Prohibited Affiliations and Exclusions.

34.1 Provider acknowledges that Company may not contract with Providers excluded from participation in federal health care programs, and may not contract for the provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly: (i) with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in accordance with 42 C.F.R. § 438.808(a), and 438.808(b)(2); (ii) with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-

procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(a); or (iii) with any individual or entity that is excluded from participation in any federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(b). Moreover, Company may not employ or contract, directly or indirectly, for the furnishing of health care, services: (i) with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(a); or (ii) with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(b). Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (State Contract §1.20.10). Health Plan may immediately terminate this Addendum in the event that Provider comes within any such prohibition or exclusion. Provider shall not receive any payment hereunder using Medicaid funds for services or items as provided in §1.20.10 of the State Contract. (State Contract § 1.20.10.3)

34.2 No person who has been involved in any manner in the development of this State Contract while employed by the State of Oklahoma shall be employed by the Company to fulfill any of the services provided under the State Contract, in accordance with 74 O.S. § 85.42(B) (State Contract § 1.20.10.3)

34.3 Provider acknowledges that Company may not contract with: (i) any such person or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal, state, local department, or agency; (ii) any such person or entity that has been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property within three years of the Health Plan's contract with the person or entity; (iii) any such person or entity that is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in the previous paragraph; or (iv) Any such person or entity that has had one or more public (federal, state, or local) contracts terminated for cause or default within three years of the Health Plan's contract with the person or entity. (State Contract § 1.20.10.3)

35. Off-Shoring. In accordance with 42 C.F.R. § 438.602(i), Company shall not enter into any subcontract for the performance of any duty under this State Contract in which such services are to be transmitted or performed outside of the United States nor will any claims be paid by Company to a Network Provider, out-of-Network Provider, Subcontractor, or financial institution located outside of the U.S. The purchase of offshore services is expressly prohibited. (State Contract § 4.5.1)

36. Provider Right to Support Enrollee Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports an Enrollee's Appeal. (State Contract § 1.14.1.2)

37. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (State Contract § 1.23.1.18)

38. Grievances and Appeals System. Provider acknowledges that it has received the following information regarding Company's Grievance and Appeals system. In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), Company operates an Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances. In accordance with the requirements of 42 C.F.R. § 438.402, Company's Grievances and Appeals System allows a Enrollee (or his or her Authorized Representative) to file a Grievance with Company, either orally or in writing, at any time, and to subsequently to request an Appeal with Company, with the ability for the Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. An Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to Company, which may be filed either orally or in writing. Unless the Enrollee is requesting an expedited resolution, an Enrollee's oral request for an Appeal must be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made. Company will make assistance available to the Enrollee with filing Grievances and Appeals including: provision of reasonable assistance to Enrollees in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Enrollee care support staff; (iv) providing auxiliary aids and services upon request, such as providing interpreter services; and (v) providing toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 C.F.R. 438.406(a). An Enrollee may be represented by an Authorized Representative, may present evidence and testimony, may make legal and factual arguments and the Company shall make Enrollee's case file available to the Enrollee at no charge. Enrollee has the right to request a State Fair Hearing by filing a request within 120 Days after receiving notice that the Adverse Benefit Determination has been upheld on Appeal. Enrollee has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing., Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Enrollee, as specified in 42 § 438.420(b)(5). (State Contract § 1.18 et. seq.)

39. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall return overpayments within 60 Days after the date on which the Overpayment was identified and shall notify Company in writing of the reason for the Overpayment. Provider acknowledges that if an Overpayment is identified by OHCA rather than by Company, OHCA may recover the Overpayment directly from Provider, or OHCA may require Company to recover and send the Overpayment to OHCA as directed by the OHCA Program Integrity and Accountability Unit. (State Contract §1.20.11.6)

40. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect Program enrollment. Enrollees who become Dual Eligible Individuals will be disenrolled as of their Medicare eligibility effective date. In the event that an Enrollee becomes retroactively Medicare eligible, Company will recover any claims payments made to Provider during the months of retroactive Medicare eligibility. Provider shall submit the claim to Medicare for reimbursement in such instances. (State Contract § 1.6.10)

41. Electronic Visit Verification. If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (State Contract § 1.21.2)

42. Encounter Data. Provider shall cooperate with Company's Encounter Data submittal requirements and shall submit required Encounter Data in accordance with Company's automated Encounter Data system, and Provider shall accept and use the State-assigned Provider IDs for Encounter Data submissions and shall accept and use the State eMPI/Medicaid IDs for Enrollees. Provider shall submit complete Encounter Data and claims data timely and in sufficient detail to support detailed utilization and tracking and financial reporting. (State Contract §§ 1.21.7 et. seq.)

43. Provider Reconsiderations and Provider Appeals. Provider acknowledges: (A) receipt from Company of the link to Company's website containing, among other things, the Provider Manual(s) detailing, among other things, the policies and procedures for (i) Company's reconsideration of decisions adverse to Provider; and (ii) Provider appeals of such adverse decisions; and (B) the availability to Provider, at the time of entering into this Addendum and upon Provider's request, of a paper copy of the Provider Manual(s). Provider shall comply with such policies and procedures in pursuing Reconsiderations and Appeals. Appeals of Company decisions adverse to the Provider shall be made in writing within 30 Calendar Days. (State Contract § 1.15.6)

44. Health Information Exchange ("***HIE***"). Provider shall comply with 63 O.S. §§ 1-133, and all subsequently promulgated rules, relating to participation in the State's SDE-HIE for the submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery. Encounter Data will include servicing provider data as required by 42 CFR § 438.242(c) (State Contract § 1.21.8)

45. Compliance with Law.

45.1 Changes in Law/Interpretation of Laws. The Parties to this Addendum acknowledge that Medicaid managed care plans are highly regulated by federal statutes and regulations. The Parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The Parties acknowledge and expect that changes may occur over the term of this Addendum regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Addendum, the Parties shall be mutually bound by the amended requirements in effect at any given time following the effective date of this Addendum. The explicit inclusion of some statutory and regulatory duties in this Addendum shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Addendum shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed. If any portion of this Addendum is found to be in violation of State or federal statutes, that portion shall be stricken from this Addendum and the remainder of this Addendum and Agreement shall remain in full force and effect. (State Contract § 1.2.20.5)

45.2 Compliance with Specific Laws. In accordance with 42 C.F.R. § 438.3(f)(1), Provider shall comply, and shall ensure that its officers, employees, Contracted Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies and guidance including but not limited to:

a) Federal requirements within 42 C.F.R. §§ 438.1, et seq., as applicable to MCOs
b) Title VI of the Civil Rights Act of 1964;
c) The Age Discrimination Act of 1975;
d) The Rehabilitation Act of 1973;
e) Title IX of the Education Amendments of 1972 (regarding education programs and activities);
f) The Americans with Disabilities Act of 1990 as amended;
g) Section 1557 of the Patient Protection and Affordable Care Act (ACA);
h) Health Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2 (HIPAA);
i) Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2 MHPAEA);
j) Oklahoma Electronic and Information Technology Accessibility (EITA) Act (Oklahoma 2004 House Bill (HB) 2197) regarding information technology accessibility standards for persons with disabilities;

k) Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, et seq
l) Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
m) Oklahoma Worker's Compensation Act, 85A O.S. §§ 1 *et seq.*;
n) 74 O.S. §§ 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to Company's entity) purchased with monies received from OHCA pursuant to the State Contract;
o) Title 317 of the Oklahoma Administrative Code ("OAC");
p) Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
q) Deceptive Trade Practices; Unfair Business Practices. (State Contract § 1.2.20.5)

45.3 Deceptive Trade Practices Violations. Provider represents and warrants that neither Provider nor any of its Subcontractors: (i) have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.*; (ii) have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding; (iii) have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding. (State Contract § 1.2.20.5)

45.4 Enrollees' Rights. In accordance with 42 C.F.R. § 438.100(a)(2), Provider shall comply with any applicable federal and State laws that pertain to Enrollees' rights and shall ensure that its employees and Contracted Providers observe and protect those rights. (State Contract § 1.2.20.5)

46. Primary Care Providers ("***PCP***"). The following provisions shall apply if Provider is a PCP. (State Contract §1.14.1.3). Provider shall:

a) deliver primary care services and follow-up care;
b) utilize and practice evidence-based medicine and clinical decision supports;
c) screen Enrollees for behavioral health disorders and conditions;
d) make referrals for Behavioral Health Services, specialty care and other covered services and, when applicable, work with Company to allow Enrollees to directly access a specialist as appropriate for an Enrollee's condition and identified needs;
e) maintain a current medical record for the Enrollee;
f) use health information technology to support care delivery;
g) provide care coordination in accordance with the Enrollee's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Enrollee's Care Manager;
h) ensure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;
i) engage active participation by the Enrollee and the Enrollee's family, Authorized Representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;
j) provide access to medical care 24 hours per day, 7 days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
k) provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
l) participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.
m) maintain medical records documenting all referrals of Enrollees.

n) meet the following "Appointment Time" obligations for the applicable Provider-type category (State Contract §§ 1.14.3.1and 1.14.3.2):

Service Category	Appointment Time
Adult PCP Pediatric PCP	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCP shall allow for at least some same-day appointments to meet acute care needs.
OB/GYN	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. Maternity Care: • First Trimester – Not to exceed 14 Calendar Days • Second Trimester – Not to exceed seven Calendar Days • Third Trimester – Not to exceed three Business Days
Adult Specialty Pediatric Specialty	• Not to exceed 60 Days from date of the Enrollee's request for routine appointment. • Within 24 hours for Urgent Care.

For purposes of the "Appointment Time" chart above, "Specialty" includes, but is not limited to, the following specialty provider-types: anesthesiologist assistants; physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package; audiologists; nutritionists; opticians; optometrists; podiatrists; and therapists to provide specialty care services as required in the SoonerSelect Program benefit package. (State Contract §1.14.3.3)

47. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.
   a) Provider shall provide inpatient psychiatric services to Enrollees and schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven Calendar Days from the date of discharge.
   b) Provider shall complete the ODMHSAS Customer Data Core form located at odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the State Contract;
   c) Provider shall provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.
   d) Provider agrees that Company will obtain the appropriate Enrollee releases to share clinical information and Enrollee health records with community-based behavioral health Providers, as requested, consistent with all State and federal confidentiality requirements and in accordance with Company policy and procedures. (State Contract §1.14.1.3.2)
   e) Provider shall meet the following "Appointment Time" obligations (State Contract §1.14.3.4):

Service Category	Appointment Time
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within seven Days for residential care and hospitalization. • Within 24 hours for Urgent Care.

f) If requested by the Enrollee and to the extent possible for OHCA-defined services that are reimbursable through Telehealth, Provider shall provide for the delivery of Behavioral Health Services via Telehealth. (State Contract §1.14.3.4)

48. Laboratory Testing Sites. The following provisions shall apply if Provider is a laboratory testing site. Provider shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration, along with a CLIA identification number. Provider understands that Company will maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Enrollees. Any Provider performing laboratory tests is required to be certified under CLIA. OHCA will continue to update the Provider file with CLIA information, which Provider acknowledges will make laboratory certification information available to Company on the Medicaid Provider file. (State Contract §1.14.1.3.3)

50. Pharmacy Providers. In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the pharmacist in charge must also be licensed by the Oklahoma State Board of Pharmacy. (State Contract § 1.14.3.5)

STATE LAW REGULATORY REQUIREMENTS

This schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Enrollees enrolled in or covered by this Product may be set forth in the Provider Manual or another Addendum. To the extent that a Coverage Agreement, or an Enrollee, is subject to the law cited in the parenthetical at the end of a provision on this Schedule B, such provision will apply to the rendering of Covered Services to an Enrollee with such Coverage Agreement, or to such Enrollee, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, an Enrollee shall not be liable to Participating Provider for any sums owed by Payor. Neither Participating Provider nor the agent, trustee or assignee of Participating Provider may maintain an action at law against an Enrollee to collect sums owed by Payor. (OKLA. STAT. ANN. tit. 36, § 6913.D)

OK-2 Termination.

(a) If Provider terminates the Agreement or Participating Provider voluntarily chooses to discontinue participation with respect to a particular Product, Provider or Participating Provider will give Company written notice by the longer of 90 days or the number of days set forth in the Agreement prior to such termination. (OKLA. STAT. ANN. tit. 36, § 6913.F; OKLA. ADMIN. CODE 365:40-5-71(4)(C))

(b) If Health Plan terminates the Agreement without cause, Health Plan will give Provider at least 90 days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than 90 days' advance notice are set forth in the Agreement (OKLA. ADMIN. CODE 365:40-5-71(1).

OK-3 Continuation of Care.

(a) If Payor becomes insolvent, Participating Provider shall provide services for the duration of the period after Payor's insolvency for which premium payment has been made, for Enrollees confined on the date of insolvency in an inpatient facility, and for pregnant Enrollees, until Enrollee's discharge from inpatient facilities, Enrollee's delivery and discharge if pregnant, and/or expiration of benefits under the Coverage Agreement. (OKLA. STAT. ANN. tit. 36, § 6913.E.2; OKLA. ADMIN. CODE 365:40-5-72(b))

(b) Following termination, Participating Provider will continue to provide services, at the terms and price under the Agreement, for up to 90 days from the date of notice for an Enrollee who: (i) has a degenerative and disabling condition or disease; (ii) has entered the third trimester of pregnancy; or (iii) is terminally ill. With respect to Enrollees that have entered the third trimester of pregnancy, terminated Participating Provider shall continue to provide services, at the terms and price under the Agreement, through at least six weeks of postpartum evaluation. (OKLA. ADMIN. CODE 365:40-5-71(4)(A).

(c) If Company or Payor authorizes such continuation of care, Participating Provider will: (i) accept reimbursement set forth in the Agreement as payment in full, (ii) adhere to the quality assurance requirements and provide necessary medical information regulated to such care, and (iii) otherwise adhere to applicable policies and procedures regarding references, and obtaining preauthorization and treatment plan approval, from the Company or Payor. (OKLA. ADMIN. CODE 365:40-5-71(4)(d).

OK-4 Delegation of Claims Processing. If Company has delegated its claims processing functions to Provider, Provider shall comply with the requirements of applicable Oklahoma law, including without limitation Chapter 40, Subchapter 5, Part 23 of the Insurance Department Regulations. (OKLA. ADMIN. CODE 365:40-5-127(d))

OK-5 Network Lease. Participating Provider expressly authorizes Company to sell, lease and otherwise transfer information regarding the payment or reimbursement terms of the Agreement, and acknowledges that Participating Provider has received prior adequate notification of such other contracting parties. (OKLA. STAT. ANN. tit. 36, §§ 1219.3.B; 7302.B)

OK-6 Indemnification. If the Agreement requires indemnification by Participating Provider, such indemnification will not apply, to the extent required by law, with respect to liability imposed by the Oklahoma Managed Health Care Reform and Accountability Act. (OKLA. STAT. ANN. tit. 36, § 6593.E).

OK-7 Contract Disclosures. Participating Provider acknowledges and agrees that the Agreement (including the Provider Manual) discloses the following:

(a) the mailing address, including a physical address, where claims are to be sent for processing whether it be the address of the Payor, a delegated claims processor, or any other entity, including a clearing house or a repricing company designated by the Payor to receive claims;

(b) the telephone number to which Participating Provider's questions and concerns regarding claims may be directed; and

(c) the mailing address, including physical address, of any separate claims processing centers for specific types of services, if applicable. (OKLA. ADMIN. CODE 365:40-5-127(a)).

FACILITY AGREEMENT

AETNA BETTER HEALTH ADMINISTRATORS, LLC, on behalf of itself and its Affiliates ("Company"), and Mangum City Hospital Authority dba Mangum Family Clinic on behalf of itself and any and all of its Facility Providers and locations ("Facility" or "Provider"), are entering into this Facility Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page, the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:

As of Effective Date, Facility agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: April 1, 2024 (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Facility has read and understood this Agreement, has had the opportunity to review it with an attorney of Facility's choice, and is authorized to bind Facility, including all Facility Providers and Facility locations, to the terms of the Agreement.

FACILITY	**COMPANY**
By:_____	**By:**_____
Printed Name:_____	**Printed Name:**_____
Title:_____	**Title:**_____

FEDERAL TAX I.D. NUMBER: 82-2087512

NPI NUMBER: 1568978708

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Facility:	**Company:**
Mangum Family Clinic	**Aetna Medicaid Administrators, LLC.**
PO Box 280	**c/o Aetna. Inc**
Mangum, OK 73554	**4500 E Cotton Center Blvd**
Attn: Hospital Administrator	**Phoenix, AZ 85040**
	ATTN: Ld Director, Network Management

GENERAL TERMS AND CONDITIONS

1.0 FACILITY OBLIGATIONS

1.1 **General Obligations**. Facility agrees that it and all Facility Providers will:

(a) provide Covered Services, including any related facilities, equipment, personnel and/or other resources necessary to provide the Covered Services, to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law and conduct all credentialing, privileging, and re-appointment in accordance with Applicable Law and its medical staff by-laws, regulations, and policies;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Facility represents that neither it nor any Facility Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Facility understands that no Facility Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Facility Providers in all Facility locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Facility's services to be made directly to Facility instead of to the Member, unless the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Facility further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Facility agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Facility will not accept any referral from persons or entities that have a financial interest in Facility, or make any referrals to persons or entities in which Facility has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Facility or a Facility Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Facility renders to Members; (ii) claims against Facility or a Facility Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks, that could reasonably have a material impact on Facility's ability to provide services to Members or to participate in Medicare or Medicaid programs; (iii) investigation or action taken by The Joint Commission (TJC) and/or other applicable accrediting organization that could adversely affect Facility's accreditation status; (iv) change in the ownership or management of Facility; (v) material change in services provided by Facility (e.g., a significant decrease in medical staff or the closure of a service unit or a material decrease in beds or emergency services departments) or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Facility or a Facility Provider related to those services;

(n) mutually commit, together with Company, to the promotion of Member safety and clinical quality, including the prevention of potentially avoidable serious adverse events. Facility agrees to comply with Company's Patient Safety Events and related policies, and any successor policies, including, but not limited to, notification to applicable reporting agencies; root cause analysis; corrective action; and the waiver of directly related charges for certain events. Facility agrees to publicly report patient safety and quality information at least annually, to one or more external reporting entities, including but not limited to: CMS Quality Reporting Program; TJC; Leapfrog Facility Survey; and March of Dimes 39-Week Initiative.

1.2 **Facility Contact and Service Information**. Facility agrees that it has provided Company with contact information that is complete and accurate as of the Effective Date. Facility will notify Company within twenty (20) business days unless Applicable Law requires Company to update its directories in a shorter timeframe, of all changes to the list of Facility Providers, the services it/they provide and all contact and billing information for Facility and Facility Providers. Facility understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Facility fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Facility.

1.3 **Compliance with Company Policies**. Facility agrees to comply with Company Policies of which Facility knows or reasonably should have known, including, but not limited to, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Facility's administration or rates under this Agreement, Company will send Facility at least ninety (90) days advance written notice of the Policy change. Facility understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Facility objects to a Policy change that will have a significant impact on Facility's administration or operations or will create a material adverse financial impact for Facility, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Facility is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Facility agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Facility Providers for services rendered, and that it will require all Facility Providers to look solely to Facility for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Facility and Facility Providers, containing all information needed to process the claims, within one hundred and eighty (180) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Facility provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Facility's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) Subject to Applicable law, to notify Company of any underpayment or payment/claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Facility's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Facility acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Facility with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

1.5 **Member Billing**. Facility agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Facility's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

1.6 **Utilization Management**. Facility agrees that it shall be subject to utilization management (including prospective, concurrent and retrospective review) and that payment for Facility services may be adjusted or denied for the inefficient delivery of services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Facility and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Facility.

1.7 **Precertification and Referrals**. Except when a Member requires emergency services, Facility agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Facility services. Facility will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Facility agrees to provide notice of all admissions of

Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the purpose of pre-admission testing, Facility agrees to directly provide testing or accept test results and examinations performed outside Facility, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a specialty program, Facility agrees to work with Company in transferring the Member's care to a specialty program Facility, as the case may be.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Facility, (ii) provide Facility with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Facility with a means to check Member eligibility; and (iv) include Facility in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Facility of periodic updates to its Policies as required by this Agreement and make current Policies available to Facility through its provider websites or other commonly accepted media.

2.2 **Claims Payment.** Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees to pay Facility for Covered Services rendered to Members; and within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim.

3.0 NETWORK PARTIPATION Facility agrees that it and Facility Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company will notify Facility of a new or revised Product Addendum and Service and Rate Schedule; provided that such addition will not go into effect unless Hospital agrees to such addition, in writing, within the time period specified in Company's notice.

4.0 CONFIDENTIALITY

Company and Facility agree that medical records do not belong to Company. Company and Facility agree that the information contained in the claims Facility submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Facility/Facility Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Facility will keep the rates and the development of rates and other terms of this Agreement confidential. However, Facility, through its staff, is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which Facility is paid. In addition, Facility and Facility Providers are encouraged to communicate with patients about

their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Facilities or Locations**. Company may terminate the participation of one or more of Facility's individual facilities or locations: (a) without cause, by providing Facility with at least one hundred and twenty (120) days written notice prior to the date of termination; or (b) for breach, as specified below, without affecting the participation of other facilities/locations.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Facility or any Facility Provider or location, with written notice to Facility, due to: (a) Facility's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) the bankruptcy or receivership of Facility, or an assignment by Facility for the benefit of creditors; (c) the exclusion, debarment or suspension of Facility or a Facility Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (d) change of control of Facility to an entity not acceptable to Company; (e) the revocation or suspension of Facility's accreditation by TJC or any other applicable accrediting agency; or (f) a determination by Company that Facility's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Facility will provide immediate notice to Company of any of the events described in (a)-(e) above. Facility may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Facility agrees to provide services, at Company's discretion, to: (a) any Member under Facility's care who, at the time of the effective date of termination, is a registered bed patient at Facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Facility will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Facility are independent contractors, and not employees, agents or representatives of each other. Company and Facility will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Facility will be liable in any way for the activities of the other Party or the other Party's employees or agents. Facility acknowledges that all Member care and related decisions are the responsibility of Facility and/or Facility Providers and that Policies do not dictate or control Facility's and/or Facility Providers' clinical decisions with respect to the care of Members. Facility agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Facility's and/or Facility Providers' provision of care to Members. Company agrees to indemnify and hold harmless Facility and Facility Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Facility agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Facility will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Facility will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Facility will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Facility and a Member, or a party designated by a Member determined by Facility to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Facility can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Facility will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND FACILITY UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum (the most current version, which may be contained in the Provider Manual)** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Facility is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by Company under this Agreement. Facility agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by facilities in the state or region in which the Facility operates. Such insurance coverage shall cover the acts and omissions of Facility as well as those of Facility's agents and employees.

8.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.5 **Assignment**. Facility may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Facility participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Facility.

8.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Company may amend the agreement for reasons other than Applicable Law by notifying Hospital in writing at least sixty (60) days prior to the effective date of the amendment. Hospital may reject the amendment upon Hospital's receipt of such notice of amendment, by notifying Company in writing of such rejection within thirty (30) days of notice of such amendment; provided, however, if Company has not received notice of such rejection within that thirty (30) day period, Hospital's silence shall constitute acceptance of such amendment.

8.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.8 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Facility, applicable accreditation agency or organization (e.g., TJC, Committee on Accreditation of Rehabilitation Facilities (CARF), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)) requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Facility Provider. Any physician or other health care provider: (a) employed by Facility; or (b) who, through a contract or arrangement with Facility, provides services to Members for which Facility is reimbursed under this Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Facility, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Facility serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria, Provider Manuals, clinical policy bulletins, credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, Institutes of Excellence™, complaint and appeals, and other policies and procedures (as modified from time to time) that are made available to Facility electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Facility participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are

conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products. Furthermore, the Parties understand and agree that if this Agreement is executed prior to execution of a State Contract and/or prior to issuance to Company of Government Approvals, the **State Compliance Addendum (Medicaid Products)** may need to be added to this Agreement after execution. After issuance of the State Contract and/or Government Approvals, Company may, in its discretion: (a) unilaterally amend the Agreement to add the **State Compliance Addendum (Medicaid Products);** and/or (b) incorporate the **State Compliance Addendum (Medicaid Products)** into the Provider Manual.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State.

B. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates:

RHC COVERED SERVICES

Medicaid Plans:	100% of the Oklahoma Medicaid Provider Specific RHC Encounter Rate, as established by OHCA and is not subject to lesser of logic. (Vaccine for Children program enrollment required)
CHIP Plans:	100% of the Oklahoma Medicaid Provider Specific RHC Encounter Rate, as established by OHCA and is not subject to lesser of logic. (Vaccine for Children program enrollment required)

PATIENT CENTERED MEDICAL HOME ("PCMH") PROGRAM

The Parties agree to negotiate in good faith participation in a Patient Centered Medical Home ("PCMH") program. In the event such negotiations are completed, the Parties agree to execute an amendment to this agreement to reimburse Facility a PMPM rate for PCMH.

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Rural Health Clinic (RHC) Encounter Rates - Payment for Covered Services shall be made in accordance with CMS methodology for Facility type. Company shall reimburse Facility equal to Facility's current encounter rate. Company will comply with CMS and OHCA regulations in administering reimbursement amounts and equal the total allowable rate, less applicable copayment or deductible amounts.

C. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

D. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

E. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

Regulatory Compliance Addendum
Governing Oklahoma Medicaid (Provider)

Aetna Better Health of Oklahoma Inc., an Oklahoma corporation ("Company" or "CE") has contracted with the Oklahoma Health Care Authority ("OHCA" or "State Agency" or "Government Sponsor") to provide Medicaid managed care services to Enrollees as part of the SoonerSelect program ("SoonerSelect"). The provisions of this Addendum are required by the State Contract, state or federal law for all of Company's participating providers. Company and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company.

If there is any conflict between the terms of this Addendum and any term of the Agreement, including any Addendums, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict or ambiguity between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract shall govern and control. If any requirement in the Agreement or this Addendum is determined by OHCA to conflict with the State Contract, such requirement shall be null and void, and all other provisions shall remain in full force and effect. References to the State Contract are for convenience only.

Each provision contained herein shall apply to Provider only to the extent applicable to the services provided by Provider pursuant to the Agreement.

1. Definitions. Terms used in this Addendum and not defined herein will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract. Terms used in this Addendum that are not otherwise explicitly defined shall be understood to have the definition set forth in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

2. Incorporation of Terms and Conditions. Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents, the solicitation for the State Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Enrollees under this Addendum. (State Contract §1.14.1)

3. Approval of State Contract. Effectiveness of the Agreement is contingent upon approval of the State Contract by the OHCA Board and the Centers for Medicare and Medicaid Services (CMS). If CMS does not approve the State Contract under the terms and conditions, the Agreement and this Addendum, OHCA may terminate the Agreement. (State Contract§ 1.2.3)

4. Termination.

   4.1 Availability of Records. In the event of termination of this Addendum or the Agreement, Provider shall immediately make available to OHCA or its designated representative, in a usable form, any or all records, whether medically or financially related to the terminated Provider's activities undertaken pursuant to this Addendum, and that the provision of such records shall be at no expense to OHCA. (State Contract §1.14.1.11.14.1.1) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Enrollee records and information are provided to Company to facilitate an orderly transition of all Enrollees' care. (State Contract § 1.14.5.2.1)

   4.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Addendum for cause upon 30 days advance written notice to the

other party, and without cause upon 60 days advance written notice to the other party (State Contract §1.14.5.1).

4.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Addendum may be immediately terminated by Health Plan in the event of the following (State Contract§ 1.14.5.1):

a) To protect the health and safety of Enrollees;
b) Upon conviction of credible allegation of Fraud on the part of Provider;
c) Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way affected to make it unlawful for Provider to provide services under this Addendum;
d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (State Contract § 1.14.1.1 and State Contract § 1.12.6.1);
e) If Provider violates Section 1.24.1.7 of the State Contract (State Contract § 1.12.1.7).
f) DHS or OJA terminates or refuses to re-contract Provider.

4.4 Company's right to deny, refuse to renew or terminate the Agreement shall be in accordance with the terms of the State Contract and any applicable statutes and regulations;

5. Independent Contractor. Provider is not a third-party beneficiary to the State Contract. Provider is an independent contractor performing services as outlined in the State Contract. (State Contract §1.14.1.1)

6. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have a National Provider Identifier ("NPI"), to the extent such Provider is not an atypical provider as defined by CMS. (State Contract §1.14.1.1)

7. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Addendum be, enrolled as a contracted provider in good standing in SoonerCare, and Provider shall, upon request of Company or OHCA, provide any and all such documentary evidence, as reasonably required by Company or OHCA, to validate such status in accordance with 42 C.F.R. 438.602(b)(1) and 438.608(b) (State Contract §§1.13.1.4.1 and 1.20.8). In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Addendum pending the outcome of the of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days but will terminate Provider immediately upon notification from the State that Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of Provider with SoonerCare. (State Contract §1.13.1.4.2)

8. Credentialing and Recredentialing. Provider shall comply with OHCA's and Company's credentialing and re-credentialing processes as set forth in the Agreement and Provider Manual. (State Contract §§ 1.14.1 and 1.14.2) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

9. Enrollee Rights and Responsibilities. Provider shall abide by the Enrollee rights and responsibilities denoted in § 1.12.5.4 of the State Contract and in Company's Enrollee Handbook. (State § Contract 1.14.1.1)

10. Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings. Provider shall display notices in public areas of Provider's facility/facilities in accordance with all State requirements and any subsequent amendments. (State Contract § 1.14.1.1)

11. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (State Contract § 1.14.1.1)

12. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters. (State Contract §§ 1.14.1.1 1.12.1.1, and 1.12.1.2).

13. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (State Contract § 1.14.1.1)

14. Confidentiality. Provider shall keep all Enrollee information confidential, as defined by State and federal laws, regulations and policy. (State Contract § 1.14.1.1)

15. Records.

    15.1 Maintenance. Provider shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Enrollees and their representatives shall be given access to and can request copies of the Enrollees' medical records to the extent and in the manner provided under State or federal law. (State Contract § 1.14.1.1)

    15.2 Record Availability. Provider shall maintain all records related to services provided to Enrollees for a 10-year period (for minors, Provider shall retain all medical records during the period of minority, plus a minimum of 10 years after the age of majority.). In addition, Providers shall make all Enrollees' medical records or other service records available for any quality reviews that may be conducted by Company, OHCA or its designated agent(s) during and after the term of the Agreement. OHCA, its personnel, designees and contractors shall be provided with prompt access to Enrollees' records. Enrollees shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (State Contract §§ 1.14.1.1 and 1.11.9.1)

16. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Enrollees shall maintain and share Enrollees' health records in accordance with professional standards. (State Contract § 1.14.1.1)

17. Critical Incident Reporting. Consistent with the reporting and tracking system established by Company, Provider shall report adverse or Critical Incidents to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). Provider shall avail itself of training and take corrective action as needed to ensure compliance with Critical Incident requirements, in the manner and format required in the Reporting Manual. Provider shall ensure that any serious incident that harms or potentially harms a Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated and corrected, in a manner that ensures Company's compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39. Provider shall report abuse, neglect and/or Exploitation to Company within less than one Business Day. Provider shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all Enrollees and respond to any emergency needs of Enrollees. Provider shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c). Provider will cooperate with any investigations and implement any corrective actions as directed by Company and/or OHCA within applicable timeframes. (State Contract § 1.11.9.3)

18. Vaccines for Children. If Provider is eligible for participation in the Vaccines for Children program, Provider shall comply with all program requirements as defined by OHCA. (State Contract § 1.14.1.1)

19. Facility and Record Access for Evaluation, Inspection or Auditing Purposes. Authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Agreement (State Contract § 1.14.1.1). Provider shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which State of federal monies are expended, unless otherwise provided by law. Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2. (State Contract § 1.20.1.4)

20. Release of Information for Monitoring Purposes. Provider shall release to Company any information necessary to monitor Provider's performance on an ongoing and periodic basis. (State Contract § 1.14.1.1)

21. Cost Sharing.

21.1 Enrollee Charges. When the Covered Service provided requires a Co-payment, as allowed by Company, Provider may charge the Enrollee only the amount of the allowed Co-payment, which may not exceed the Co-payment amount allowed by OHCA. Provider shall accept payment made by Company as payment in full for Covered Services, and Provider shall not solicit or accept any surety or guarantee of payment from the Enrollee, OHCA or the State. (State Contract § 1.14.1.1)

21.2 Exemption from Cost Sharing. In accordance with 42 C.F.R. 447.56, Provider shall not seek cost sharing from "Exempt Populations," including, but not limited to, AI/AN Enrollees (State Contract §§1.19.2 and 1.17.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (State Contract § 1.19.3)

21.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Enrollee's Cost Sharing obligations, regardless of whether Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, Company shall not reduce payments to Provider, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing. (State Contract § 1.19.4)

21.4 Balance Billing. In accordance with §1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), Provider agrees to, and agrees that any of its Contracted Providers or subcontractors will, hold harmless Enrollee for the costs of Covered Services, except for any applicable Co-payment amount allowed by OHCA. (State Contract §1.16.1.3)

22. Third-Party Liability. Provider shall identify Enrollee Third-Party Liability coverage, including Medicare and long-term care insurance, as applicable; and except as otherwise required, Provider shall seek such Third-Party Liability payment before submitting claims to Company. (State Contract § 1.14.1.1)

23. Claims Submission and Payment. Provider shall comply with all claim submittal obligations of the State Contract. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to an Enrollee. Health Plan may not impose requirements to file claims within a shorter period. (State Contract 1.14.1.1). Except for those exceptions set forth in § 1.16.5 of the State Contract, resubmitted claims must be filed within an additional six months thereafter. (State Contract §§ 1.16.5 and 1.16.6)

24. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, may be set forth in the Agreement between Company and Provider (including any Amendments, Attachments, Exhibits or Appendices) or the Company's Provider Manual. (State Contract § 1.14.1.1)

25. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external Quality Management/Quality Improvement (QM/QI) monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or Company, and Provider shall participate in any corrective action processes taken to improve quality of care. (State Contract § 1.14.1.1)

26. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (State Contract § 1.14.1.1)

27. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (State Contract §1.8.5)

28. Indemnify and Hold Harmless. At all times during the term of the Agreement, Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by Provider or Contracted Providers pursuant to the Agreement. (State Contract § 1.14.1.1)

29. Non-discrimination. Provider agrees that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of Company's program or otherwise subjected to discrimination in the performance of the Agreement with Company or in the employment practices of Provider. Provider shall identify Enrollees in a manner which will not result in discrimination against the Enrollee in order to provide or coordinate the provision of Covered Services and shall not use discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients. (State Contract § 1.14.1.1)

30. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (State Contract § 1.14.1.1)

31. Timely Access to Care. Provider shall comply with State standards for timely access to care and services, as specified in the State Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. §438.206(c)(1)(i). Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, or if Provider serves only Medicaid Enrollees, hours of operation comparable to other State Medicaid populations, in accordance with 42 C.F.R. §438.206(c)(1)(ii). Provider shall comply with any corrective action directed by Company to remedy any failure to comply with timely access to care obligations. (State Contract § 1.13.1.2)

32. Database Screening and Criminal Background Check of Employees. Provider shall comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Enrollees and/or access to Enrollees' PHI. Provider is prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.20.10 of the State Contract, entitled "Prohibited Affiliations and Exclusions." Provider shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. Provider shall immediately report to Company any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate this Addendum as provided under State and/or federal law. (State Contract § 1.14.1.1)

33. Prohibited Payments. Provider acknowledges that Company will not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services (State Contract § 1.16.2.4):

33.1 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

33.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

33.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

33.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

33.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (State Contract § 1.7.15)

33.6 Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with § 1.20.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (State Contract § 1.16.2.2).

33.7 In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include: in accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to a Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include:

33.8 Health-acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of HHS under § 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of the Act; other than DVT/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients; and

33.9 Conditions meeting the following criteria:

a) Is identified in the State Plan;

b) Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

c) Has a negative consequence for the Enrollee;

d) Is auditable; and

e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

34. Prohibited Affiliations and Exclusions.

34.1 Provider acknowledges that Company may not contract with Providers excluded from participation in federal health care programs, and may not contract for the provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly: (i) with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in

accordance with 42 C.F.R. § 438.808(a), and 438.808(b)(2); (ii) with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(a); or (iii) with any individual or entity that is excluded from participation in any federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(b). Moreover, Company may not employ or contract, directly or indirectly, for the furnishing of health care, services: (i) with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(a); or (ii) with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(b). Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (State Contract §1.20.10). Health Plan may immediately terminate this Addendum in the event that Provider comes within any such prohibition or exclusion. Provider shall not receive any payment hereunder using Medicaid funds for services or items as provided in §1.20.10 of the State Contract. (State Contract § 1.20.10.3)

34.2 No person who has been involved in any manner in the development of this State Contract while employed by the State of Oklahoma shall be employed by the Company to fulfill any of the services provided under the State Contract, in accordance with 74 O.S. § 85.42(B) (State Contract § 1.20.10.3)

34.3 Provider acknowledges that Company may not contract with: (i) any such person or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal, state, local department, or agency; (ii) any such person or entity that has been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property within three years of the Health Plan's contract with the person or entity; (iii) any such person or entity that is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in the previous paragraph; or (iv) Any such person or entity that has had one or more public (federal, state, or local) contracts terminated for cause or default within three years of the Health Plan's contract with the person or entity. (State Contract § 1.20.10.3)

35. Off-Shoring. In accordance with 42 C.F.R. § 438.602(i), Company shall not enter into any subcontract for the performance of any duty under this State Contract in which such services are to be transmitted or performed outside of the United States nor will any claims be paid by Company to a Network Provider, out-of-Network Provider, Subcontractor, or financial institution located outside of the U.S. The purchase of offshore services is expressly prohibited. (State Contract § 4.5.1)

36. Provider Right to Support Enrollee Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports an Enrollee's Appeal. (State Contract § 1.14.1.2)

37. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (State Contract § 1.23.1.18)

38. Grievances and Appeals System. Provider acknowledges that it has received the following information regarding Company's Grievance and Appeals system. In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), Company operates an Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances. In accordance with the requirements of 42 C.F.R. § 438.402, Company's Grievances and Appeals System allows a Enrollee (or his or her Authorized Representative) to file a Grievance with Company, either orally or in writing, at any time, and to subsequently to request an Appeal with Company, with the ability for the Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. An Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to Company, which may be filed either orally or in writing. Unless the Enrollee is requesting an expedited resolution, an Enrollee's oral request for an Appeal must be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made. Company will make assistance available to the Enrollee with filing Grievances and Appeals including: provision of reasonable assistance to Enrollees in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Enrollee care support staff; (iv) providing auxiliary aids and services upon request, such as providing interpreter services; and (v) providing toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 C.F.R. 438.406(a). An Enrollee may be represented by an Authorized Representative, may present evidence and testimony, may make legal and factual arguments and the Company shall make Enrollee's case file available to the Enrollee at no charge. Enrollee has the right to request a State Fair Hearing by filing a request within 120 Days after receiving notice that the Adverse Benefit Determination has been upheld on Appeal. Enrollee has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing., Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Enrollee, as specified in 42 § 438.420(b)(5). (State Contract § 1.18 et. seq.)

39. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall return overpayments within 60 Days after the date on which the Overpayment was identified and shall notify Company in writing of the reason for the Overpayment. Provider acknowledges that if an Overpayment is identified by OHCA rather than by Company, OHCA may recover the Overpayment directly from Provider, or OHCA may require Company to recover and send the Overpayment to OHCA as directed by the OHCA Program Integrity and Accountability Unit. (State Contract §1.20.11.6)

40. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect Program enrollment. Enrollees who become Dual Eligible Individuals will be disenrolled as of their Medicare eligibility effective date. In the event that an Enrollee becomes retroactively Medicare eligible, Company will recover any claims payments made to Provider during the months of retroactive Medicare eligibility. Provider shall submit the claim to Medicare for reimbursement in such instances. (State Contract § 1.6.10)

41. Electronic Visit Verification. If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (State Contract § 1.21.2)

42. Encounter Data. Provider shall cooperate with Company's Encounter Data submittal requirements and shall submit required Encounter Data in accordance with Company's automated Encounter Data system, and Provider shall accept and use the State-assigned Provider IDs for Encounter Data submissions and shall

accept and use the State eMPI/Medicaid IDs for Enrollees. Provider shall submit complete Encounter Data and claims data timely and in sufficient detail to support detailed utilization and tracking and financial reporting. (State Contract §§ 1.21.7 et. seq.)

43. Provider Reconsiderations and Provider Appeals. Provider acknowledges: (A) receipt from Company of the link to Company's website containing, among other things, the Provider Manual(s) detailing, among other things, the policies and procedures for (i) Company's reconsideration of decisions adverse to Provider; and (ii) Provider appeals of such adverse decisions; and (B) the availability to Provider, at the time of entering into this Addendum and upon Provider's request, of a paper copy of the Provider Manual(s). Provider shall comply with such policies and procedures in pursuing Reconsiderations and Appeals. Appeals of Company decisions adverse to the Provider shall be made in writing within 30 Calendar Days. (State Contract § 1.15.6)

44. Health Information Exchange ("***HIE***"). Provider shall comply with 63 O.S. §§ 1-133, and all subsequently promulgated rules, relating to participation in the State's SDE-HIE for the submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery. Encounter Data will include servicing provider data as required by 42 CFR § 438.242(c) (State Contract § 1.21.8)

45. Compliance with Law.

45.1 Changes in Law/Interpretation of Laws. The Parties to this Addendum acknowledge that Medicaid managed care plans are highly regulated by federal statutes and regulations. The Parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The Parties acknowledge and expect that changes may occur over the term of this Addendum regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Addendum, the Parties shall be mutually bound by the amended requirements in effect at any given time following the effective date of this Addendum. The explicit inclusion of some statutory and regulatory duties in this Addendum shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Addendum shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed. If any portion of this Addendum is found to be in violation of State or federal statutes, that portion shall be stricken from this Addendum and the remainder of this Addendum and Agreement shall remain in full force and effect. (State Contract § 1.2.20.5)

45.2 Compliance with Specific Laws. In accordance with 42 C.F.R. § 438.3(f)(1), Provider shall comply, and shall ensure that its officers, employees, Contracted Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies and guidance including but not limited to:

a) Federal requirements within 42 C.F.R. §§ 438.1, et seq., as applicable to MCOs
b) Title VI of the Civil Rights Act of 1964;
c) The Age Discrimination Act of 1975;
d) The Rehabilitation Act of 1973;
e) Title IX of the Education Amendments of 1972 (regarding education programs and activities);
f) The Americans with Disabilities Act of 1990 as amended;
g) Section 1557 of the Patient Protection and Affordable Care Act (ACA);

h) Health Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2 (HIPAA);
i) Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2 MHPAEA);
j) Oklahoma Electronic and Information Technology Accessibility (EITA) Act (Oklahoma 2004 House Bill (HB) 2197) regarding information technology accessibility standards for persons with disabilities;
k) Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, et seq
l) Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
m) Oklahoma Worker's Compensation Act, 85A O.S. §§ 1 *et seq.*;
n) 74 O.S. §§ 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to Company's entity) purchased with monies received from OHCA pursuant to the State Contract;
o) Title 317 of the Oklahoma Administrative Code ("OAC");
p) Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
q) Deceptive Trade Practices; Unfair Business Practices. (State Contract § 1.2.20.5)

45.3 Deceptive Trade Practices Violations. Provider represents and warrants that neither Provider nor any of its Subcontractors: (i) have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.*; (ii) have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding; (iii) have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding. (State Contract § 1.2.20.5)

45.4 Enrollees' Rights. In accordance with 42 C.F.R. § 438.100(a)(2), Provider shall comply with any applicable federal and State laws that pertain to Enrollees' rights and shall ensure that its employees and Contracted Providers observe and protect those rights. (State Contract § 1.2.20.5)

46. Primary Care Providers ("***PCP***"). The following provisions shall apply if Provider is a PCP. (State Contract §1.14.1.3). Provider shall:

a) deliver primary care services and follow-up care;
b) utilize and practice evidence-based medicine and clinical decision supports;
c) screen Enrollees for behavioral health disorders and conditions;
d) make referrals for Behavioral Health Services, specialty care and other covered services and, when applicable, work with Company to allow Enrollees to directly access a specialist as appropriate for an Enrollee's condition and identified needs;
e) maintain a current medical record for the Enrollee;
f) use health information technology to support care delivery;
g) provide care coordination in accordance with the Enrollee's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Enrollee's Care Manager;
h) ensure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;
i) engage active participation by the Enrollee and the Enrollee's family, Authorized Representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;
j) provide access to medical care 24 hours per day, 7 days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
k) provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and

l) participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.
m) maintain medical records documenting all referrals of Enrollees.
n) meet the following "Appointment Time" obligations for the applicable Provider-type category (State Contract §§ 1.14.3.1and 1.14.3.2):

Service Category	**Appointment Time**
Adult PCP Pediatric PCP	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCP shall allow for at least some same-day appointments to meet acute care needs.
OB/GYN	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. Maternity Care: • First Trimester – Not to exceed 14 Calendar Days • Second Trimester – Not to exceed seven Calendar Days • Third Trimester – Not to exceed three Business Days
Adult Specialty Pediatric Specialty	• Not to exceed 60 Days from date of the Enrollee's request for routine appointment. • Within 24 hours for Urgent Care.

For purposes of the "Appointment Time" chart above, "Specialty" includes, but is not limited to, the following specialty provider-types: anesthesiologist assistants; physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package; audiologists; nutritionists; opticians; optometrists; podiatrists; and therapists to provide specialty care services as required in the SoonerSelect Program benefit package. (State Contract §1.14.3.3)

47. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.
a) Provider shall provide inpatient psychiatric services to Enrollees and schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven Calendar Days from the date of discharge.
b) Provider shall complete the ODMHSAS Customer Data Core form located at odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the State Contract;
c) Provider shall provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.
d) Provider agrees that Company will obtain the appropriate Enrollee releases to share clinical information and Enrollee health records with community-based behavioral health Providers, as

requested, consistent with all State and federal confidentiality requirements and in accordance with Company policy and procedures. (State Contract §1.14.1.3.2)

e) Provider shall meet the following "Appointment Time" obligations (State Contract §1.14.3.4):

Service Category	Appointment Time
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within seven Days for residential care and hospitalization. • Within 24 hours for Urgent Care.

f) If requested by the Enrollee and to the extent possible for OHCA-defined services that are reimbursable through Telehealth, Provider shall provide for the delivery of Behavioral Health Services via Telehealth. (State Contract §1.14.3.4)

48. Laboratory Testing Sites. The following provisions shall apply if Provider is a laboratory testing site. Provider shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration, along with a CLIA identification number. Provider understands that Company will maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Enrollees. Any Provider performing laboratory tests is required to be certified under CLIA. OHCA will continue to update the Provider file with CLIA information, which Provider acknowledges will make laboratory certification information available to Company on the Medicaid Provider file. (State Contract §1.14.1.3.3)

50. Pharmacy Providers. In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the pharmacist in charge must also be licensed by the Oklahoma State Board of Pharmacy. (State Contract § 1.14.3.5)

STATE LAW REGULATORY REQUIREMENTS

This schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Enrollees enrolled in or covered by this Product may be set forth in the Provider Manual or another Addendum. To the extent that a Coverage Agreement, or an Enrollee, is subject to the law cited in the parenthetical at the end of a provision on this Schedule B, such provision will apply to the rendering of Covered Services to an Enrollee with such Coverage Agreement, or to such Enrollee, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, an Enrollee shall not be liable to Participating Provider for any sums owed by Payor. Neither Participating Provider nor the agent, trustee or assignee of Participating Provider may maintain an action at law against an Enrollee to collect sums owed by Payor. (OKLA. STAT. ANN. tit. 36, § 6913.D)

OK-2 Termination.

(a) If Provider terminates the Agreement or Participating Provider voluntarily chooses to discontinue participation with respect to a particular Product, Provider or Participating Provider will give Company written notice by the longer of 90 days or the number of days set forth in the Agreement prior to such termination. (OKLA. STAT. ANN. tit. 36, § 6913.F; OKLA. ADMIN. CODE 365:40-5-71(4)(C))

(b) If Health Plan terminates the Agreement without cause, Health Plan will give Provider at least 90 days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than 90 days' advance notice are set forth in the Agreement (OKLA. ADMIN. CODE 365:40-5-71(1).

OK-3 Continuation of Care.

(a) If Payor becomes insolvent, Participating Provider shall provide services for the duration of the period after Payor's insolvency for which premium payment has been made, for Enrollees confined on the date of insolvency in an inpatient facility, and for pregnant Enrollees, until Enrollee's discharge from inpatient facilities, Enrollee's delivery and discharge if pregnant, and/or expiration of benefits under the Coverage Agreement. (OKLA. STAT. ANN. tit. 36, § 6913.E.2; OKLA. ADMIN. CODE 365:40-5-72(b))

(b) Following termination, Participating Provider will continue to provide services, at the terms and price under the Agreement, for up to 90 days from the date of notice for an Enrollee who: (i) has a degenerative and disabling condition or disease; (ii) has entered the third trimester of pregnancy; or (iii) is terminally ill. With respect to Enrollees that have entered the third trimester of pregnancy, terminated Participating Provider shall continue to provide services, at the terms and price under the Agreement, through at least six weeks of postpartum evaluation. (OKLA. ADMIN. CODE 365:40-5-71(4)(A).

(c) If Company or Payor authorizes such continuation of care, Participating Provider will: (i) accept reimbursement set forth in the Agreement as payment in full, (ii) adhere to the quality assurance requirements and provide necessary medical information regulated to such care, and (iii) otherwise adhere to applicable policies and procedures regarding references, and obtaining preauthorization and treatment plan approval, from the Company or Payor. (OKLA. ADMIN. CODE 365:40-5-71(4)(d).

OK-4 Delegation of Claims Processing. If Company has delegated its claims processing functions to Provider, Provider shall comply with the requirements of applicable Oklahoma law, including without limitation

Chapter 40, Subchapter 5, Part 23 of the Insurance Department Regulations. (OKLA. ADMIN. CODE 365:40-5-127(d))

OK-5 Network Lease. Participating Provider expressly authorizes Company to sell, lease and otherwise transfer information regarding the payment or reimbursement terms of the Agreement, and acknowledges that Participating Provider has received prior adequate notification of such other contracting parties. (OKLA. STAT. ANN. tit. 36, §§ 1219.3.B; 7302.B)

OK-6 Indemnification. If the Agreement requires indemnification by Participating Provider, such indemnification will not apply, to the extent required by law, with respect to liability imposed by the Oklahoma Managed Health Care Reform and Accountability Act. (OKLA. STAT. ANN. tit. 36, § 6593.E).

OK-7 Contract Disclosures. Participating Provider acknowledges and agrees that the Agreement (including the Provider Manual) discloses the following:

(a) the mailing address, including a physical address, where claims are to be sent for processing whether it be the address of the Payor, a delegated claims processor, or any other entity, including a clearing house or a repricing company designated by the Payor to receive claims;

(b) the telephone number to which Participating Provider's questions and concerns regarding claims may be directed; and

(c) the mailing address, including physical address, of any separate claims processing centers for specific types of services, if applicable. (OKLA. ADMIN. CODE 365:40-5-127(a)).

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. **Name of Contract:** Evident Thrive Communications Center
3. **Contract Parties: Evident Thrive and MRMC**

4. **Contract Type Services:** Service Contract

5. **Impacted Hospital Departments: Hospital Records**

6. **Contract Summary:** To provide access and Service to the communication center of CPSI, will allow faxing from the medical record and promotes interoperability.

7. **Cost: No increase in monthly fee**

8. **Prior Cost:**

9. **Term: Will run the length of the original Thrive Contract**
10.
11. **Termination Clause: None**

12. **Other:**

Evident™

Subscription Services Agreement
Service Addendum

This **SERVICE ADDENDUM** (this "Addendum") dated this **5th** day of **December 2023** is hereby entered into by and between **EVIDENT, LLC** ("Evident") and **MANGUM REGIONAL MEDICAL CENTER** ("Customer").

WHEREAS, Customer wishes to obtain additional services from Evident under the terms and conditions of the Subscription Services Agreement (the "Agreement") executed by and between the parties and dated **December 19, 2018** and Evident is willing to provide such additional services;

NOW THEREFORE, it is mutually understood and agreed to by the parties that:

1. **Engagement for Additional Services:** Evident agrees to furnish, and Customer agrees to accept and pay for, the Service(s) as set forth in the Exhibit A attached hereto under the terms and conditions of the Agreement.

2. **Effective Date:** The Service Term for each Exhibit A attached hereto, unless otherwise specified therein, shall be deemed to have commenced on the first day of the first month in which service is provided under the given Exhibit A.

3. **Charges:**
   (a) **Service Fees:** Customer agrees to pay Evident the fees set forth in EXHIBIT A. For the avoidance of doubt, the monthly subscription fees specified in EXHIBIT A are in addition to Customer's existing monthly subscription fee obligations.
   (b) **Fee Increases:** Notwithstanding anything in the Agreement to the contrary, Customer understands that the monthly subscription fees may be increased by Evident by not more than five percent (5%) on an annual basis without further notice.

4. **Entire Addendum:** This Addendum, to include Exhibit A, sets forth the entire understanding of the parties hereto with respect to the subject matter contained herein and supersedes all other oral or written representations with respect to the same.

5. **Miscellaneous:** Except as may be specifically modified in this Addendum, all other terms and conditions of the Agreement that are in effect as of the date of this Addendum shall remain fully in force. In the event of a conflict between this Addendum and the Agreement or any prior addendum or amendment thereto, the terms and conditions of this Addendum shall govern and control. This Addendum may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute a single instrument.

[*Signature page follows*]

Evident™

Subscription Services Agreement
Service Addendum

IN WITNESS WHEREOF, the parties hereto have executed this Subscription Services Agreement Service Addendum

MANGUM REGIONAL MEDICAL CENTER
1 Wickersham Drive
Mangum, OK 73554

By: _____
(Authorized Signature)

Name: _____
(Printed)

Title: _____

Date: _____

EVIDENT, LLC
54 Saint Emanuel Street
Mobile, AL 36602

By: _____
(Authorized Signature)

Name: Christopher L. Fowler
(Printed)

Title: Chief Executive Officer

Date: _____

Evident™

Subscription Services Agreement
Exhibit A
Services and Service Fees

Service: Software Subscription – Communication Center

A. **Services and Fees:**

1. **Services:** The Software Subscription will include:

   - Subscription to access and use the Communication Center software (the "Service Software");
   - Communication Center functionality includes:
     - Internal Electronic Mail – emails may be saved to the patient's record.
     - Secure Text – for both internal and external hospital network contacts and text conversations may be saved to the patient's record.
   - Integrated faxing available within the Service Software via third party.
   - Configuration and implementation of the Service Software.
   - Unlimited access to the Service Software.
   - Training via web-based sessions to educate Customer personnel in the operation of the Service Software.
   - Provision of ongoing support for the Service Software to include routine updates and updates and help desk services.

Subscription/Limitations: Customer understands and agrees that it is being granted a subscription to access and use the Service Software during the term of this Exhibit A. Evident expressly reserves and Customer expressly consents that the entire right and title to the Service Software is and shall remain in Evident. Evident has the exclusive right to protect by copyright or otherwise, to reproduce, publish, sell and distribute the Service Software to any other customer. Customer may not rent, lease, transfer, modify, assign, loan, resell, act as a service bureau, time share or otherwise transfer the Service Software or any portion thereof. Customer may not permit third parties to benefit from the use or functionality of the Service Software via a timesharing, service bureau or other arrangement.

Service Requirement: The Internet Faxing functionality **requires** the execution and maintenance of an agreement between Customer and Faxage. Costs associated with Faxage services are not included in the fees specified herein and shall be the responsibility of Customer. **Termination of Faxage services will result in the unavailability of the Internet Faxing function.**

Note: Software Subscriptions do not include connectivity.

Evident™

Subscription Services Agreement
Exhibit A
Services and Service Fees

Service: Software Subscription – Communication Center

2. **Service Fees/Payment Schedule:**
   a. **Initial Subscription Fee**: Included
   b. **Monthly Subscription Fee:** Included
   c. **Inclusion in nTrust:** The Initial Subscription Fee and, so long as the Exhibit A for Electronic Health Record (EHR) Services remains in effect, the Monthly Subscription Fee are included in the service fees for EHR Services.

B. **Service Term:** Five (5) Years

C **Third Party Software/Content:** The Service Software incorporates third party software and content which is subject to the following additional terms and conditions which are hereby incorporated into the Agreement so long as this Exhibit A remains in effect.

1. **QliqSOFT:** The Service Software utilizes software which is owned and licensed by QliqSOFT. QliqSOFT's Terms of Use and Privacy Policy are applicable to this product and can be viewed at https://www.qliqsoft.com/terms-of-service/ and https://www.qliqsoft.com/privacy-policy/ respectively. By using the Service Software, Customer expressly agrees to QliqSOFT's Terms of Use and Privacy Policy.

Mangum Regional Medical Center

FY 2024 BUDGET - Income Statement Summary

Accrual Basis

	CY Annualized	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	FY24	Budget vs CY Incr (Decr)	% Incr (Decr)
Patient service revenue, gross	26,790,926	2,273,698	1,986,356	2,310,452	2,107,607	2,230,778	2,097,891	2,239,141	2,273,155	2,219,312	2,192,724	2,160,324	2,247,657	26,339,096	(451,830)	-1.7%
Contractual adjustments	(9,587,114)	(811,935)	(578,835)	(846,535)	(677,735)	(774,835)	(669,835)	(783,135)	(816,635)	(787,735)	(740,135)	(731,735)	(793,935)	(9,013,017)	574,097	-6.0%
Provision for bad debts	(973,213)	(82,595)	(72,595)	(84,595)	(76,595)	(80,595)	(75,595)	(81,595)	(82,595)	(80,595)	(79,595)	(78,595)	(81,595)	(957,137)	16,076	-1.7%
Patient service revenue, net	16,230,599	1,379,169	1,334,926	1,379,323	1,353,278	1,375,348	1,352,462	1,374,412	1,373,926	1,350,983	1,372,995	1,349,994	1,372,128	16,368,942	138,343	0.9%
340B revenue	151,283	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	12,607	151,283	-	0.0%
Other revenue	37,150	3,098	3,089	3,099	3,089	3,098	3,093	3,097	3,102	3,094	3,099	3,095	3,096	37,151	1	0.0%
Total operating revenue	16,419,032	1,394,874	1,350,623	1,395,029	1,368,974	1,391,053	1,368,161	1,390,116	1,389,635	1,366,684	1,388,701	1,365,696	1,387,831	16,557,376	138,344	
Salaries and benefits	4,881,323	393,394	372,079	393,394	389,736	400,394	389,736	400,394	400,394	389,736	400,394	389,736	400,394	4,719,779	(161,544)	-3.3%
Contract labor	4,421,897	368,478	345,347	368,478	349,581	361,146	349,581	361,146	361,146	349,581	361,146	349,581	361,146	4,286,356	(135,541)	-3.1%
Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0%
Professional fees	1,749,018	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	143,994	1,727,934	(21,084)	-1.2%
Purchase Services	1,604,087	141,523	141,304	141,523	141,413	141,523	141,413	141,523	141,523	141,413	141,523	141,413	141,523	1,697,615	93,528	5.8%
Management fees	2,700,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	225,000	2,700,000	-	0.0%
Supplies expense	1,148,749	97,944	94,132	100,444	95,038	97,944	95,038	97,944	97,944	95,038	97,944	95,038	97,944	1,162,390	13,640	1.2%
Rental expense	361,136	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	30,300	363,605	2,468	0.7%
Utilities	220,295	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	18,358	220,295	-	0.0%
Travel & Meals	13,022	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	1,085	13,021	(1)	0.0%
Repairs & Maintenance	141,108	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	12,130	145,560	4,452	3.2%
Insurance expense	136,977	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	11,415	136,977	-	0.0%
340B expenses	98,446	8,187	8,084	8,187	8,135	8,187	8,135	8,187	8,187	8,135	8,187	8,135	8,187	97,934	(512)	-0.5%
Other expense	260,618	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	20,773	249,279	(11,339)	-4.4%
Total operating expenses	17,736,677	1,472,581	1,424,002	1,475,081	1,446,959	1,472,249	1,446,959	1,472,249	1,472,249	1,446,959	1,472,249	1,446,959	1,472,249	17,520,745	(215,932)	-1.2%
EBIDA	(1,317,646)	(77,707)	(73,379)	(80,053)	(77,985)	(81,196)	(78,798)	(82,133)	(82,614)	(80,275)	(83,548)	(81,263)	(84,418)	(963,369)	354,276	
Interest expense	86,161	29,916	28,774	27,623	26,461	25,958	25,451	24,938	24,420	23,897	23,368	22,835	22,295	305,937	219,776	255.1%
Depreciation	596,375	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	49,698	596,375	-	0.0%
Net income (loss)	(2,000,182)	(157,321)	(151,851)	(157,373)	(154,144)	(156,852)	(153,946)	(156,769)	(156,732)	(153,870)	(156,615)	(153,795)	(156,411)	(1,865,681)	134,501	-6.7%
Non-Operating Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0%
Change in net assets	**(2,000,182)**	**(157,321)**	**(151,851)**	**(157,373)**	**(154,144)**	**(156,852)**	**(153,946)**	**(156,769)**	**(156,732)**	**(153,870)**	**(156,615)**	**(153,795)**	**(156,411)**	**(1,865,681)**	**134,501**	-6.7%

KEY STATISTICAL DATA

Month	CY Annualized	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	FY24	Budget vs CY Incr (Decr)	% Incr (Decr)
Days in Month	**365**	**31**	**29**	**31**	**30**	**31**	**30**	**31**	**31**	**30**	**31**	**30**	**31**	**366**	**1**	0.27%
Business Days	**249**	**21**	**20**	**21**	**22**	**22**	**22**	**19**	**22**	**22**	**20**	**19**	**21**	**251**	**2**	0.80%
Acute Patient Days	**573**	**47**	**44**	**47**	**46**	**47**	**46**	**47**	**47**	**46**	**47**	**46**	**48**	**558**	**-15**	-2.62%
Swing-Bed Patient Days	**3562**	**294**	**275**	**294**	**284**	**294**	**284**	**294**	**294**	**284**	**294**	**284**	**293**	**3468**	**-94**	-2.64%
Acute and Swing-Bed Patient Days	**4135**	**341**	**319**	**341**	**330**	**341**	**330**	**341**	**341**	**330**	**341**	**330**	**341**	**4026**	**-109**	-2.64%
TOTAL OP VISITS or Dept Specific Stats	**2126**	**189**	**147**	**193**	**147**	**188**	**163**	**183**	**207**	**169**	**191**	**175**	**180**	**2132**	**6**	0.28%
ER visits	**1950**	**171**	**124**	**168**	**163**	**164**	**126**	**143**	**198**	**191**	**202**	**157**	**159**	**1966**	**16**	0.82%

Mangum Regional Medical Center

Mangum City Hospital Authority
2024 Schedule of Regular Meetings

The regular meetings of the Trustees of the Mangum City Hospital Authority will be held on the following dates. The meetings are on the fourth Tuesday of each month, unless there is a holiday, beginning at 5:00pm. The meetings will be held in the City Administrative Building, 130 N Oklahoma Ave., Mangum, Oklahoma.

2024 Meeting Dates are as follows:

Tuesday, January 23, 2024
Tuesday, February 27, 2024
Tuesday, March 26, 2024
Tuesday, April 23, 2024
Tuesday, May 28, 2024
Tuesday, June 25, 2024
Tuesday, July 23, 2024
Tuesday, August 27, 2024
Tuesday, September 24, 2024
Tuesday, October 22, 2024
Tuesday, November 26, 2024
Tuesday, December 17, 2024 ** Meeting schedule earlier due to Christmas

Filed in the office of the City Clerk at 10:00am on December 1st, 2023.

_____
Ally Kendall, City Clerk